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

## HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

**DAVID R. OBEY, Wisconsin, *Chairman***

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NOTE: Under Committee Rules, Mr. Obey, as Chairman of the Full Committee, and Mr. Lewis, as Ranking Minority Member of the Full Committee, are authorized to sit as Members of all Subcommittees.

CHERYL SMITH, SUE QUANTIUS, NICOLE KUNKO,
STEPHEN STEIGLEDER, and ALBERT LEE,
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## PART 5



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

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WEDNESDAY, MARCH 25, 2009.

## RAISING WAGES AND LIVING STANDARDS FOR FAMILIES AND WORKERS

Mr. OBEY. Well, good morning, everyone.

Before we start, I was telling Professor Krugman I know he came in harried and worried he was going to be late. I recall, when I was in college, one of my best friends was a person by the name of Bill Steiger, who later came to Congress two years before I did. Unfortunately, he was on the wrong side of the political aisle but we remained very good friends. But we were both in a constitutional law class together and I remember the second day of class our professor was David Feldman, who was tough. He was like the old character you saw in The Paper Chase, the old TV series a long while ago.

And Feldman had begun his lecture when Bill Steiger walked in, about two minutes late to the class, and Feldman pulled his glasses down on the end of his nose, looked over at Steiger and said, Mr. Steiger, he said, let me apologize. He said, ordinarily we would have an usher escort you to your seat. Unfortunately, our carnations have not yet arrived.

So I got a kick out of it to think that it was the professor who was two minutes late, rather than the student. But I know how tough it is to get down here. I appreciate your coming and I appreciate all the panelists being with us here today.

Let me simply make a few remarks, Mr. Tiahrt can make a couple remarks, and then turn to our first witness.

This Subcommittee has a huge amount of work to do and it is really, I think, the workhorse of our domestic discretionary portion of the budget, certainly in terms of the work that we do in trying to deliver help and services to millions of American families all across the Country. And we have had an especially rocky time trying to deal with, first of all, the economic stimulus package and then the omnibus appropriations bill. And now, shortly, we will have a budget from the new President and we will have to act on that in short order.

But I thought that it would be important to place everything we have been doing, as well as everything the President will be doing in his new budget, in the proper context, and here is what I mean.

Both parties seem to have a narrative about what has happened in the economy. The Republican party seems, by and large, to say,

well, this was all caused, or largely caused, by what happened in the housing market and it is the collapse of housing that has led to this problem. And I think the Democratic narrative seems to be, well, if those guys on Wall Street had just behaved like adults, we would not be in this mess.

I frankly think that both narratives are oversimplified. I will agree that those two events were the triggering events that caused a lot of problems in the economy, but I think there is an underlying problem that I would like to see addressed today, and that problem is simply this: From World War II until about 1973, this economy grew in a fairly healthy fashion, and that increased prosperity was shared roughly across the board, regardless of income group.

That started to change around the middle 1970s, and from 1980 on we saw a much larger share of income growth go into the pockets of the most well-off 10 percent; and certainly, in this decade, we have seen an even larger share of income growth in the economy go into the pockets of the top 10 percent.

And that has meant that the other 90 percent have really been struggling to stay even, they have been struggling for table scraps. And I think they tried to maintain their living standard or expand their living standard by borrowing, so they borrowed for lots of things—for education, to pay for health care, to pay for consumer goods, to pay for cars, you name it. And that house of cards sort of came crashing down when the housing and banking and credit crises hit.

So now we have the question not only of how we get out of this recession, but also how we build the kind of economy in which all families can share in what we hope will be the renewed growth in prosperity down the line once this recession is over.

So we are going to have two panels today to talk about that problem, and especially with our first panel this morning we will have a focus on the inequality that has developed in this society and what might be done to deal with that inequality as we try to dig ourselves out of this recession; and our first witness, Dr. Krugman, will address himself to that.

But before he does, I would like to call on Mr. Tiahrt for whatever comments he would like to make.

Mr. TIAHRT. Thank you, Mr. Chairman. I would like to also welcome the witnesses for both panels and welcome Dr. Krugman.

Mr. Chairman, I want to thank you for putting today's hearing together. I think our discussion today will really get to the heart of the philosophical differences in America when it comes to the issues surrounding our economy. There is no question in my mind that everyone in this room wants to return to our Country's historic economic success. I think there is considerable disagreement on how we get there. But I think at least we can start with the statement that we all want to end up in the same place, a place where our children can start a business or find a high quality and high-paying job.

Today's discussion—indeed, the focus of the entire Congress—should be on how we renew the dream, the American dream. I do not subscribe to Keynesian economics. Every thin dime Congress spends or, more appropriately, borrows is the functional equivalent

of a thick quarter that our children in Kansas and across the rest of America will have to pay back later.

And I have yet to see a Government job that pays for itself. I do not believe that massive deficit spending on things like comparative effectiveness research, which I believe will read to rationed health care, or propping up local and State governments, as done by the stimulus bill recently, is going to create the private sector jobs in the short term or revive our economy.

All we seem to be creating is more bureaucracy. And, as I said, I have yet to see a government job that pays for itself.

My view is that one of the worst things that we can do as Congress is to follow macro economic policies that result in raising taxes on American citizens and employers. We have enjoyed economic success in the past in large part because of our relatively low tax rates. To raise taxes will, in my view, not only hurt the American wallets immediately, but also stifle the prospect of economic prosperity in America in the near future. Sadly, this is where the Administration is headed.

What is even more concerning to me is the discussion of a second stimulus bill. Frankly, I do not think the first one has been around long enough to determine it has had any impact. My view is that the first stimulus bill will not work, not because it is not big enough, but because it is misguided in its economics. To pass a second stimulus bill that makes the same mistakes as the first seems unwise to me.

The President has made a great deal recently about Republicans being the party of no. Simply not true. We have great ideas that simply have been shut out of the process.

And, by the way, Chairman, I want to thank you for not shutting us out of this process today.

I am ready to say yes; to say yes to policies that will help rebuild a sound economy for today and the future. We need to pursue common sense microeconomic policies that work and reduce the uncontrollable costs that people are facing, those who keep and create jobs here in America. And I think it starts by reducing the size and scope of the government that has strangled growth.

We need to move towards a competitive business tax whose rates will compete with the rest of the world. Ireland, though it has been caught up in a worldwide downturn, is well poised to recover as it welcome companies and fosters growth.

We need desperately to pursue common sense approaches to regulation, with a cost-base justification of the rules our bureaucrats impose on those who keep and create jobs.

We need to be energy independent. I think it is well passed the time that we adopt a loser-pays approach to litigation, as the United Kingdom follows.

And, finally, I hope we discuss the rising cost of health care, in addition to ensuring health care access, which is one of the biggest burdens on our economy. I believe a consumer-based approach to health care delivery can benefit patients and the economy.

These ideas build the fundamental strength of our economy, and that is how we can renew the dream and renew the opportunity for ourselves and our children.

I would just like to close by saying although we are struggling today, I am confident and optimistic that the American people will overcome this downturn, as they always have. My concern is that borrowing and spending will prolong the pain, instead of fixing the problem.

I look forward to the discussion today and yield back.

Mr. OBEY. Thank you.

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WEDNESDAY, MARCH 25, 2009.

## RAISING WAGES AND LIVING STANDARDS FOR FAMILIES AND WORKERS

### WITNESS

### PAUL KRUGMAN, PH.D., NOBEL LAUREATE IN ECONOMICS

Mr. OBEY. Let me simply welcome our first witness, Dr. Paul Krugman. As I mentioned earlier, Mr. Krugman is a distinguished Nobel Prize winner and Professor of Economics at Princeton University. He is also a Centenary Professor at the London School of Economics and an op-ed columnist for The New York Times, and one of the 50 most influential economists in the world today. His professional reputation rests significantly on his work in international trade and finance. He is the author or editor of 20 books and more than 200 papers. He is also well known for his work on income distribution and public policy, which is the subject of his remarks, largely, this morning.

I want to mention that we have agreed to let Dr. Krugman go at 11:30 so he can make a prior commitment at the Swedish Embassy.

I appreciate your being here, Dr. Krugman. Please proceed with your statement.

Mr. KRUGMAN. Thank you, Mr. Chairman. And thank you, Mr. Tiahrt.

Well, as everyone is aware, this hearing is taking place at a time of economic crisis. Unemployment is rising steeply and the outlook for working Americans is the grimmest it has been since The Great Depression. Two years ago, few, including myself, imagined that things could get this bad.

We all hope that the President's policies can pull the economy out of its tailspin. But even if he does succeed in that goal, that will not be enough. The U.S. economy was failing to serve the needs of the American people even during the good years of the current business cycle.

I find it instructive and depressing to consider the state of the economy for ordinary Americans in 2007, which was as good as it got in recent years. By almost any measure, the economy was worse for a majority of families in 2007 than it had been in 2000, and there was, if you believe the numbers, which I mostly do, surprisingly little progress even over a much longer period, reaching back three decades.

So median family income, adjusted for inflation, was actually slightly lower in 2007 than it had been in 2000. And if we got back several decades, to 1979, we find that median income rose only 15

percent over a period of almost 30 years, less than half a percent annually. Virtually all of that rise, by the way—this is not a partisan point, but just an observation—took place during the Clinton years. That compares with sustained income growth at more than 2 percent a year during the great post-war boom, post-war generation.

The poverty rate in 2007, which was an alleged boom year, was 12.5 percent, not only higher than the 11.3 percent rate in 2000, but higher than the 11.7 percent rate in 1979. If one believes the numbers, none of America's economic growth over the past generation has trickled down to America's poor.

And the health insurance situation worsened substantially. The percentage of the American population without insurance rose sharply in the late 1980s and the early 1990s, sparking an unfortunately failed attempt at health reform. The situation then improved somewhat for a while, thanks to cost control and a booming economy. But since 2000 health care costs have once again risen much faster than wages, leading to a growing problem of uninsured Americans even when the economy is growing. It is almost certain that the current crisis will soon present us with a major crisis of lost health care coverage.

So why has a growing economy failed to deliver for ordinary Americans? One major reason is growing income inequality. Many of the gains in income went to a small minority of very well-off people, with most workers seeing little rise in real wages. Even using Census data, which missed the growth in the highest incomes, average household income rose twice as fast as median household income; that is, income growth over the past 30 years would have been twice as fast if it had not been for growing inequality.

There is also a secondary reason for the failure of economic growth to help many Americans, which is our dysfunctional health care system. We are unique among advanced countries in not having some form of universal coverage, yet we spend far more to cover 85 percent of our population than our counterparts spend to cover everyone, with no evidence that we receive correspondingly better care.

For both these reasons, there has been a remarkable disconnect between the state of the economy, as measured by the growth of GDP, and the experience of most Americans. And if that disconnect continues, recovering from the current recession, urgent though it is, will still leave major economic problems unsolved.

So what can we do to end the disconnect? Reducing income inequality is a difficult task. The truth is that while we have some ideas about what might work, there is little reason to be confident about the efficacy of whatever measures we try. The Great Compression of the New Deal, which created the middle class society of the post-war era, the society I grew up in, is an inspiring role model, but, in honesty, I cannot promise that we know how to repeat that experience.

Health care reform, on the other hand, is something we know can work. Study after study has demonstrated that the U.S. health care system is not just harsh and unfair, it is highly inefficient. We have extremely high administrative costs, largely because insurers work so hard not to cover the people who need insurance most. We

lag in the use of information technology. We have a combination of inadequate care for many Americans and vast spending on dubiously effective care for many other Americans.

I might also note that our health care system under-invests in preventive measures that could save money, as well as lives.

A reasonable estimate is that successful health reform could eventually save several percent of GDP while substantially improving the lives of most Americans. As anyone who has studied proposals to promote economic growth knows, that is huge. Even a drastic increase in private investment, achieved by whatever means, would be highly unlikely to yield that big a result.

Can we afford health care reform in the face of projected large fiscal deficits? To borrow a phrase, yes, we can. In fact, we must. First of all, there is no reason to be concerned about the level of deficits, per se, the dollar figure per year, in the near term, by which I mean the period likely to extend for three or four years before the economy recovers.

In normal times there is reason to worry that deficits will crowd out private investment and raise interest rates. In the current situation, however, the world economy is, in effect, suffering from an excess of desired saving. Even at a zero interest rate, businesses are not willing or able to invest all the savings the private sector wants to undertake. As a result, government deficits actually stimulate economic activity in the current situation by giving those savings a place to go. Those deficits do not crowd out private investment. In fact, they may well crowd it in.

We do need to worry about Government debt. There are real concerns about the sustainability of very high levels of debt in the future. However, we need to realize, even though this sounds striking, maybe a little crazy, that a trillion dollars, more or less, of debt over the next decade is virtually irrelevant to America's long-term fiscal position. That position is, instead, dominated by the rising projected costs of our entitlement programs, mainly Medicare and Medicaid.

And the only way to reign in Medicare and Medicaid costs is through a thorough reform of our health care system. To put off health care reform out of fear of deficits would be a monstrous case of being penny wise and pound foolish, sacrificing the Nation's long-run fiscal prospects for the sake of holding current numbers below some artificial threshold.

In dealing with the deficit, and also in dealing with health care, we need to take the long view, and that long view says that we should proceed with massive reform now.

Thank you.

[The information follows:]

PREPARED TESTIMONY FOR HEARING OF THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH, AND HUMAN SERVICES, MARCH 25, 2009

Paul Krugman

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We all hope that President Obama's policies can pull the economy out of its tailspin. But even if he does succeed in that goal, that will not be enough. For the U.S. economy was failing to serve the needs of the American people even during the "good" years of the current business cycle.

I find it instructive (and depressing) to consider the state of the economy for ordinary Americans in 2007 – which was as good as it got in recent years. By almost any measure, the economy was worse for most families in 2007 than it had been in 2000, the previous business cycle peak. And there was, if you believe the numbers, surprisingly little progress even over a longer period, reaching back three decades.

Thus, median family income, adjusted for inflation, was slightly lower in 2007 than it had been in 2000. And if we go back several business cycles, to 1979, we find that median income rose only 15 percent over a period of almost 30 years – less than half a percent annually. Virtually all of that rise, by the way, took place during the Clinton years. That compares with sustained income growth at more than 2 percent a year during the postwar generation.

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And the health insurance situation worsened substantially. The percentage of the American population without insurance rose sharply in the late 1980s and the early 1990s, sparking an unfortunately failed effort at health reform. The situation then improved somewhat thanks to cost control and a booming economy. But since 2000 health care costs have once again risen much faster than wages, leading to a growing problem of uninsured Americans even when the economy is growing. It's almost certain that the current crisis will soon present us with a major crisis of lost coverage.

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For both these reasons there has been a remarkable disconnect between the state of the economy, as measured by the growth of GDP, and the experience of most Americans. And if that disconnect continues, recovering from the current recession, urgent though it is, will still leave major economic problems unsolved.

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stimulate economic activity by giving those savings a place to do; they do not crowd out private investment, in fact they may well crowd it in.

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In dealing with the deficit, and also in dealing with health care, we need to take the long view. And that long view says that we should proceed with massive reform, now.

Thank you.

## Paul Krugman

Paul Krugman joined The New York Times in 1999 as a columnist on the Op-Ed Page and continues as professor of Economics and International Affairs at Princeton University.

On October 13, 2008, it was announced that Mr. Krugman would receive the Nobel Prize in Economics.

Mr. Krugman received his B.A. from Yale University in 1974 and his Ph.D. from MIT in 1977. He has taught at Yale, MIT and Stanford. At MIT he became the Ford International Professor of Economics.

Mr. Krugman is the author or editor of 20 books and more than 200 papers in professional journals and edited volumes. His professional reputation rests largely on work in international trade and finance; he is one of the founders of the "new trade theory," a major rethinking of the theory of international trade. In recognition of that work, in 1991 the American Economic Association awarded him its John Bates Clark medal, a prize given every two years to "that economist under forty who is adjudged to have made a significant contribution to economic knowledge." Mr. Krugman's current academic research is focused on economic and currency crises.

At the same time, Mr. Krugman has written extensively for a broader public audience. Some of his recent articles on economic issues, originally published in Foreign Affairs, Harvard Business Review, Scientific American and other journals, are reprinted in Pop Internationalism and The Accidental Theorist.

## Subcommittee on Labor, HHS, Education and Related Agencies

## Witness Disclosure Form

**Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization <u>other</u> than a federal agency, or a state, local or tribal government.**

Your Name, Business Address, and Telephone Number:

Paul Krugman
Woodrow Wilson School
Princeton University
Princeton NJ 08544

609-258-1548

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

Myself

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2006?

Yes (No)

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Signature: _____ Date: 3/24/09

Please attach a copy of this form, along with your curriculum vitae (resume) to your written testimony.

Mr. OBEY. Thank you very much, Dr. Krugman. Let me ask a couple questions. As you know, we have passed a significant budget stimulus package, and there are those who feel that that is a significant mistake because it adds to the deficit. You have indicated in your testimony that what we ought to be focused on is not the near-term, year-by-year deficit, but the long term level of deficit; and that, in fact, in the short term, deficits may be essential in order to prevent worsening of the economic situation.

We now have the Budget Committee about to mark up budget resolutions for the year. The Budget Committee process is fairly interesting; it is the only process I know where you can cut budgets without cutting programs, because they do not have to tie macroeconomic decisions to micro results. And there are those who will say that, now that we have passed an economic stimulus package, about a month ago, we need to scale back on the size of expenditures and scale back on deficits next year and the following year.

Tell me why you think that that would not be a good idea at this time.

Mr. KRUGMAN. We first need to measure the stimulus package against the current needs of the economy. President Obama estimates that his package will, at its peak, add about 3.5 million jobs to what we would otherwise have had, and that estimate is consistent with most economists' ballpark models. That is helpful, but the U.S. economy has already lost almost 4.5 million jobs in this recession, and that is against the backdrop of a growing population. So we are almost 6 million jobs short of where we should be already, and losing jobs at the rate of 600,000 a month.

So the package as it now stands is mitigating, it is not even enough to prevent us from having a very severe recession; it is just a mitigating factor.

If we respond to concern about the size of the package by scaling back other government spending, we are undoing the effects of the stimulus package, making it even more inadequate. And it is really important to bear in mind, to have some sense of what the long-run magnitudes are here.

The stimulus package is approximately $800,000,000,000. That is the headline number. Because it will stimulate the economy, some of that comes back in the form of higher tax revenues. A reasonable guess at the true cost is on the order of $500,000,000,000, which is 3 percent of GDP. That is significant, but it is certainly not make or break if we are thinking about the long-run budget prospects of the United States; and we certainly should not be sacrificing crucial priorities in the interest of offsetting the cost of this very necessary temporary measure.

Mr. OBEY. Another question, on the issue of inequality. Why should we be concerned with growing inequality in the economy? I mean, it may offend our sense of fairness and justice, but in terms of the long-term strength of the economy, why should we be concerned if we have growing inequality?

Mr. KRUGMAN. Okay, there are two levels of answer to that. The first is that rising inequality means that the majority of the population gets less than an equal share of economic growth. And I actually addressed that briefly in the opening remarks. If we had not had rising inequality these past three decades and had had the

same rate of economic growth, the standard of living of the typical family, the median family, would have grown at least twice as fast as it did. The pie may be growing, but if an ever-growing share of that pie is going to a small group of people, most people end up not seeing their incomes rise as fast as the average.

Beyond that, we have more speculative, but probably real, aspects in which a highly unequal society ends up being a dysfunctional society. There are somewhat abstract, but very real, issues of trust, sense of community, and there are much more real, I think, economic concerns. If we ask ourselves how did we get into this financial crisis, an important aspect of it was that players in the financial market were prepared to take huge risks with other people's money because, at least for a while, they could earn extraordinary incomes.

People who defend high inequality says that it creates incentives, which it does, but I think what we have just learned is that those incentives are not necessarily incentives to do good things; they can sometimes be incentives to do extremely socially destructive things.

If I just say look at the historical record, the most equal income distribution the United States has ever had was during the generation following World War II. That was when we truly were a middle class society, when we were certainly not an egalitarian society. We were not Cuba, but we were a relatively equal society. That was also the era of the greatest economic growth that we have ever achieved, before or since.

So I do not want to push those things too far. I think the most important, the clearest argument is if you have rising inequality, then most people do not share fully in economic growth. But there are reasonably good reasons, looking at the historical record, to think that a highly unequal economy is a worse economy and a worse society.

Mr. OBEY. One last question before I pass the witness. There has been some considerable debate in this Country about the relevance of what Roosevelt did in 1932 to the existing situation. As I read history, what happened is that when Roosevelt came in to power, we had unemployment approaching 25 percent, and that Roosevelt took actions to build confidence and provide some modest stimulus, which brought down the unemployment levels to a modest degree. But then, after 1936, he seemed to feel that the economy was recovering and on the road back, and he throttled back and tried to turn more toward a balanced budget and, as a result, the economy again dipped and it took until World War II to really achieve full employment.

The lesson I would draw from that is that it would be a mistake for us to throttle back too soon on stimulating the economy. What is your reaction to that interpretation of those events?

Mr. KRUGMAN. Very much in agreement. What happened in 1937 was a broad resurgence of the old orthodoxy, both about balanced budgets, even in a time of high unemployment, and monetary policy. So there was a shift towards a more contractionary monetary policy as well. And the economy slid back down in what was, at the time, often referred to as the Second Depression and did a great deal to undermine the economy, as well as the New Deal agenda.

We can also look at the Japanese experience in the 1990s, which offers a quite similar story. If we look at the Japanese behavior circa 1996, same thing. It is often said that the Japanese policy of public works to support the economy did not work. Actually, it did when it was pursued; it did expand the economy. But they too had a sudden burst of premature orthodoxy, leading to the Japanese economy slipping back again.

So there is a real concern. And one of the great concerns, I may say, about the stimulus bill as written is that it will deliver its peak support to the economy next year and then fade out quite quickly, and there is no solid reason to believe that stimulus will cease to be necessary in 2011. The CBO's projections show the economy recovering, but that is not a result, it is an assumption. They basically simply imposed the idea that we will return to normalcy five years from now, and it is very hard to see what the forces leading to that return are. So I am very concerned that it will, in fact, be deja vu all over again, that just as the Japanese repeated Roosevelt's experience, that we will then repeat the Japanese experience.

Mr. OBEY. Thank you very much.

Mr. Tiahrt.

Mr. TIAHRT. Thank you, Mr. Chairman.

First, I would like to talk about your statement on rising inequality. I think, in looking at those broad categories, we fail to see what has happened during that time with people who were previously in those categories. There has been a mobility of out-of-the-bottom, the lowest quintile, or people we would consider poor, into the middle class. About 54 percent moved out of the bottom quartile into either the next quartile or the middle quartile. I am sorry, quintile, five categories instead of four.

So when you just look at the number—because we do have new people coming into the economy, people coming in to work now that did not work before; and that happened during the time period that you are referring. So if you look at the upward mobility, there has been a high rate of people moving out of that bottom quintile into other categories during the same period of time.

And you mentioned the 1950s. It is an interesting study of economics from the Depression up until today, because I think we remained stagnant. There were some ups and downs, but our economy was relatively stagnant during the 1930s, where we borrowed a lot and spent a lot. I think it was the capitalization that occurred during World War II and the opportunity when these people came back from World War II, young men and women with a can-do attitude that took this capital investment that occurred during World War II and came up with new ideas and new innovation, and that is how we saw this expansion of the middle class.

So my concern today, as we move forward, is that we focus on this macro level and we say—and I believe that 98 percent of the people in Congress today are macroeconomics Keynesians. I believe there are very few that look at the microeconomics that build the aggregates that you study in macroeconomics. In order to build that microeconomic concept, we have to go down and look at small businesses, the people who keep and create jobs. In Kansas today, four out of five jobs are small business jobs.

So developing a structure where they can have opportunity is what I am concerned about. I think that is what builds a strong economy from the bottom up, and not from government down.

And I look at policies. You mentioned that this massive spending may have some failure in the future. We will have a spur or a bump in 2010 that could go away in 2011, if I understood your testimony right. If I look at what we are doing today, this year the Federal Government is going to go out and borrow $3,000,000,000,000. And apparently we are not doing too well because last week the Fed printed $1,000,000,000,000 in new money. So we are putting more money into the economy by creating, by printing it. What impact does that have on inflation when you print money and have more money available in an economy?

Mr. KRUGMAN. Okay, that is a long list of questions. Let me do the best I can.

Just, first, about income mobility. Yes, we are not a caste society. People do move up and down. However, the extent of those moves is often greatly exaggerated. Yes, there is a changing mix of people, but the last study I have seen says that, even after a decade, if we are looking at the top 1 percent or so of the population, after a decade, most of the top 1 percent is the same people who were still in the top 1 percent a decade earlier. We are not actually looking at a situation where it is a constantly changing cast of characters.

And perhaps most important for comparisons across time, income mobility has, if anything, probably declined in the United States. So to the extent that we have always been a Country in which people move up and down, which somewhat reduces the sort of lifetime inequality of income, that is no more true and, if anything, less true now, than it was 40 years ago.

Mr. TIAHRT. I think if you look at the lifestyle of people in these five quintiles, people have a better lifestyle today than they had in the 1950s.

Mr. KRUGMAN. I think that there is a substantial illusion in that. I mean, certainly people are better off than they were in the 1950s, and in some respects there are things that we——

Mr. TIAHRT. Well, let me ask you this. And I have been to the poorest area in Kansas. People there live in single-family units; they have refrigerators, they have telephones, they have cable TV, they have microwaves, they have cell phones. How much of that existed in the middle class in the 1950s?

Mr. KRUGMAN. Obviously, not microwaves and cell phones, which had not been invented yet. But this is always—I think your relevant comparison would be how secure did people feel in a middle class lifestyle in, let us say, not 1950, let us say 1970 versus now. I think people are much less secure in that style.

And, yes, some things are much better. Other things are worse. People were more sure that their local public school would give their children a decent education in 1970 than they are today. People were more sure that their company retirement fund would continue to cover them, that they actually had a secure retirement. People were less terrified that they would lose health insurance and be bankrupted by medical costs.

Mr. TIAHRT. I would agree with you, and I think it is macroeconomics and the Keynesian policies that got us in this position.

And what will get us out, in my belief,—and I would like your view on this—is if we create jobs, private sector jobs—and how you do that is the question—if we create jobs that will generate revenue for the government and will create investment.

I disagree with you on savings. I think savings is a good thing, not a bad thing. And if you look at the spending we have been doing here on the Federal level, spending is not the answer. But if we create opportunity so we can create jobs, by doing that I think you remove the uncontrollable costs that employers are facing today. Those costs are all driven by the government, but reduce or remove those costs. Having more jobs in America is one of the things we are looking for, is it not? And how do we get to that?

Mr. KRUGMAN. Two things. First, nothing in the experience of the last two decades supports at all the view that changing taxes in the range that is under discussion is going to be a bad thing for job creation. We have as close to a controlled experiment as you will ever get in economics. We had one President who came in, raised taxes, raised the top marginal rate, was followed by an extraordinary explosion of job creation, and then the next President cut the top marginal rate and even before the recession took place, job creation was quite anemic.

You can say there were other factors, but there is certainly nothing in that record to support a hardline view that any increase in taxes is going to be destructive of jobs and that cutting taxes is always the way to create them. It just did not work that way in the past 20 years.

And the view that as long as the microeconomics, the private sector is all good, then nothing bad can happen to the economy is completely belied by economic history. The U.S. economy of the 1920s was a marvel, it was more creative, arguably, than it has ever been. It was full of driving innovation, full of remarkable new businesses, new business ideas; and then something terrible happened. And I guess my basic view is, by all means, entrepreneurship, innovation, productivity are wonderful things, but one Great Depression can ruin your whole day.

Mr. TIAHRT. Thank you for being very generous with your time, our Committee's time, Mr. Chairman.

I just think if you look at, for example, the 1990s, a tax increase was followed by limiting the growth of government during the 1990s. We limited the growth of government and that, coupled with revenues, as you say, increased, was what allowed us to balance the budget for four consecutive years. And my concern is if we do not control the growth of government, no matter what we do there is going to be a problem.

Thank you, Mr. Chairman.

Mr. OBEY. Mrs. Lowey.

Mrs. LOWEY. Thank you very much.

As an admirer and reader of your column, many of us look at it as the truth. So we are very happy that you are out there.

For many of us, discussing wages and standard of living without acknowledging the impact that the economic crisis is having on families across the Country certainly is not adequate, and one of the most troubling aspects that I see is that almost every check in place to present this kind of disaster failed.

For example, if a lender approved a loan likely to fail, an underwriter responsible for verifying the income on the application should have flagged the loan. When that did not happen, an investment firm on Wall Street began buying bad mortgages and bundling them into securities. Executives there should have investigated the mortgages' level of risk, which they did not because they were all making so much money. And even if both the lenders and investment banks were not effective in weeding out bad loans, rating agencies charged with analyzing the risk of mortgage-backed securities should have been raising red flags.

Yet, in case after case, each of these levels, from the lender to the underwriter to the investment firms to the rating agencies, there was monumental failure.

Now, many of us recognize that there is not a silver bullet solution to solving the crisis, and it will take a combination of approaches, and I appreciate your mentioning health care. And, as we know, this is a prime focus of this Administration, this President.

And I read your column the day after, or it was probably the day of Geithner's presentation of his plan and the market soared. Now, there are many out there who will say, well, the market is soaring, Geithner is right, Summers is right, Krugman is wrong. I wonder from you what can be done to change both the industry and the culture that led to the poor decisions and investments that harmed our economy, and how do we prevent this happening again.

I will speak to many of my constituents—my district is very varied, but many will say, oh, it is just a cycle, you know, it goes up and it goes down, and do not worry about it. And then they see the market going up and there can be a great big move, and, okay, things are working again, forgetting the greed and the 40:1 leverage, etc., etc., etc.

So how do we make these changes? Are you confident that we can do it, given the fact that health care will remain key on the agenda?

Mr. KRUGMAN. Okay, Mrs. Lowey. About the market reaction——

Mrs. LOWEY. They would read your column.

Mr. KRUGMAN. My old teacher, Paul Samuelson, famously said that the market had predicted 9 of the last 5 recessions. More contemporaneously, though still showing my age a bit, I would say that the market thought that pets.com was a great idea. So I do not want to place too much weight, certainly, on what happens on a day or even a year in the market.

There is a fundamental, philosophical, you might say, debate, which you will probably read a bit more about in my next column, about whether the system of finance that we developed, not just these past couple of years, but over the past quarter century or more, was fundamentally a good idea or a deeply, deeply flawed system. And I believe that the Administration still thinks it was mostly a good thing. I think that is a point of difference between them and myself.

We went from the old modeling, in which there were banks and banks made loans and they held on to those loans, to a model of highly securities finance, where a loan originator would make a loan and then sell off the loan, which would then be sliced and diced and turned into more complex financial instruments.

And what we know for sure is that the incentives in our financial system were deeply, deeply flawed. Essentially, if you were a manager in that system, you made a great deal of money by creating the appearance of profit. And even if the whole thing blew up after five years, you would walk away with a large sum of money. And at some level, ultimately getting the compensation schemes right is critical.

I think we can also ask ourselves—and I will just try to end this—do we have too much finance in this Country. I have been working on this a bit and noticing that during the 1960s the finance sector was about 4 percent of GDP. In recent years it has been 8 percent of GDP. Is that extra 4 percent of GDP creating value or is it, as I am now starting to think, actually destroying it?

Mr. OBEY. We are going to have to hold people to five minutes or some members will not get a chance to question Dr. Krugman before he leaves at 11:30. So I am sorry to say the gentlewoman's time has expired.

Mrs. LOWEY. I have to go back to my hearing. Hopefully, we will have another session at Rosa DeLauro's house, where we enjoyed you.

Mr. KRUGMAN. Yes.

Mrs. LOWEY. And Elizabeth Warren came the other night, and she agrees with you.

Mr. KRUGMAN. I am sure Betsy does, yes.

Mrs. LOWEY. Thank you.

Mr. OBEY. Mr. Alexander.

Mr. ALEXANDER. Thank you, Mr. Chairman.

Doctor, on the second page of your testimony you said, talking about the dysfunctional health care system: "We spend more to cover 85 percent of our population than our counterparts spend to cover everyone, with no evidence that we receive correspondingly better care." Could one assume, after reading that, that you are implying that if we cover everyone, we would both get it cheaper and better?

Mr. KRUGMAN. Yes. Just take the issue of administrative costs. Medicare, which, although we do not think of it this way often, is a single payer system covering Americans 65 and older, spends about 3 percent of its budget on administration. Private health insurance companies spend approximately 14, even though most of their practice is group coverage through corporations, which should be relatively cheap.

The best available estimates suggest that the U.S. system spends about 30 percent of its total on administration; whereas, other countries' systems spend on the order of half that.

Why are administrative costs so high? Essentially because of the cost of underwriting, insurance companies attempting to figure out who not to cover, and because of attempting to shift the cost onto someone else. It is very high costs imposed by the non-universality of coverage. And if you try and look at who the uninsured are and what it would cost, just on the administrative cost savings alone, it ought to be cheaper in total to cover everybody than to do what we now do.

Mr. ALEXANDER. Okay. I also find it puzzling you said that, comparing the amount of money, cash, that is in the system today, we are 8 percent versus 4 percent at some time in the past. If that is the case, then why do we have those excited about the idea that the Treasury might inject yet another $1,000,000,000,000 into the system, if you are implying that we already have too much cash might be the problem?

Mr. KRUGMAN. As you may have gathered, I was not fond of the plan announced by the Treasury this week, and there is a great difference between the measures that the Federal Reserve has been undertaking, which are an attempt to promote new lending, and the Treasury plan, which is simply an attempt to pour money into the existing banks without necessarily coming out and lending on the other side.

We do have a problem that financial institutions, some of the key ones, are crippled by inadequate capital, and we need to find a means of recapitalizing them. But that is not the same thing as saying that we want the sector to expand. And, no, I think we do need to face up. We will eventually have to face up to the notion that there is not going to be as much of a finance sector as we had in 2006, and that it will be a good thing when it becomes a smaller part of our economy than it has been in recent years.

Mr. ALEXANDER. And if it appeared that I was implying you were excited about it, I apologize. I did not intend to.

Thank you, Mr. Chairman.

Mr. KRUGMAN. May I say, if you were an owner of bank stock, the notion that the Treasury is about to throw $1,000,000,000,000 in your general direction would probably be regarded as a good thing, regardless of whether it works or not.

Mr. ALEXANDER. We have sensed there is some excitement out there.

Mr. KRUGMAN. Yes.

Mr. ALEXANDER. Thank you.

Mr. OBEY. Ms. DeLauro.

Ms. DELAURO. Thank you very much, Mr. Chairman.

Thank you, Dr. Krugman. It is a pleasure to have you here this morning. I am going to pass on the temptation to talk about the financial situation, but let me move, because I think this whole issue, one that has been a real concern to me over the years, is the whole issue of income disparity.

You say in your testimony that when reducing income inequality "there is little reason to be confident about the efficacy of whatever measures we try." Let me ask why such pessimism. If you were at the helm of a policy-making institution like this institution, what are some of the ideas that you would develop and implement to try to turn this around?

You point to health care, and I understand that. That is something that we need to do and something that we can work at. What else? Where else would you prioritize in terms of this issue?

Mr. KRUGMAN. I am sorry you asked that question. Let me say, quickly, two things. The great leveling of the American income distribution, the Great Compression which took place under FDR, took place under extraordinary circumstances. First, there was a tripling of the size of the union movement thanks to the combina-

tion of the Depression and a change in the political environment; and, secondly, there was World War II, which was a great equalizing factor. And the important lesson from that was that those changes stuck for 30 years. It turned out that having altered, in effect, the bargaining position of American workers, we got a more equal distribution, which lasted a long time, without any adverse economic effects. So that is the great inspiring lesson.

But since we are not planning to have a second Great Depression and a third World War, I hope, it is going to be difficult to carry out measures on anything like that scale.

What we can do are, I think, on two fronts. Some of the increased inequality reflects increasing disparities based on educational level training skill. So it is almost certainly a good thing to invest in better education, especially not at the highest end, but for the population at large training. But my read says that that is probably going to have only a modest impact on inequality, even if we do a lot of it.

The second thing we can do is try to enhance the bargaining power of workers. And I am very much a supporter of the Employee Free Choice Act, which is the cutting edge of that discussion right now. There is no fundamental reason in people who say that a stronger labor movement does not make sense in the 21st century I think are missing the realities. They are thinking that modern labor negotiations have to look exactly like the industrial labor negotiations of 40 years ago to be effective, and I do not think that is right.

But the reason for my pessimism is that we are not sure. If you ask me to put a number on what the passage of EFCA would do to the Gini coefficient, I have no idea. If you ask me what would comprehensive health care reform do to the number of uninsured, I can be quite exact and highly optimistic about that.

Ms. DELAURO. I am going to yield back my time, Mr. Chairman, because I am going to the Budget Committee, where we are going to do battle to see if every time we get to thinking about where the cuts ought to be made, it winds up in the nondefense discretionary portion of the budget, which is where you have health care and where you have education and some of the issues that might in fact make a difference in people's lives. So thank you, Mr. Chairman.

Thank you, Dr. Krugman.

Mr. KRUGMAN. Thank you.

Mr. OBEY. Mr. Bonner.

Mr. BONNER. Thank you, Mr. Chairman.

Dr. Krugman, I am going to steer away from your testimony today, because I feel like some of my colleagues will take an opportunity to talk to you about that. I would like to focus on a couple of articles that you wrote recently, one February 1st, Protectionism in Stimulus; and on March 16th, A Continent Adrift.

Let me give you a quick update on my thoughts and then, more importantly, I would like to hear from you on yours.

Last week, many of our colleagues on both sides of the aisle took the opportunity to rush to the microphones and I know sincerely, but, nevertheless, express their outrage and dismay over the fact that there were bonuses that had been allowed for some of the small number of employees at AIG. The President was outraged

over it and we were all outraged over it, although we never really answered the question who actually instructed Senator Dodd to take the language out of the conference committee that would have addressed this issue in the stimulus bill.

One of the reasons I opposed the stimulus bill was an easy one for me, but a harder one to explain to some of my colleagues, and that was there was also a Buy American provision in it. Now, every member of this Committee is American; probably every person in this room is American; and we are all for buy America to create American jobs. Yet, the example I used with a steel caucus hearing was we have a company in Germany, ThyssenKrupp, that invested, two years ago, $4,500,000,000 of their money to come to the United States to create jobs in America, 20,000 construction jobs right. They actually were looking at Louisiana, but we ended up bringing them to Alabama, so we were grateful to have them come. These are good paying jobs with good paying health benefits. They will replace lower wage jobs in the textile industry and timber industry jobs, many of which have gone offshore.

And, yet, one of the provisions—and I talked to Secretary Summers about this—was that, in an effort to wrap our arms around American jobs, we ended up saying, okay, you can come invest $4,500,000,000, create 20,000 construction jobs, 2700 permanent jobs, but, by the way, you cannot sell any of the steel that you happen to manufacture to the U.S. Department of Transportation because that is not American, even though those jobs and the product would actually be finished here.

So since you have opined in a couple columns about what is going on in Europe and specifically also about the Buy American provision in the stimulus, I would like for you to help me understand, from your perspective, do we run a risk when we rush to judgment about an issue and hold up something as popular as Buy American in setting off a trade war and building walls of isolationism, much like we did in the 1920s and 1930s, do we run a risk of actually doing more harm than good with policies like that?

And I apologize for the confusion of the question.

Mr. KRUGMAN. No, it was not confused at all. This is exactly the issue on which I have to talk at my next engagement today.

Let me say where we are. The problem with protectionism of any form—and the Buy American provision is not the grossest form of protection, but it is certainly a step in that direction. The problem with it is that it is very hard to undo. The relatively open world trading system that we have now has been a very good thing for the world. Less so, I would say, I think not so much about American workers, where there are some ambiguous effects, but for the poorest countries. When someone asks me why is relatively free trade important, my answer is think about Bangladesh. Think about the poorest countries, which cannot survive unless they can export their products.

That relatively open system we have now took 70 years to create. After the highly protectionist responses that the world undertook during the Great Depression, it took generations of painstaking, slow negotiations to basically get back to where we started. And if you smash it apart right now, putting Humpty Dumpty back to-

gether again might take another three generations. So that is the reason to be extremely cautious about it.

You do not want to say, I think it is incorrect to say that protectionism caused the Great Depression or even to say that protectionism would necessarily make our current crisis worse. Particularly given that the United States is being more aggressive in grappling with this crisis than the Europeans are, the temptation to say, well, let us keep the benefits of our stimulus at home is real and not foolish. But if you think about the costs, think about what could happen if we break up the system which has been so hard won, those are very serious to worry about.

Mr. OBEY. The gentleman's time has expired.

Mr. Jackson.

Mr. JACKSON. Let me thank you, Mr. Chairman, and let me also apologize to my colleagues who may not know that I was here on time at the appropriate beginning of the hearing. But Congresswoman Lowey and I are trapped in a dueling hearing across the hall, and I wanted to make sure that they were understanding of why the queue is reflective of the way it is; and I thank the Chairman.

Professor Krugman, I know that you have concerns about the public-private partnership presented by Secretary Geithner on Monday. A number of us do. And some of the concerns that you have articulated are clear to many of us, and there are certain hazards associated with the public-private partnership offered by the Secretary.

But I wanted to present to you another concept of public-private partnerships written about by your colleague, Bob Herbert, at The New York Times just a week or two ago.

The Congress of the United States has been trying, and a number of States have been trying, to attract more private investment in public works projects. A little different than the bank rescue plan, but, nevertheless, there is an acknowledgment by this institution that there is sufficient private capital available to build and expand the domestic economy and the domestic job creation base by attracting private capital to public works projects if the private investors can find a way in a public works project to get their profit out of the project. Obviously, combining the best of public governance with the best of private experience, there is a potential match made in heaven.

Bob Herbert specifically talked about a greenfield airport outside of my congressional district that could provide an opportunity to create, initially, 15,000 jobs, but, upon its final expansion, nearly 350,000 jobs to the local economy. No public works project does for an area what an airport does. An airport comes, for example, the accelerator and the multiplier effect: Hyatt, Hilton, UPS, Federal Express, DHL, etc.

Could you distinguish for the Committee the difference between many State efforts, many local efforts, including Federal efforts to encourage private investment in public-private partnerships from the kind of public-private partnership that Secretary Geithner articulated with respect to banks and share with us some of the hazards associated with the latter?

Mr. KRUGMAN. Thank you. There is no problem with bringing the private sector in on a project; it is a pragmatic issue. If the financing can be more easily arranged, if the expertise that private firms can bring to a project can be best brought in not simply by hiring them as a contractor, but by making them a stakeholder, that is fine. If you go through American economic history, you can find that we have done things in a variety of ways. The Erie Canal was a straight public works project, but the building of the Transcontinental Railroad was essentially what they did not call at the time, but was a public-private partnership, where land grants were used to encourage the railroads to do the job.

The issue about the PPIP really has nothing to do with these things. My way of understanding what Secretary Geithner has presented is that it is, in essence, the same plan that former Secretary Paulson presented six months ago. It is really a proposal to have the taxpayer buy up a bunch of assets at more than anyone in the private sector is currently willing to pay. It is disguised a little bit, or at least it is made obscure by the complexity of the financing scheme and by the fact that the headline number of public investment is not going to be quite as large.

But what it really does is it gives the private equity investors, in effect—I am being a little inflammatory here, but it basically bribes public investors to go out and buy the toxic assets. It offers them what is in effect a large put option because the FDIC is guaranteeing debt which is 85 percent of the total and, if things go bad, the investors can simply walk away. So if the investments turn out to be bad, there is a strong element of heads, they win, tails, the taxpayer loses.

Now, that is being defended by Treasury on the grounds that these assets are in fact being greatly undervalued, and that what we really need is a large subsidy to make people buy it. But it has nothing to do with it. Buying up toxic paper from troubled banks is not at all like building an airport.

Mr. OBEY. The gentleman's time has expired.

Mr. Rehberg.

Mr. REHBERG. No questions.

Mr. OBEY. Mr. Honda.

Mr. HONDA. Thank you, Mr. Chairman.

It is a pleasure to listen to the testimony, and your prepared statement, for a person who did not study economics, is easier to read for me.

The question I have is there is a lot of debate on measuring economic growth and measuring inequities in our system within our population. The measure that we use, from what I hear, is GDP. Are there other measures that would be more precise that would create a greater contrast in what you are trying to talk about using GDP? Is there another way of doing that so that it is more precise and perhaps even more on point?

Mr. KRUGMAN. Congressman, I am tempted to act professorial and say that is a good question, which is a way of playing for time because you do not actually know the answer yourself. What I would say is, first off, no serious economist believes that GDP is a sufficient measure of economic success. We all know, every principles of economics textbook, including my own, has a couple of

pages on what GDP does not do; and simply having a higher GDP does not necessarily tell you the actual improvement in the quality of life.

It helps to use some measure which comes closer to the experience of the typical family, which is why people like myself often focus on things like median family income. But even that misses quite a lot. Whether there is a single measure that can capture all of what we want to talk about is highly dubious. People have tried to do that; they always end up being somewhat arbitrary constructions.

To take the example if we are comparing the United States and France, we have substantially higher GDP per capita. We have approximately the same labor productivity. The difference is partially that they have higher unemployment, but largely that they just take longer vacations that we do. How much of that is a loss and how much of that is simply a different choice?

For what it is worse, gross changes in GDP almost always reflect comparable changes in any measure of the quality of life. There is no question that if you have country A, which has twice the GDP per capita of country B, country A is going to be a happier country.

But I think you are asking too much to have a single number. We use GDP, we use a few other measures, but then we are not so much presenting a number as telling a story: what is it like in this Country; what is it like in our society.

Mr. HONDA. I was not looking for a single metric, I thought maybe there might be a series of metrics out there that can be used to contrast one to another.

Mr. KRUGMAN. Certainly, we have life expectancy, infant mortality; we have survey results about life satisfaction, which tell you something about how people perceive their lives; we have measures of household security or lack thereof. All of these things come together. There is not a whole lot of difference between rankings of countries by simple GDP per capita and rankings by these others, but there are some important difference. Particularly, more equal, less insecure societies look better, rank better on most of these measures than looking at GDP would have told you.

Mr. HONDA. Thank you.

Mr. OBEY. Ms. Lee.

Ms. LEE. Let me first just thank you for being here, but also thank you for your testimony, Dr. Krugman, and also how you kind of break down economic analysis as it relates to public policy. I always read your columns and your articles, and looking at your testimony today, it is very consistent with ordinary folks being able to read and understand what is taking place in the economy and what we need to consider as we move forward.

I wanted to just mention one of your comments in your testimony. You talked about the poverty rates. A boom year was about 12.5 percent. I would have added, in addition, for people of color, for instance, for African-Americans, it was 24.5 percent to 27.9 percent; for Latinos, 21.5 percent to 27.1 percent.

I wanted to ask you how—and we understand the environment we are currently in in terms of the consideration of race. Race and class have always been a big issue in this Country, and I want to find out, as it relates to the poverty rates now, how you see race.

Is it still a factor? What would you say would account for these huge gaps? I mean, 12.5 percent is bad enough, but when you go to 24 to 27, 21 to 27, that is twice as bad. So by leaving out communities of color, people of color, does that send a different type of message that race is not a factor anymore in our economic strategies, or how do you see this at this point with, quite natural, President Obama as President?

Mr. KRUGMAN. I think there is only so much I can say here. One is that, clearly, there are large racial differences in poverty rates in income. While we like to emphasize that a majority of the poor in the United States, contrary to popular impression, are not in fact African-American, certainly, the poverty rates are much higher among African-Americans. And it would be clearly foolish to suppose that, simply because we have finally had an African-American President, that race has ceased to be an issue in America, it is very much still an issue, very much still a large part of our social scene, of our economic scene.

The causes of the racial differences are probably complex. I, for one, do not believe that discrimination has ceased to be a factor. I do not believe that we wiped away all of our centuries of history; I believe it is a real issue. There are also social issues. There are simple persistent issues.

Referring to some of the remarks we had earlier, we are not a society of perfect social mobility. There is actually a great deal of hereditability of economic status. And the fact that we had undeniably vast discrimination in this Country not that long ago continues to color our income distribution, our poverty rates today.

Now, many of the things we can do to mitigate suffering, to mitigate poverty can be color-blind even though we are aware of the issues of race. Universal health care is going to be good for people. Probably the biggest beneficiary, certainly rates of insurance are highest among African-Americans. But that does not mean that you have to think about that in devising the program; you simply have universal coverage and it serves those most vulnerable especially well. Other things, certainly we need to take them into account.

I would agree with the President, race is our original sin in this Country. We have made far more progress in coming to terms with that over the past 50 years than many would have imagined, but we have certainly not come pass it.

Ms. LEE. Thank you very much. The second question I have is with regard to income inequality and this recent unethical and immoral and probably, possibly criminal behavior by many of the Wall Street firms as it relates to the bonuses, I have a bill, it is the Income Equity Act, and what I am trying to do is close some of these loopholes that would allow these unlimited kinds of bonuses. But what this bill would do would be to only allow the deduction of $500,000 or more, 25 times the pay of the lowest wage worker to receive a Federal tax deduction.

Mr. OBEY. Could I ask you to be very brief in the answer? The gentlewoman's time has expired.

Mr. KRUGMAN. Yes. I cannot respond without knowing much more than I do about the bill. I am all in favor of seeking ways to limit this and certainly some of the deeply unjust tax privileges

that some people in the financial industry have received, but beyond that I cannot go.

Ms. LEE. Thank you very much.

Mr. OBEY. Ms. Roybal-Allard.

Ms. ROYBAL-ALLARD. Thank you, Mr. Chairman.

Mr. Krugman, in your book, Confronting Inequality, you state that the principle of equality of opportunity, not equality of results, is a largely fictitious distinction. Could you elaborate on what you mean by that?

Mr. KRUGMAN. Yes. It is often stated that, well, what we want is equality of opportunity, and that does not mean everybody has to end up in the same place. But if you have a highly unequal society, as we do, the children of those who do well are given a great advantage. The children of those who do poorly are put at a great disadvantage.

And in the book, The Conscience of a Liberal, I cited the studies on educational attainment versus socioeconomic status, where it turns out that high-scoring students as of eighth grade, from the bottom quartile, measured by socioeconomic status, are less likely to graduate college than low-scoring students from the top quartile on socioeconomic status.

Loosely speaking, that rich dumb kids are more likely to make it through college than poor smart kids. And that is telling you that we are a society in which, whatever we may like to imagine, we are not a society that has anything like equality of opportunity; that there is strong passing down through the generations of social and economic status.

Ms. ROYBAL-ALLARD. You go on also to say that this high inequality imposes serious costs on our society that goes beyond the purchasing power, and one of the things that you give an example is how it corrupts politics. Could you elaborate on that and maybe given some other examples?

Mr. KRUGMAN. Yes. We certainly see that our political system is utterly democratic on paper and much less so in reality; that we can see—and I think everyone on this panel knows better than I do—the role of money, of influence, and simply of voice; that in a society where many people are poorly educated, scraping by, their voices are not heard in our political system. It undermines. People who have extreme views would say that we are a democracy in name only, and are really an oligarchy. I think we are better than that, but there is certainly a grain of truth to that.

My colleague, Larry Bartell, in the Politics Department in Princeton, has shown that really the bottom third of the U.S. population is entirely ignored by the political process, that the views of the poorer constituents, even lower income working people are essentially ignored by the process. And that is not the Country we should be.

Ms. ROYBAL-ALLARD. Is my time up, Mr. Chairman?

Mr. OBEY. No. You have one minute left.

Ms. ROYBAL-ALLARD. Okay.

So basically what you are saying is that although we, as Americans, like to think that, in this Country, we have equal opportunities, that basically that is a fantasy and that not only that we do not have equal opportunities, but that it is reflected in equal re-

sults that negatively impacts the ability of people to move upward in our society?

Mr. KRUGMAN. That is right. We still see ourselves as a society of Horatio Alger stories. And they do happen, but they happen much more rarely than people imagine. And, for what it is worth, we are less a society of Horatio Alger stories at this point than some other advanced countries. The chance of somebody born in the bottom quintile of making it into wealth or even substantial affluence is less in the United States than in Canada or Finland, largely because of things like the inadequacy of our health care system.

So there are opportunities. We are not a caste society, but we are not the kind of wide open society that we hold up to ourselves as an ideal and sometimes imagine that we actually fulfill and practice.

Ms. ROYBAL-ALLARD. And, as a result, we are all impacted by this inequality, regardless of where we are on the income standard.

Mr. KRUGMAN. That is right. We are at the level of value judgments at some level, but we are more—let me just say one thing. We are certainly wasting a great deal of human potential. Those smart kids from the bottom quartile who do not manage to make it through college essentially because they are so disadvantaged, that is talent that we could use, that we need.

Ms. ROYBAL-ALLARD. Okay. Thank you.

Mr. OBEY. Thank you.

Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman.

I appreciate it. I enjoy reading your column during the week and I have enjoyed your books. I think you have provided a lot of guidance for those of us who are trying to deal with a lot of these issues.

I represent a district that is in Northeast Ohio, Youngstown, Akron, who have been hit in a major way not just recently, but I think over the course of the last 25 or 30 years, and you can see where our local economy is based on what has happened just in the past few months. We see a General Motors plant who gets rid of a third shift, gets rid of a second shift, and three or four days later the seat manufacturer lays off a couple hundred of people, and a few days later the logistics company lays off a few more people, and Delphi, right down the line.

So my question is in two parts. One is an issue that I think the Secretary of the Treasury kind of tipped his hat at a little bit early on, the issue of China, currency manipulation in China, what your thoughts are on that and maybe how we can address that as a Congress and from the Administration perspective.

And then, also, as I stated earlier, how the ripple effect of manufacturing and how manufacturing leads to more job creation than the financial sector. I know you mentioned earlier about going from 4 percent of our GDP to 8 percent of our GDP is finance, and that would be healthy if that gets reduced back to 4 percent. So something has got to fill that void. Is it manufacturing? How can we put together a good comprehensive manufacturing policy in the United States?

So China currency and a manufacturing policy. And you have four minutes to solve that.

Mr. KRUGMAN. Right. China currency policy. I think I was struck by Secretary Geithner's excessive clarity. It seemed to me that that was a case where a little bit of Greenspan clouds of words was appropriate. It is a very difficult issue. Of course China is manipulating its currency. They got those $2,000,000,000,000 of reserves somehow.

The question is what you want to do about it, and that is a very tricky issue, especially given that while, on the one hand, we do not like those Chinese exports competing with U.S. goods, although that is not as great an issue as people imagine, on the other hand, we do not want them abruptly dumping all their dollars. So it is a trick issue for which I have no good answers. It is just one of those things that one hopes just fades away.

Mr. RYAN. Is now a bad time to try to address that?

Mr. KRUGMAN. Probably now is a bad time. Let me just say right now the woes of manufacturing—and I think this is the crucial thing right now—this is not that U.S. jobs are being stolen by other people. Manufacturing is in a catastrophic state around the world. It is collapsing everywhere because of the severity of the economic slump. Just this morning we had the news that Japan's exports have fallen 50 percent over the past year, just catastrophic collapse in their exports of manufactured goods. Same thing is happening to China. Same thing is happening to Germany.

So the urgent thing that we need right now is not how can we get some slightly bigger share of this global manufacturing pie, but how do we stop this—I am going to have trouble with my metaphor here, but how do we stop this pie from shrinking to insignificance for all of us. There are longer term manufacturing issues, but right now what we need is economic recovery. We need to do whatever we can do to get it. And manufacturing is on the leading edge, is paying the biggest costs from the slump and would then be the biggest beneficiary if we can get a recovery.

Mr. RYAN. Some people kind of pooh-pooh the idea that a green revolution can lead to resuscitating manufacturing in the United States. We have a lot of little machine shops that are making the bolts that go in the windmills. I mean, from a policy perspective, is that a realistic expectation that all of this investment in green technology will lead to reviving manufacturing?

Mr. KRUGMAN. It would help. I think it is unrealistic to expect manufacturing ever to be the same share of GDP that it was 30 years ago, just as it is unrealistic to expect us ever to go back to a Country where a large proportion of the population is farmers. There is a transition; we have moved, everyone has moved towards becoming increasingly a service economy. But manufacturing is especially depressed right now. It could come back significantly.

The whole green investment, green spending is real. I have not been able to form any judgment of my own about how big it will be ultimately. It certainly will be a factor, but how big I do not know.

Mr. RYAN. Thank you.

Thank you, Mr. Chairman.

Mr. OBEY. I promised Dr. Krugman [remarks made off microphone]. So I would simply give Mr. Tiahrt one minute for whatever summary thoughts he might have.

Mr. TIAHRT. Thank you, Mr. Chairman.

And thank you, Dr. Krugman, for being with us. It has been very enlightening. I enjoyed your conversation and your positions. I would disagree with your colleague about the poorer class or the lower class being ignored by the political process. I know that Ms. Lee and Chairman Obey and others here pay a great deal of attention to it, and I would argue with him that they do have access to Medicaid, EITC, public schools, unemployment, and they do vote; and we all realize that, so we pay a lot more attention to them than your colleague may realize.

I just want to conclude by saying that my concern in the direction that the Country is going ignores the fact that a rising tide raises all boats, and when we have a strong economy, even those who do not have access to college have access to opportunity. And if we can provide access to opportunity, those that do not complete college—Bill Gates would probably be the most large example—but others do take that opportunity and bring these ideas to the marketplace, and it is those private sector jobs that help us keep the lights on in the Federal Government and at the State and local governments.

So my concern is how do we raise the tide. And your input, I think, has helped give me a different perspective on some of the things that we are looking at. Thank you very much.

Mr. KRUGMAN. Thank you.

Mr. TIAHRT. Thank you, Mr. Chairman.

Mr. OBEY. And I guess all I would say is that I would like to think that in all cases a rising tide lifts all boats. The problem is that, as has been said by others in the past, at some times in our recent history it appears that a rising tide has raised only all yachts.

Let me say that I appreciate your comments today. I think it is important to hear what you said with respect to the stimulus package, when you indicated that there is no great certainty that the need for stimulating the economy will evaporate within a year and a half. I certainly do not think it is going to. I wish I did.

With respect to your acknowledgment of the difficulties that we have in trying to reduce inequality, I guess all I would say is that I do believe that, whether directly or indirectly, we can at least impact that around the edges by what we do to enhance educational opportunity, and by what we do to strengthen the bargaining position of workers at the bargaining table. We certainly can impact their welfare by the shape and nature of the tax code and we can certainly strengthen the safety net for those who do not do well in the economy through actions such as universal health care and pension protection and the like.

If you would like to comment for a minute before you leave, the floor is yours.

Mr. KRUGMAN. Yes, Mr. Chairman, I would very much agree. The fact that you do not know just how much effect you are going to get from a policy is not a reason not to do it if you think it will move things in the right direction. And I believe that education en-

hanced opportunities for labor to organize would help reduce inequality.

I think I am thinking a little bit as an author when I wrote my last book but one. I put health care first because that was the one where I thought I could promise some very specific results, and I put reducing inequality as a more of here are some things we ought to try, and they would probably all help, but I do not know how much, and that is not to say we should not do them.

We can do a lot better than this. I think the main point is that we have a tremendously vital private sector. We have entrepreneurship; we have innovation. What we do not have is an adequate way of making sure that all Americans are benefitting from what that private sector creates, and we can do much better at that than we have been doing. Thank you.

Mr. OBEY. Amen to that. Thank you very much. Good luck at your next engagement.

Mr. KRUGMAN. Thank you.

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WEDNESDAY, MARCH 25, 2009.

## RAISING WAGES AND LIVING STANDARDS FOR FAMILIES AND WORKERS

### WITNESSES

**KEITH HALL, PH.D., COMMISSIONER, BUREAU OF LABOR STATISTICS, DEPARTMENT OF LABOR**

**JOAN FITZGERALD, PH.D., DIRECTOR, LAW, POLICY AND SOCIETY PROGRAM, NORTHEASTERN UNIVERSITY**

**PHAEDRA ELLIS-LAMKINS, CHIEF EXECUTIVE OFFICER, GREEN FOR ALL**

Mr. OBEY. Let me next call our second panel. First, Dr. Keith Hall, who is currently Commissioner of the Bureau of Labor Statistics. Dr. Hall has led the Bureau since January 2008, having been appointed Commissioner by President Bush. He has also served as Chief Economist for the White House Council on Economic Advisors and the Department of Commerce and International Trade Commission.

Dr. Joan Fitzgerald, Director of the Law, Policy and Society Program at Northeastern University in Boston, is the author of Moving Up in the New Economy: Career Ladders for U.S. Workers, and has written extensively about models for training and career advancement in the health care sector.

I understand that Mr. Honda would like to briefly introduce Ms. Phaedra Ellis-Lamkins.

Mr. HONDA. Thank you, Mr. Chairman.

Members of the Committee, I would like to introduce a personal friend, Ms. Phaedra Ellis-Lamkins. Phaedra hails from San Jose, California, and is the CEO of Green For All, an organization dedicated to building an inclusive green economy, fighting pollution and poverty together. Prior to her position at Green For All, she was the head of the South Bay Labor Council and Working Partnerships in Santa Clara County.

She is nationally recognized for creative and innovative approaches to improving the lives of working families and her brilliant, charismatic leadership style.

And I do not think I am embarrassing her yet, but I will get there.

She has co-founded the Partnership for Working Families, a national coalition to bring the principles of good jobs and community benefits to local economic development. She fought to create one of the first community benefits agreements in the Country, providing community standards for large-scale development projects in San Jose.

She has been featured in The Wall Street Journal online, San Francisco Chronicle, San Jose Mercury News, America At Work, NBC News, and ABC News.

Finally, she serves on the board of the Leadership Council of California.

She has many other accomplishments that I could name, but, in the interest of time, Mr. Chairman, let me just extend a warm welcome to her today.

Mr. OBEY. Thank you.

Ms. Lee, I understand you wanted to make a comment?

Ms. LEE. Well, just welcome and congratulations to you. Now, of course, we share, as the new CEO for Green For All, now with Van Jones, advising our President and our Country on the greening of our economy and ensuring that no one will be left behind. I really thank you very much for your leadership and for making this transition now. We look forward to working with you, of course, in Oakland, California also. Thank you.

Mr. HONDA. We share good.

Mr. OBEY. I am going to forego my opening statement for this panel because I am informed that we are about to have three votes beginning sometime after 11:45. This place would function very well if we did not have to interrupt our work to go vote, but that is part of the job.

So what I would hope we could do is get each of you to get your statements in before we have to leave. When we do leave, we will be gone for about half an hour, I am afraid. So I would like to squeeze as much in as we can before we leave.

Dr. Hall, why do you not proceed first? Take about five minutes to summarize your statement.

Mr. HALL. Thank you, Mr. Chairman and members of the Committee. I appreciate the opportunity to discuss the Bureau of Labor Statistics' occupational outlook information with you. I would like to provide a very brief overview of the current economy and then discuss long-term employment trends through 2016. In light of the Committee's interest in health care, I will address this field specifically. Finally, concerning a topic of current intense interest, green jobs, I want to briefly discuss the challenge of measuring the number and characteristics of these jobs.

As you know, the Nation is in the midst of a sharp and widespread contraction of the labor market. Since the start of the recession, 4.4 million payroll jobs have been lost and the unemployment rate has increased from 4.9 percent to 8.1 percent, the highest level in over 25 years.

Job losses have occurred in nearly all major industry sectors, and employment has grown only in health care, private education, and government. Unemployment is up among all major demographic groups, and the number of people working part-time and voluntarily has jumped to 4 million. Job losses have occurred throughout the economy, as four States now have an unemployment rate above 10 percent.

The BLS prepares long-term national projections every two years, including the labor force, industry output, and industry and occupational employment. The most recent projections were published for the 2006–2016 period. We rely on data from a number of BLS programs, including the Current Employment Statistics, Occupational Employment Statistics, the Current Population Survey, and the Producer Price Index. We also use data from other Federal statistical agencies, primarily the Census Bureau and the Bureau of Economic Analysis.

I want to first note that the 2006–2016 projections were completed before the current recession. The impact of the recession and financial market turmoil on the long-run structure of the economy may not be known for some time, and may well impact the long-term trends that are the focus of our projection analysis. For example, we do not yet know if recent large declines in retirement wealth may impact future labor force participation rates of older workers.

To put the occupational projections into context, let me briefly review the broad trends. We expect growth in the labor force and total employment to slow, and the decline in manufacturing employment and shift toward services employment to continue. We expect that employment in manufacturing, mining, and the Federal Government and utilities will all decline. All other major industry groups are projected to gain jobs, with the most rapid job growth expected in health care and social assistance, professional and business services, and educational services.

Total employment is expected to growth 10 percent over the decade, resulting in 16.5 million new jobs. The two groups with the largest employment in 2006, professional and related occupations, and service occupations are also expected to grow faster than other groups, each increasing by 17 percent. Both include occupations within the large and fast-growing health care and social assistance, and professional and business services industries, such as registered nurses, home health aides, and computer software engineers.

These two groups also represent the opposite ends of education and earnings ranges. Many occupations in the professional and related group pay wages above median for all occupations and require higher levels of education or training, while many service occupations pay lower wages and require less education and training.

So far I have mentioned only job growth; however, job openings arise not only when new jobs are added to the economy, but also when existing jobs become permanently vacant, such as when workers retire. These replacement needs are expected to generate more than twice as many job openings as job growth alone. The retirement of the baby boom generation will create many replacement openings, where replacement needs will be significant in any

large occupation, even some that were not expected to grow. Also, many rapid growing occupations have relatively low employment and will, therefore, add relatively few job openings.

When the two sources for job openings, growth and replacement, are added together, a different picture emerges. Service occupations where replacement needs are high are expected to generate the most job openings. And although professional and related occupations will likely add more new jobs through growth than service occupations, it has lower replacement needs and will therefore generate slightly fewer job openings.

Increasing demand for health care services will generate significant employment growth throughout the health care sector. The primary driver of this growth is an aging population. Advances in medical technology will continue to improve the survival rate of severely ill and injured patients who will then need extensive therapy and care. At the same time, cost containment policies will generate faster than average growth and demand for health care workers who assist health care practitioners and have lower training requirements.

BLS produces comprehensive employment wage data for 670 industries and over 800 occupations. While we can identify some of the industries and occupations that are likely to have green jobs, most green activities either cut across industries and occupations or account for a subset of activity within an individual industry and occupation category. For example, retrofitting buildings to increase energy efficiency currently falls in the construction industry, but likely support only a small fraction of the current 6.6 million construction jobs in the U.S.

In closing, I just want to express my appreciation to the Committee for inviting me to be part of the distinguished panel today, and I want to thank you for your support of the Bureau and its programs, and I am looking forward to working with you.

Mr. OBEY. Thank you.

[The information follows:]

**ASTATEMENT OF KEITH HALL**
**COMMISSIONER**
**BUREAU OF LABOR STATISTICS**

**BEFORE THE**
**COMMITTEE ON APPROPRIATIONS**
**SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES**

**U.S. HOUSE OF REPRESENTATIVES**

**MARCH 25, 2009**

Thank you for the opportunity to discuss the Bureau of Labor Statistics' occupational outlook information with you.

I will provide a brief overview of the current economy and then discuss long-term employment trends through 2016, with special attention to occupations with above average wages and large numbers of job openings, as well as those with above average growth rates. In light of the Committee's interest in healthcare, I will address this field specifically.

Finally, concerning a topic currently of intense interest -- "green jobs" -- I want to briefly discuss with you the challenge of measuring the number and characteristics of these jobs.

***The current economy.*** As you know, the Nation is in the midst of a sharp and widespread contraction of the labor market. Since the start of the recession in December 2007, 4.4 million payroll jobs have been lost, and the unemployment rate has increased from 4.9 to 8.1 percent, the highest level in over 25 years. Job losses have occurred in nearly all major industry sectors; employment has grown only in healthcare, private education, and government. Unemployment is up among all major demographic groups, and the number of people working part time involuntarily has jumped by 4.0 million. Job losses have occurred throughout the country, and, in January, 4 states had unemployment rates above 10 percent.[1]

***BLS projections.*** The BLS prepares long-term national projections every two years, including the labor force, industry output, and industry and occupational employment. The most recent projections were published in December 2007 for the 2006-2016 period.

The projections are widely used by individuals and career guidance counselors for career exploration, by public officials for policy decisions regarding workforce development, and for many other purposes. Our State partners use BLS projections as an input into state and area projections, which help drive the State and local decisions on education,

[1] These states and their January 2009 preliminary unemployment rates are Michigan (11.6 percent), South Carolina (10.4 percent), Rhode Island (10.3 percent), and California (10.1 percent).

training and workforce policy and funding, as well as helping individuals in their career decision-making and job search.

The projections describe the composition of a full-employment economy in 2016, and the change in employment by industry and occupation required to achieve that economy. We make specific assumptions about several economic, demographic, and policy topics, such as rates of productivity growth. We conduct a series of analytical processes ranging from econometric and time-series modeling to explicitly subjective analysis.

We use data from many sources, including the Current Employment Statistics, Occupational Employment Statistics, and Producer Price programs, along with labor force data from the Current Population Survey and productivity data. We also use data from other Federal statistical agencies, primarily the Census Bureau and the Bureau of Economic Analysis.

***Impact of the recession on projections.*** I want to note that the 2006-2016 projections were completed before the current economic downturn and therefore are based on a pre-recession perspective of the economy. The impact of the current recession on the accuracy of our depiction of a full-employment economy in 2016 projections is uncertain. It may not be clear for some time whether the recession will have permanent impacts on the structure of the economy and on the long-term trends that are the focus of the projections analysis.

***Broad trends.*** To put the occupational projections into context, let me briefly review the broad trends. We expect growth in the labor force and total employment to slow, and the decline in manufacturing employment and shift towards services employment to continue. We project the labor force to grow at an annual rate of 0.8 percent between 2006 and 2016, down from a 1.2 percent rate during the previous decade (1996-2006). Nonagricultural wage and salary employment is projected to grow at an annual rate of 1.0 percent over 2006-2016, slower than the 1.3 percent annual rate during 1996-2006.

Manufacturing employment is projected to decline at an annual rate of -1.1 percent, down 1.5 million jobs over the decade. Manufacturing output is expected to grow, however, reflecting continued increases in productivity. Declining employment is also projected for the mining, federal government, and utilities industries. All other major industry groups are projected to gain jobs, with the most rapid growth expected in health care and social assistance at 2.4 percent annual growth, professional and business services at 2.1 percent, and educational services at 1.9 percent. (See charts 1 and 2.)

***Occupational trends.*** Turning to occupations, we categorize occupational employment into 10 major groups. The three largest major groups are professional and related occupations, service occupations, and office and administrative support occupations, with 2006 employment of 30 million, 29 million, and 24 million, respectively. These 3 groups accounted for well over half of the Nation's total employment. The smallest occupational group is farming, forestry, and fishing occupations, with just 1 million jobs. (See chart 3.)

Total employment is expected to grow about 10 percent over the decade, resulting in 15.6 million new jobs. The two groups with the largest employment in 2006—professional and related occupations and service occupations—also are expected to grow faster than any other groups, with each increasing by 17 percent. (See chart 4.)

Because of their large size and projected fast growth, these 2 groups also will add the most new jobs to the economy—nearly 10 million—accounting for more than 60 percent of all new jobs. (See chart 5.) Both groups include detailed occupations that are concentrated in the large and fast-growing health care and social assistance and professional and business services industries, such as registered nurses, home health aides, and computer software engineers

These 2 major groups also represent the opposite ends of education and earnings ranges. Many occupations in the professional and related group pay wages above the median for all occupations and require higher levels of education or training, while many service occupations pay lower wages and require less education or training.

Two occupational groups are expected to decline over the long term, continuing their past trends. Farming, forestry, and fishing occupations are projected to decline by 3 percent, losing 29,000 jobs, and production occupations are projected to decline by 5 percent, losing over half a million jobs. Production occupations are concentrated in manufacturing, where strong productivity growth and rising import penetration will lower demand for workers.

All other groups are expected grow at or below the 10 percent average rate of growth. Expected job gains in these groups range from 1.7 million for office and administrative support occupations to about 462,000 for transportation and material moving occupations.

So far, I have mentioned only job growth. However, job openings arise not just when new jobs are added to the economy, but also when existing jobs become permanently vacant, such as when workers retire. This second source, known as replacement needs, is expected to generate 33.4 million job openings, or more than twice as many openings as job growth alone.

For this reason, examining job openings information, instead of focusing primarily on fast growth, provides a more complete picture of expected job opportunities and the extent of training that must be provided to prepare workers to fill these jobs.

As the baby boom generation ages, retirements will create many replacement openings. Replacement needs also are strong in occupations—such as waiters and waitresses—that employ large numbers of young workers who usually work in such occupations temporarily before leaving for more permanent employment elsewhere.

Large occupations are likely to be the source of large numbers of job openings regardless of whether they are growing rapidly. Some occupations that are not growing, or are even

declining, can generate significant numbers of openings because of replacement needs. On the other hand, many rapidly-growing occupations are small in employment and, therefore, will add relatively few openings.

When the two sources for job openings—growth and replacements—are added together, a different picture emerges than given by expected job growth. Service occupations, where replacement needs are high, top the list, and are expected to generate more than 12 million total job openings. Although professional and related occupations are expected to add more new jobs than service occupations, replacement needs are lower. This group is expected to generate 11 million job openings. (See chart 6.)

***Detailed occupations.*** To examine detailed occupations, I will refer to 2 tables. Table 1 lists the 30 occupations expected to be the fastest-growing and also have wages above the median. Table 2 lists the 30 occupations expected to have the most job openings and also have wages above the median.

Many of the fastest-growing higher wage occupations are related to information technology and health care. Of the 30 occupations listed in Table 1, six are computer-related, including network systems and data communication analysts (53 percent growth and $64,600[2]); computer software engineers, applications (45 percent and $79,780); and computer systems analysts (29 percent and $69,760). Demand for computer occupations is driven by organizations' need to adopt and integrate increasingly sophisticated and complex technologies, and to address computer network security issues.

Eight health-related occupations fall into the top 30 list of fastest growth, higher wage occupations, and include physical therapist assistants (32 percent and $41,360), dental hygienists (30 percent and $62,800), and mental health counselors (30 percent and $34,380). I will discuss health occupations in more detail later.

Every occupation listed in Table 1 has at least some postsecondary education as its most significant source of education or training. For most, a bachelor's degree or higher is typically required.

As I noted earlier, fast-growing occupations do not necessarily generate large numbers of job openings, including replacement needs as well as new jobs. Occupations that were relatively large in 2006 will have many openings, despite their sometimes slower growth. Table 2 indicates that several education, health-related, and computer-related occupations are among those with the most job openings and that pay relatively well.

Unlike many of the fastest growing occupations, some level of education or training below the bachelor's level is sufficient for many occupations in Table 2, including truck drivers (moderate-term on-the-job training) and bookkeeping, accounting, and auditing clerks (moderate-term on-the-job training).

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[2] All wages are 2006 median annual wages from the BLS Occupational Employment Statistics program. The median wage for all occupations was $30,400 in 2006.

***Education and training requirements.*** In addition to information on job growth, job openings, and wages, it is important to be aware of the education and training requirements for in-demand occupations. To provide this information, we classify occupations by the most significant source of education or training required for entry. The education and training categories range from short-term on-the-job training to a graduate degree.

Occupations falling in the categories generally requiring a postsecondary award or degree are projected to have faster than average growth between 2006 and 2016. However, the largest number of new jobs—4.6 million—is expected in occupations in the short-term on-the-job training category. Many of these are service occupations, such as retail salespersons, home health aides, janitors and cleaners, waiters and waitresses, child care workers, and landscaping and groundskeeping workers. An additional 3.1 million new jobs are expected to require a bachelor's degree, many of which are professional and related, such as computer software engineers, applications; accountants and auditors; and elementary school teachers. (See chart 7.)

***Healthcare occupations.*** Increasing demand for healthcare services will generate significant employment growth throughout the healthcare sector. The primary driver of this growth is an aging population. The number of people in older age groups, with substantially more health care needs than younger cohorts, will grow faster than the total population over the next decade. Advances in medical technology will continue to improve the survival rate of severely ill and injured patients, who will then need extensive therapy and care. At the same time, cost-containment policies will generate faster-than-average growth in demand for healthcare workers who assist health care practitioners and have lower training requirements.

In presenting healthcare occupations, we look at two groups: health care practitioners and technical occupations, which are found in the professional and related major group, and healthcare support occupations, which are found in the service occupations major group.

Health care practitioners and technical occupations accounted for 7.2 million jobs in 2006 and are projected to add 1.4 million new jobs over the decade and generate 279,000 job openings annually. (See table 3.) Technological advances in medicine will lead to increased demand for more medical procedures and the workers who perform them. Physicians and surgeons are projected to add about 90,000 jobs. Registered nurses, already the largest healthcare occupation with 2.5 million jobs in 2006, is projected to add about 587,000 new jobs. Strong employment growth is projected for many healthcare technicians and assistants as these workers become more productive and perform more medical procedures that have been typically performed by healthcare practitioners. For example, physician assistants are projected to add about 18,000 jobs, while physical therapists are projected to add about 47,000 jobs.

Healthcare support occupations accounted for 3.7 million jobs in 2006 and are projected to add 1 million jobs over the 2006-2016 decade. (See table 3). The broad occupation of

nursing, psychiatric, and home health aides, accounting for 2.3 million jobs in 2006, is expected to add 647,000 jobs through 2016 as demand increases for these lower-cost workers. Home health aides, in particular, are projected to experience much faster than average employment growth. An emphasis on less costly home care and outpatient treatment of the elderly population, as opposed to expensive institutional care, will lead to a growing number of aides who provide in-home health care. In addition, patients of all ages are being sent home from hospitals and nursing facilities more quickly, and they often require continued health care at home. Other large and fast growing healthcare support occupations include medical assistants, projected to increase 35 percent between 2006 and 2016, and dental assistants, projected to increase 29 percent.

***Measuring green jobs.*** Any time there are emerging industries or occupations, there is a growing need by households, businesses, and policy-makers to understand and evaluate the levels and types of jobs created. This often requires us to adapt and/or expand our programs and generates some measurement challenges.

BLS produces comprehensive employment and wage data for 670 industries and over 800 occupations following the North American Industrial Classification System (NAICS) and the Standard Occupational Classification (SOC) system, respectively. While we can identify some of the industries and occupations that are likely to have green jobs, most green activities either cut across industries and occupations or account for a subset of activity within an individual industry and occupational category.

For example, retrofitting buildings to increase energy efficiency currently falls within the construction industry, but likely supports only a small fraction of the current 6.6 million construction jobs in the U.S. There are, of course, a few industries where this problem does not exist. For example, the production of renewable electric power exactly matches the hydroelectric and other electric power generation industries[3] in the current NAICS.

Accurately measuring employment in green industries and in green occupations will therefore require additional research and data collection to supplement our existing information on industries and occupations. We are developing approaches that include surveying establishments in industries where green activity is expected to occur to identify both the extent they are performing green activities and the occupations of the employees who are doing such work.

An additional challenge for us will come from the number of alternative definitions of what constitutes green activity. For example, the White House Task Force on the Middle Class defined green activity quite broadly as anything dealing with some aspect of environmental improvement. They concluded that "definitions of green jobs are so broad at this point in time, it is impossible to generate a reliable count of how many green jobs there are in America today."[4] There will likely always be some alternative definitions of green jobs since many are driven by specific policy initiatives. For example, the Green

[3] NAICS industries 221111 and 221119 employed 68,000 workers in the second quarter of 2008.
[4] Middle Class Task Force, The Vice President of the United States, "Green Jobs: A Pathway to a Strong Middle Class," February 28, 2009, page 2.

Jobs title of the Energy Independence and Security Act of 2007 (co-sponsored by Secretary of Labor Solis during her time in Congress) focuses on a number of energy efficiency and renewable energy industries.

BLS welcomes the opportunity to help inform the discussion on green jobs. We are learning more about the questions being asked and about green technology so we can fashion a useful and measurable definition – or perhaps multiple definitions.

**Table 1. Detailed occupations with the fastest job growth and above-the-median wages, 2006 and projected 2016, ranked by percent change**
(Numbers in thousands)

| Detailed occupation title | Major occupational group | Employment | | | 2006 Median annual wages | Most significant source of postsecondary education or training |
|---|---|---|---|---|---|---|
| | | 2006 | 2016 | Percent change | | |
| Network systems and data communications analysts | Professional and related | 262 | 402 | 53.4 | $64,600 | Bachelor's degree |
| Computer software engineers, applications | Professional and related | 507 | 733 | 44.6 | 79,780 | Bachelor's degree |
| Personal financial advisors | Management, business, and financial | 176 | 248 | 41.0 | 66,120 | Bachelor's degree |
| Makeup artists, theatrical and performance | Service | 2 | 3 | 39.8 | 31,820 | Postsecondary vocational award |
| Veterinarians | Professional and related | 62 | 84 | 35.0 | 71,990 | First professional degree |
| Substance abuse and behavioral disorder counselors | Professional and related | 83 | 112 | 34.3 | 34,040 | Bachelor's degree |
| Financial analysts | Management, business, and financial | 221 | 295 | 33.8 | 66,590 | Bachelor's degree |
| Physical therapist assistants | Service | 60 | 80 | 32.4 | 41,360 | Associate degree |
| Forensic science technicians | Professional and related | 13 | 17 | 30.7 | 45,330 | Bachelor's degree |
| Dental hygienists | Professional and related | 167 | 217 | 30.1 | 62,800 | Associate degree |
| Mental health counselors | Professional and related | 100 | 130 | 30.0 | 34,380 | Master's degree |
| Mental health and substance abuse social workers | Professional and related | 122 | 159 | 29.9 | 35,410 | Master's degree |
| Marriage and family therapists | Professional and related | 25 | 32 | 29.8 | 43,210 | Master's degree |
| Computer systems analysts | Professional and related | 504 | 650 | 29.0 | 69,760 | Bachelor's degree |
| Database administrators | Professional and related | 119 | 154 | 28.6 | 64,670 | Bachelor's degree |
| Computer software engineers, systems software | Professional and related | 350 | 449 | 28.2 | 85,370 | Bachelor's degree |
| Environmental science and protection technicians, including health | Professional and related | 36 | 47 | 28.0 | 38,090 | Associate degree |
| Physical therapists | Professional and related | 173 | 220 | 27.1 | 66,200 | Master's degree |
| Network and computer systems administrators | Professional and related | 309 | 393 | 27.0 | 62,130 | Bachelor's degree |
| Physician assistants | Professional and related | 66 | 83 | 27.0 | 74,980 | Master's degree |
| Health educators | Professional and related | 62 | 78 | 26.2 | 41,330 | Bachelor's degree |
| Multi-media artists and animators | Professional and related | 87 | 110 | 25.8 | 51,350 | Bachelor's degree |
| Cardiovascular technologists and technicians | Professional and related | 45 | 57 | 25.5 | 42,300 | Associate degree |
| Environmental engineers | Professional and related | 54 | 68 | 25.4 | 69,940 | Bachelor's degree |
| Occupational therapist assistants | Service | 25 | 31 | 25.4 | 42,060 | Associate degree |
| Environmental scientists and specialists, including health | Professional and related | 83 | 104 | 25.1 | 56,100 | Master's degree |
| Securities, commodities, and financial services sales agents | Sales and related | 320 | 399 | 24.8 | 68,500 | Bachelor's degree |
| Radiation therapists | Professional and related | 15 | 18 | 24.8 | 66,170 | Associate degree |
| Environmental engineering technicians | Professional and related | 21 | 26 | 24.8 | 40,560 | Associate degree |
| Social and community service managers | Management, business, and financial | 130 | 162 | 24.7 | 52,070 | Bachelor's degree |

**Table 2. Occupations with the most job openings and above-the-median wages, 2006 and projected 2016, ranked by numeric change**
(Numbers in thousands)

| Detailed occupation title | Major occupational group | Employment | | | Annual average job openings, 2006-16 (1) | 2006 Median annual wages | Most significant source of postsecondary education or training |
|---|---|---|---|---|---|---|---|
| | | 2006 | 2016 | Percent change | | | |
| Registered nurses | Professional and related | 2,505 | 3,092 | 23.5 | 100 | $57,280 | Associate degree |
| Postsecondary teachers | Professional and related | 1,672 | 2,054 | 22.9 | 66 | 56,120 | Doctoral degree |
| Bookkeeping, accounting, and auditing clerks | Office and administrative support | 2,114 | 2,377 | 12.5 | 59 | 30,560 | Moderate-term on-the-job training |
| Elementary school teachers, except special education | Professional and related | 1,540 | 1,749 | 13.6 | 55 | 45,570 | Bachelor's degree |
| Truck drivers, heavy and tractor-trailer | Transportation and material moving | 1,860 | 2,053 | 10.4 | 52 | 35,040 | Moderate-term on-the-job training |
| Executive secretaries and administrative assistants | Office and administrative support | 1,618 | 1,857 | 14.8 | 50 | 37,240 | Work experience in a related occupation |
| Sales representatives, wholesale and manufacturing, except technical and scientific products | Sales and related | 1,562 | 1,693 | 8.4 | 48 | 49,610 | Work experience in a related occupation |
| Accountants and auditors | Management, business, and financial | 1,274 | 1,500 | 17.7 | 45 | 54,630 | Bachelor's degree |
| General and operations managers | Management, business, and financial | 1,720 | 1,746 | 1.5 | 44 | 85,230 | Bachelor's or higher degree, plus work experience |
| First-line supervisors/managers of retail sales workers | Sales and related | 1,676 | 1,747 | 4.2 | 42 | 33,960 | Work experience in a related occupation |
| Secondary school teachers, except special and vocational education | Professional and related | 1,038 | 1,096 | 5.6 | 37 | 47,740 | Bachelor's degree |
| First-line supervisors/managers of office and administrative support workers | Office and administrative support | 1,418 | 1,500 | 5.8 | 37 | 43,510 | Work experience in a related occupation |
| Carpenters | Construction and extraction | 1,462 | 1,612 | 10.3 | 35 | 36,550 | Long-term on-the-job training |
| Licensed practical and licensed vocational nurses | Professional and related | 749 | 854 | 14.0 | 31 | 36,550 | Postsecondary vocational award |
| Computer software engineers, applications | Professional and related | 507 | 733 | 44.6 | 30 | 79,780 | Bachelor's degree |
| Computer systems analysts | Professional and related | 504 | 650 | 29.0 | 28 | 69,760 | Bachelor's degree |
| Automotive service technicians and mechanics | Installation, maintenance, and repair | 773 | 883 | 14.3 | 27 | 33,780 | Postsecondary vocational award |
| Management analysts | Management, business, and financial | 678 | 827 | 21.9 | 26 | 68,050 | Bachelor's or higher degree, plus work experience |
| Police and sheriff's patrol officers | Service | 648 | 719 | 10.8 | 24 | 47,460 | Long-term on-the-job training |
| Computer support specialists | Professional and related | 552 | 624 | 12.9 | 24 | 41,470 | Associate degree |
| Lawyers | Professional and related | 761 | 844 | 11.0 | 23 | 102,470 | First professional degree |
| Electricians | Construction and extraction | 705 | 757 | 7.4 | 23 | 43,610 | Long-term on-the-job training |

**Table 2. Occupations with the most job openings and above-the-median wages, 2006 and projected 2016, ranked by numeric change**
(Numbers in thousands)

| Detailed occupation title | Major occupational group | Employment | | | Annual average job openings, 2006-16 (1) | 2006 Median annual wages | Most significant source of postsecondary education or training |
|---|---|---|---|---|---|---|---|
| | | 2006 | 2016 | Percent change | | | |
| Middle school teachers, except special and vocational education | Professional and related | 658 | 732 | 11.2 | 22 | 46,300 | Bachelor's degree |
| Physicians and surgeons | Professional and related | 633 | 723 | 14.2 | 20 | (2) | First professional degree |
| Network systems and data communications analysts | Professional and related | 262 | 402 | 53.4 | 19 | 64,600 | Bachelor's degree |
| First-line supervisors/managers of construction trades and extraction workers | Construction and extraction | 772 | 842 | 9.1 | 18 | 53,850 | Work experience in a related occupation |
| Correctional officers and jailers | Service | 442 | 516 | 16.9 | 18 | 35,760 | Moderate-term on-the-job training |
| Maintenance and repair workers, general | Installation, maintenance, and repair | 1,391 | 1,531 | 10.1 | 17 | 31,910 | Moderate-term on-the-job training |
| Securities, commodities, and financial services sales agents | Sales and related | 320 | 399 | 24.8 | 16 | 68,500 | Bachelor's degree |
| Plumbers, pipefitters, and steamfitters | Construction and extraction | 502 | 555 | 10.6 | 16 | 42,770 | Long-term on-the-job training |

Notes: (1) Annual average job openings due to both growth and net replacement needs.
(2) Wage is equal to or greater than $145,600 per year.

**Table 3. Healthcare practitioner and technical and healthcare support occupations: projected employment growth, 2006-16, 2006 wages, and education and training category**
(Numbers in thousands)

| Occupation title | Employment | | | Annual average job openings, 2006-16 (1) | 2006 Median annual wages | Most significant source of postsecondary education or training |
|---|---|---|---|---|---|---|
| | 2006 | 2016 | Percent change | | | |
| **Healthcare practitioner and technical occupations** | **7,198** | **8,620** | **19.8** | **279** | **$51,980** | ____ |
| Chiropractors | 53 | 60 | 14.4 | 1 | 65,220 | First professional degree |
| Dentists, general | 136 | 149 | 9.2 | 4 | 132,140 | First professional degree |
| Oral and maxillofacial surgeons | 8 | 8 | 9.1 | 0 | (2) | First professional degree |
| Orthodontists | 9 | 10 | 9.2 | 0 | (2) | First professional degree |
| Prosthodontists | 1 | 1 | 10.7 | 0 | (2) | First professional degree |
| Dentists, all other specialists | 7 | 7 | 6.8 | 0 | 91,200 | First professional degree |
| Dietitians and nutritionists | 57 | 62 | 8.6 | 2 | 46,980 | Bachelor's degree |
| Optometrists | 33 | 36 | 11.3 | 1 | 91,040 | First professional degree |
| Pharmacists | 243 | 296 | 21.7 | 10 | 94,520 | First professional degree |
| Physicians and surgeons | 633 | 723 | 14.2 | 20 | (2) | First professional degree |
| Physician assistants | 66 | 83 | 27.0 | 3 | 74,980 | Master's degree |
| Podiatrists | 12 | 13 | 9.5 | 1 | 108,220 | First professional degree |
| Registered nurses | 2,505 | 3,092 | 23.5 | 100 | 57,280 | Associate degree |
| Audiologists | 12 | 13 | 9.8 | 0 | 57,120 | First professional degree |
| Occupational therapists | 99 | 122 | 23.1 | 4 | 60,470 | Master's degree |
| Physical therapists | 173 | 220 | 27.1 | 7 | 66,200 | Master's degree |
| Radiation therapists | 15 | 18 | 24.8 | 1 | 66,170 | Associate degree |
| Recreational therapists | 25 | 26 | 3.7 | 0 | 34,990 | Bachelor's degree |
| Respiratory therapists | 102 | 126 | 22.6 | 4 | 47,420 | Associate degree |
| Speech-language pathologists | 110 | 121 | 10.6 | 3 | 57,710 | Master's degree |
| Therapists, all other | 35 | 38 | 10.0 | 1 | 42,250 | Bachelor's degree |
| Veterinarians | 62 | 84 | 35.0 | 3 | 71,990 | First professional degree |
| Health diagnosing and treating practitioners, all other | 65 | 73 | 11.8 | 2 | 61,570 | Bachelor's degree |
| Medical and clinical laboratory technologists | 167 | 188 | 12.4 | 5 | 49,700 | Bachelor's degree |
| Medical and clinical laboratory technicians | 151 | 174 | 15.0 | 5 | 32,840 | Associate degree |
| Dental hygienists | 167 | 217 | 30.1 | 8 | 62,800 | Associate degree |
| Cardiovascular technologists and technicians | 45 | 57 | 25.5 | 2 | 42,300 | Associate degree |
| Diagnostic medical sonographers | 46 | 54 | 19.1 | 1 | 57,160 | Associate degree |
| Nuclear medicine technologists | 20 | 23 | 14.8 | 1 | 62,300 | Associate degree |
| Radiologic technologists and technicians | 196 | 226 | 15.1 | 6 | 48,170 | Associate degree |
| Emergency medical technicians and paramedics | 201 | 240 | 19.2 | 6 | 27,070 | Postsecondary vocational award |
| Dietetic technicians | 25 | 29 | 14.8 | 1 | 24,040 | Postsecondary vocational award |
| Pharmacy technicians | 285 | 376 | 32.0 | 18 | 25,630 | Moderate-term on-the-job training |
| Psychiatric technicians | 62 | 60 | -3.3 | 2 | 27,780 | Postsecondary vocational award |
| Respiratory therapy technicians | 19 | 19 | 0.9 | 1 | 39,120 | Associate degree |
| Surgical technologists | 86 | 107 | 24.5 | 5 | 36,080 | Postsecondary vocational award |
| Veterinary technologists and technicians | 71 | 100 | 41.0 | 5 | 26,780 | Associate degree |
| Licensed practical and licensed vocational nurses | 749 | 854 | 14.0 | 31 | 36,550 | Postsecondary vocational award |

**Table 3. Healthcare practitioner and technical and healthcare support occupations: projected employment growth, 2006-16, 2006 wages, and education and training category**
(Numbers in thousands)

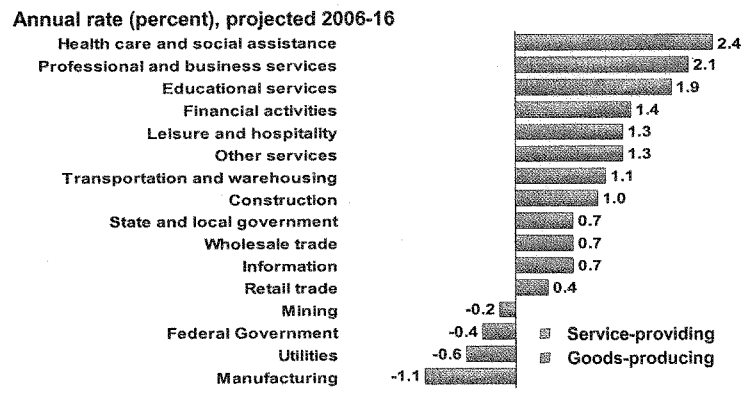
| Occupation title | Employment | | | Annual average job openings, 2006-16 (1) | 2006 Median annual wages | Most significant source of postsecondary education or training |
|---|---|---|---|---|---|---|
| | 2006 | 2016 | Percent change | | | |
| Medical records and health information technicians | 170 | 200 | 17.8 | 8 | 28,030 | Associate degree |
| Opticians, dispensing | 66 | 72 | 8.7 | 3 | 30,300 | Long-term on-the-job training |
| Orthotists and prosthetists | 6 | 6 | 11.8 | 0 | 58,980 | Bachelor's degree |
| Healthcare technologists and technicians, all other | 79 | 91 | 15.0 | 2 | 35,140 | Postsecondary vocational award |
| Occupational health and safety specialists | 45 | 49 | 8.1 | 1 | 58,030 | Bachelor's degree |
| Occupational health and safety technicians | 10 | 12 | 14.6 | 0 | 42,160 | Bachelor's degree |
| Athletic trainers | 17 | 21 | 24.3 | 1 | $36,560 | Bachelor's degree |
| Healthcare practitioners and technical workers, all other | 53 | 61 | 14.8 | 2 | 37,200 | Bachelor's degree |
| **Healthcare support occupations** | **3,723** | **4,721** | **26.8** | **140** | **22,870** | — |
| Home health aides | 787 | 1,171 | 48.7 | 45 | 19,420 | Short-term on-the-job training |
| Nursing aides, orderlies, and attendants | 1,447 | 1,711 | 18.2 | 39 | 22,180 | Postsecondary vocational award |
| Psychiatric aides | 62 | 62 | -0.1 | 1 | 23,900 | Short-term on-the-job training |
| Occupational therapist assistants | 25 | 31 | 25.4 | 1 | 42,060 | Associate degree |
| Occupational therapist aides | 8 | 10 | 21.9 | 0 | 25,020 | Short-term on-the-job training |
| Physical therapist assistants | 60 | 80 | 32.4 | 3 | 41,360 | Associate degree |
| Physical therapist aides | 46 | 58 | 24.4 | 2 | 22,060 | Short-term on-the-job training |
| Massage therapists | 118 | 142 | 20.3 | 4 | 33,400 | Postsecondary vocational award |
| Dental assistants | 280 | 362 | 29.2 | 13 | 30,220 | Moderate-term on-the-job training |
| Medical assistants | 417 | 565 | 35.4 | 20 | 26,290 | Moderate-term on-the-job training |
| Medical equipment preparers | 45 | 52 | 14.2 | 1 | 25,950 | Short-term on-the-job training |
| Medical transcriptionists | 98 | 112 | 13.5 | 3 | 29,950 | Postsecondary vocational award |
| Pharmacy aides | 50 | 45 | -11.1 | 1 | 19,440 | Short-term on-the-job training |
| Veterinary assistants and laboratory animal caretakers | 75 | 86 | 15.7 | 2 | 19,960 | Short-term on-the-job training |
| Healthcare support workers, all other | 204 | 236 | 15.6 | 6 | 26,990 | Short-term on-the-job training |

**Table 3. Healthcare practitioner and technical and healthcare support occupations: projected employment growth, 2006-16, 2006 wages, and education and training category**
(Numbers in thousands)

| Occupation title | Employment | | | Annual average job openings, 2006-16 (1) | 2006 Median annual wages | Most significant source of postsecondary education or training |
|---|---|---|---|---|---|---|
| | 2006 | 2016 | Percent change | | | |

Notes: (1) Annual average job openings due to both growth and net replacement needs.
(2) Wage is equal to or greater than $145,600 per year.

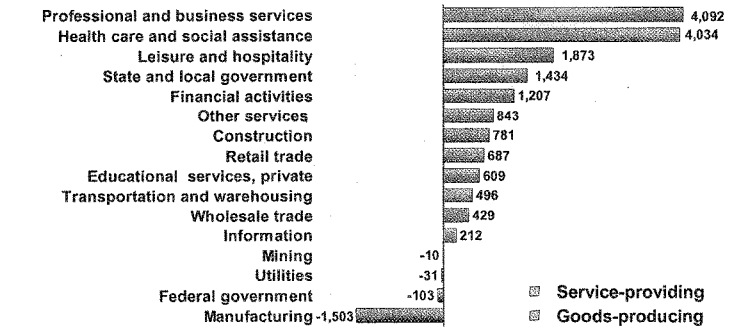
## Chart 1. Growth rate for wage and salary employment by industry sector




Source: Bureau of Labor Statistics

1

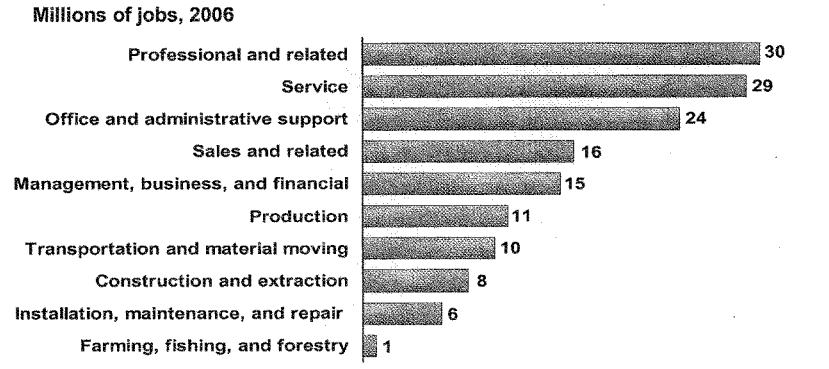
## Chart 2. Net (numeric) change in wage and salary employment by industry sector




Source: Bureau of Labor Statistics

2

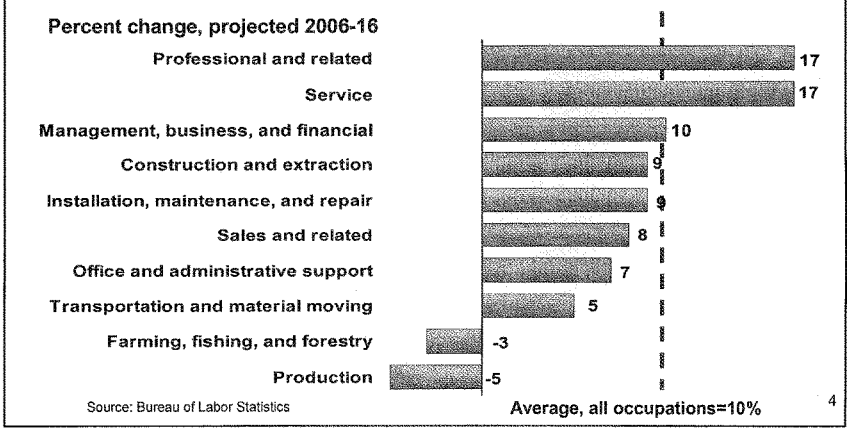
## Chart 3. Employment by major occupational group




Source: Bureau of Labor Statistics

3

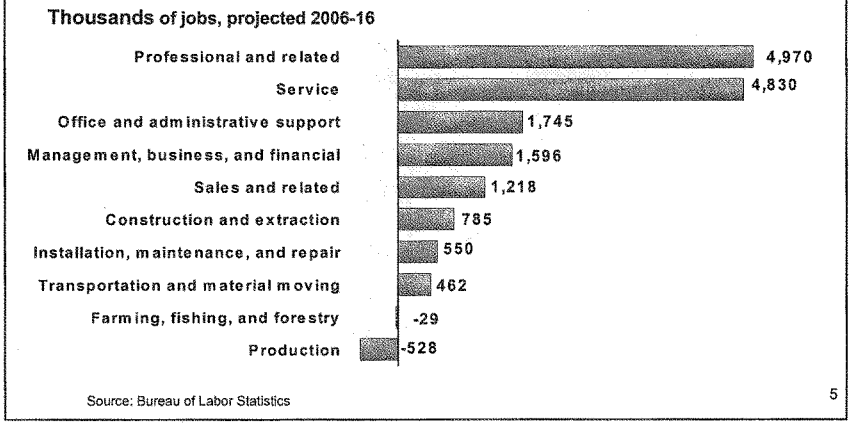
## Chart 4. Percent change in employment by major occupational group



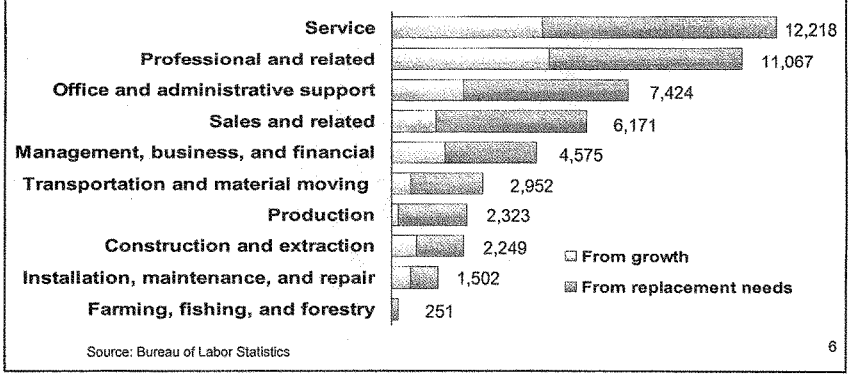

Source: Bureau of Labor Statistics

4

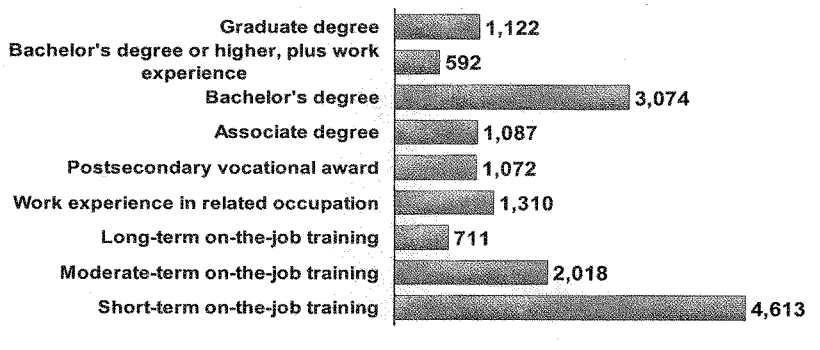
## Chart 5. Numeric change in employment by major occupational group




## Chart 6. Job openings by major occupational group



## Chart 7. Numeric growth in employment by education or training category




Source: Bureau of Labor Statistics

7

Dr. Keith Hall

Keith Hall is the Commissioner of Labor Statistics for the U.S. Department of Labor. As Commissioner, he oversees the Bureau of Labor Statistics (BLS), which is the principal fact-finding agency in the Federal Government in the broad field of labor economics and statistics. The BLS is an independent national statistical agency that collects, processes, analyzes, and disseminates essential statistical data to the American public, the U.S. Congress, other Federal agencies, State and local governments, business, and labor. The BLS also serves as a statistical resource to the Department of Labor.

Dr. Hall also served as chief economist for the White House Council of Economic Advisers for two years where he analyzed a broad range of fiscal, regulatory and macroeconomic policies and directed a team that monitored the state of the economy and developed economic forecasts. Prior to that, he was Chief Economist for the U.S. Department of Commerce where he provided technical advice regarding the scope, emphasis, and state of the economic and statistical activities of the Bureau of Census, the Bureau of Economic Analysis, and STAT-USA. Dr. Hall also spent ten years at the U.S. International Trade Commission. He taught full time on the faculties of the University of Arkansas and University of Missouri.

Dr. Hall received his B.A. degree from the University of Virginia and his M.S. and Ph.D. degrees in economics from Purdue University. Dr. Hall and his wife Karen have four grandchildren.

Mr. OBEY. Dr. Fitzgerald.

Ms. FITZGERALD. Yes. Thank you, members of the Committee, for having me here today.

I would like to talk about the health care sector and its potential for creating middle class jobs for people who are already in the sector.

There are three interconnected issues here. The first one is improving the quality of care; the second one is improving skills of the workers who are in the profession; and the third is improving wages.

In 2006, I published a book called Moving Up in the New Economy, where I examined career ladder programs in health care and several other sectors throughout the Country. They were led by community colleges, community organizations, unions, employers, and combinations of those groups. I identified two types of career ladder strategies: one that creates ladders within an occupation that already exists, and others that help people in lower levels advance to higher levels.

But before I talk about those, I would like to also mention simply the importance of raising wages, irrespective of training. And let us just take the case of the lowest paid workers in these occupations, that is, home health care workers and those who work in long-term care, either as something called home health aides or certified nursing assistants. Basically, these are jobs that take anywhere from 6 to 12 weeks of training.

They are very poorly paid. People in these occupations get very little respect on the job and, as a result, the turnover rate is very, very high. That high turnover rate affects the quality of care. The person who is coming in to take care of your parent, whether in a nursing home or in their home, when they leave and that job turns, you are also losing the person who knew something about the person they are caring for and their special needs.

So what we find is, by increasing wages, we decrease turnover, and that, in and of itself, helps to improve the quality of care.

But let us look a little bit at some of the strategies. One is to create tiers within occupations. If we look at certified nursing assistant, the next tier up is to become what is called a licensed practical nurse, in some States a licensed vocational nurse.

For someone who is working full-time, raising a family, and going to school, it is an 18-month path; and what happens is, if a person—and this is often the case—trying to make that advance does not make it, she has nothing to show for it, she is still a CNA. So the idea is to create tiers within the occupation so that you recognize increases in skills.

There are many in my book that I talk about, programs like this throughout the Country. There is one problem with them, though: they are usually developed by an employer, and if you become a CNA–2 or a CNA–3 at one place of employment, that is not a portable credential that you can take along with you.

And the other problem is because they are working in occupations that are, for the most part, subsidized by government funding, there is not enough money in the system to really raise their wages out of the poverty track. There is potential here, though, but we have not achieved it yet.

Let us move on quickly to career ladders. In theory, what we have is a career ladder that starts at the certified nursing assistant, moves up to the licensed practical nurse, then moves up a step to the Associate degree registered nurse, the Bachelor's degree registered nurse. You could take it up to Masters and Ph.D. in nursing, for example. In practice, the most likely—and this is a very difficult career ladder jump—is from the CNA to LPN.

I have looked, as I said before, all around the Country. Everything you need to know about how to do this you can learn from AFSME's District 1199–C Training and Upgrading Fund in Philadelphia. There is simply nothing else comparable in the Country. It serves over 10,000 workers a year; it is operated mostly on Taft-Hartley money that the employer kicks in 1.5 percent of payroll; and it is the Nation's only union-run LPN school.

But because the union also receives grants from the Department of Labor and other government funding sources, they can serve people in the community as well.

I could go on for some time about the features of the program that make it great. I think one of the things that is unique among this program is the three people who started it—Henry Nicholas, Cheryl Feldman, and the late Jim Ryan—have been with the program for all of its 35 years and have really been able to adapt it. But here is a case where a certified nursing assistant can almost double her wages by moving on to an LPN.

But one of the problems facing these kinds of programs and any kind of advancement program for people in the nursing occupations is the shortage of nursing faculty. And there have been programs throughout the Country by different States trying to address this shortage, but here again the problem is a wage gap. A Bachelor's degree or even an Associate degree nurse makes about $72,000 a year, and it is about $62,000. It is less than that for a Master's degree or Ph.D. trained nurse working in a university. So you are a nurse; what decision are you going to make in terms of where you are going?

So that has to be part of the whole picture of how we improve career ladder opportunities in nursing. And we have tried to deal with that once at the Federal level with the Nurse Education, Expansion and Development Act, but the legislation never passed. It has been reintroduced by Durbin.

I could go on and tell you about several other types of programs not only in nursing, but in behavioral health, surgical technician, orthopedic technicians, but you can read about those later. What I want to point out is how contradictory the Federal policy is on this.

On the one hand, we have cost containment guidelines for Medicare and Medicaid, and we know there is a lot of corruption in the system that needs to be fixed. But those cost containment restrictions are also responsible for maintaining this low wage industry.

Then, on the other hand, we have the U.S. Department of Labor creating these special pools of funds to improve worker training, and these demonstration projects cannot compensate for the low wages that exist in the sector.

Then, if we had a third hand, we could say the other thing we do is use H1–B funding to bring in nurses trained from other coun-

tries, so essentially we are outsourcing the education and training of nursing and other health technicians in this Country.

So, to close, I would argue that we have to set as a national goal not just the expansion of these various small programs here and there and training, but an ideal that all positions in the health care field pay at least a good paraprofessional salary and provide benefits to workers; and it is only by linking those two goals that we will really create middle class jobs in the health sector.

Thank you.

Mr. OBEY. Thank you.

[The information follows:]

**Pathways to Living-Wage Jobs in Health Care**

Health care is seemingly an ideal sector to pursue a career-ladder strategy. It has lots of entry-level and paraprofessional positions, and demand will continue to grow with the aging of the population, the growth of nursing home and community-based care, and the reorganization of hospital care. But are there really career ladders for, say, dietary aides or certified nursing assistants (CNAs) and others on the lowest rungs? It depends. The challenge of creating career opportunities along the broad spectrum of health care occupations goes beyond merely educating more people. The wages of many entry-level workers in health care are determined by government reimbursement. Without increasing government funding to a level that allows offering decent pay raises for increased skills, career ladder training programs are not pathways out of poverty. We cannot address the skills and labor shortage without paying higher wages.

**Care Career Ladders in Nursing**

There are a number of programs across the nation that have had some success in helping home health aides and certified nursing assistants advance into LPN and RN positions. Going to scale requires more than identifying the features of best practice programs, however. To assess the potential for advancement in nursing one has to understand broader contextual factors such as what type of facilities employ nurses, what career progressions exist, and the pay structure for nurses and nurse educators.

Many health care career ladder programs focus on the certified nursing assistant (CNA). Long-term care facilities and nursing homes rely on CNAs for most of the day-to-day care of patients. The licensed practical nurse (in some states licensed vocational nurse) takes on the role of the registered nurse (RN) charge nurse in these settings. In long-term and nursing home care the career ladders have been creating higher levels of training and a career ladder within the nursing home setting and creating a career ladder between CNA and LPN. Hospitals employ fewer CNAs, so the career ladders for entry-level workers in hospitals tend to be into allied health and administrative and clerical occupations.

In my 2006 book, *Moving Up in the New Economy*, I examined numerous health career ladder programs throughout the country.[1] They were led by community colleges, community organizations, unions, employers, and every possible combination of these organizations. I identified two career-ladder strategies: 1) creating tiers within occupations; and 2) career ladder programs.

For a CNA, moving up just one rung to LPN is a long pathway. Pursued as a full-time program, a high school graduate can earn this credential in one year. Pursuing it part-time is a much longer path because many CNAs have to start by taking remedial courses before completing a part-time program (few of which exist) while working (often more than one job) and raising a family. If the CNA quits the program at any time short of

[1] Fitzgerald, Joan. 2006. Moving Up in the New Economy. Thousand Oaks, Ca.: Sage.

earning the LPN degree, she gains nothing for whatever skills she has acquired along the way. Recognizing this, several programs have attempted to create tiers within the CNA occupation to recognize higher level skills and knowledge.

Perhaps the best known of these programs is the Extended Care Career Ladder Initiative program in Massachusetts.[2] Several participating facilities created tiers within the CNA occupation and developed training programs for workers. The programs created in 8 nursing homes and 3 home health agencies provided very modest pay raises, improvements in morale, job performance, and reduction of turnover. I identify similar programs in other parts of the country in the book, but conclude that even in the most successful programs, a key problem is that the new job titles (e.g. CNA I, II, III) are recognized only by the employer offering them, and thus do not provide a portable credential. Thus, new occupational categories need to be created and endorsed by professional organizations at the state level for these programs to succeed. Most problematic is that the programs do not lift workers out of poverty wages. Because wages in long-term care are based on federal reimbursements, we need to increase reimbursements and earmark them for wages to motivate CNAs to stay on the job and to become more skilled at what they do.

In theory, the nursing career pathway is as follows: CNA→LPN→RN (assoc. degree)→BSN (bachelor's degree)→MSN/ Nurse Practitioner→Ph.D.[3] In practice, the most likely career ladder for long-term care workers is CNA to LPN.[4] And this pathway offers the biggest jump in pay and benefits for the amount of time invested. Of the numerous programs I examined across the country, by far the most effective were those led by unions. And of these, the 1199C Training and Upgrading Fund stands out as the nation's best CNA to LPN program.

In Philadelphia, the American Federation of State, County and Municipal Employees (AFSCME) District 1199C Training and Upgrading Fund has been operating for 35 years. The fund is a trust negotiated between the union local and the hospitals and nursing homes and other health care facilities, to which management contributes 1.5 percent of gross payroll. It serves over 10,000 workers annually through various training programs, counseling, placement, certification testing, and workshops. The fund opened a school of practical nursing that is approved by the Pennsylvania Board of Nursing and is the only union-run LPN school in the country. Because the union receives grants from the Department of Labor and other government funding sources and foundations, it can make

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[2] ECCLI is part of the Massachusetts Nursing Home Quality Initiative, which started in 2000.

[3] I should note that many in the nursing profession advocate for the entry-level certification for a registered nurse being a bachelor's degree. This argument is based on considerable research on quality of care, particularly that of Dr. Linda Aiken. Those arguing this position would argue that the CNA or LPN is no more a rung on the nursing career ladder than a physician's assistant is to a doctor or a paralegal is to a lawyer.

[4] Some small percentage of LPNs advance to RN, and mostly move into a hospital setting. Practices vary considerably geographically, as hospitals in some cities, such as Boston, hire only bachelor's degree nurses.

the program available to community residents as well as union members. As local hospitals have cut their programs due to high costs, the 1199C program is now the only LPN program in the Philadelphia area.

The first LPN class of 31 students started in 2001. The program extends the full-time, year-long course to 18 months because it is offered on evenings and weekends to accommodate work schedules. Students who want to advance, but don't have the math or English skills, have several options. The union fund offers two levels of pre-nursing prep that combine English, math, and anatomy and tie these topics to health care. These courses have been an important vehicle for recruiting people who may not qualify initially. About half of the students have to take at least one of the basic education or pre-nursing courses. According to Cheryl Feldman, executive director of the fund, the Philadelphia area has a shortage of LPNs, so graduates are practically guaranteed a job. Union CNAs make $13 an hour in hospitals and $8-10 in nursing homes. Working as LPNs, they would make over $20 an hour.

The elements of the program that contribute to its effectiveness include the experiential remedial work, tuition support, using instructors who themselves advanced from entry-level positions, and creating a sense of community and support. Although 1199C has worked successfully with non-union facilities, Feldman explains that the union difference is that the labor-management trust created by giving workers a strong voice in the program means that workers who advance are likely to stay on the job. The program is a true labor-management partnership.

Assistance in paying tuition is essential to career ladder programs. For all of 1199C's programs, union members may apply for tuition reimbursement, leaves of absence with stipends, and other forms of assistance. Employers pay for half of the workers' time while they are in training, making both workers and employers feel they have a stake in the program's success. In the past scholarships have been available to RN and LPN students through a U.S. Department of Labor H1-B grant and employer matches.

An unusual feature of the 1199C training fund is that residents in the nearby communities in welfare-to-work programs are eligible for scholarships. Funding from federal, state and foundation sources have made this possible. As foundation support dries up in the current economy, continued federal support will be essential to 1199C and other training programs to assisting unemployed and displaced workers move into health care occupations.

One barrier facing 1199C and other nursing career ladder programs is the shortage of nursing faculty (and although not the topic of my testimony, the shortage of RNs persists).[5] In recent years, anywhere between 80,000 and 150,000 qualified applicants

[5] With an average salary of $56,888, registered nursing should be an attractive occupation. But the United States had about 126,000 nursing vacancies last year. And the U.S. Bureau of Labor Statistics predicts that the shortfall could go as high as 800,000 by 2020. The U.S. Department of Health and Human Services predicts that by 2020 at least 36 percent of RN positions will be vacant ((see Health Resources and Services Administration. 2004. What is Behind HRSA/s Projected Supply, Demand and Shortage of Registered

have been turned down by U.S. schools of nursing (both associate and baccalaureate degrees) due to insufficient faculty and classroom or lab space, or lack of clinical sites. There are two underlying reasons. The first is that nursing programs are often money losers for community colleges and universities because of the low student to faculty ratio required for clinical education. The second is the unattractiveness of teaching careers for nurses due to low pay and long working hours. Master's level faculty average $66,588 annually -- about the same as an associate degree RN in clinical practice and substantially less than a nurse-practitioner with a master's degree who makes $81,517 a year. Beginning assistant professors at universities (with Ph.Ds in nursing) typically make about $72,000 annually and work long hours to balance the teaching, research, and service components of their positions.

Investing in career ladder programs for those at the bottom of the nursing career ladder has to be done in parallel with programs to address the faculty shortage problem. Many universities are developing creative programs to increase faculty capacity and deliver curricula in nursing programs. These initiatives have received federal, state, foundation, and industry funding.[6]

At the state level, the Oregon Nursing Leadership Council, a consortium of state nursing and credentialing organizations, community colleges, and university deans, developed a statewide strategic plan for addressing all aspects of the nursing shortage problem. This initiative has increased the state's nursing graduation rate by 11 percent per year since 2001 by having nursing schools share some clinical facilities and maximizing use of faculty by developing a shared curriculum and simulation education. The Oregon Council for Nursing also created a software program to coordinate clinical placements regionally. Typically hospitals have affiliations with schools with an agreed upon number of clinical placements. Sometimes scheduling is such that a school can't fill its allotted slots, so they go unused. Now, all hospitals and schools in the Portland region pool their unused slots so that none are wasted. Potential students, particularly minorities at the high school level, are being recruited into nursing through several creative programs. Hospitals are offering scholarships to nursing students who agree to work at the hospital for at least three years after graduation. Several universities are developing new graduate nursing programs and there is a statewide partnership between eight community colleges and the public university to create a shared, competency-based curriculum. Once in place schools will have the same prerequisites, with one application and dual enrollment so students

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Nurses? ftp://ftp.hrsa.gov/bhpr/workforce/behindshortage.pdf). Meanwhile, 500,000 RNs have left the profession and are working in other jobs. The reasons for the shortage are complex, but boil down to nurses leaving the profession and fewer people are entering because of education bottlenecks. Both reflect massive failures of national policy. And instead of making it possible for more Americans to take these good jobs, policy is luring immigrant nurses from poor countries. The current economy seems to be easing the shortage—now, as in past periods of high unemployment, former nurses are returning to work to supplement family income. But in the long-term, the lack of new recruits will create severe shortages (See Allan, Janet D. and Jillian Aldebron. 2008. A Systematic Assessment of Strategies to Address the Nursing Faculty Shortage, U.S. *Nursing Outlook*. 56: 286-297).

[6] See Allan and Aldebron, 2008 and Fitzgerald, Joan. 2006. Getting Serious About Good Jobs. *The American Prospect*. (October).

and their financial aid can move between programs. Although the initial goal of doubling nursing program enrollments by 2004 wasn't reached, the council is well on the way to achieving its 2010 goals of increasing retention of nurses in the first three years of practice and increasing the state's nursing faculty by 65 instructors.[7]

This foundation-funded initiative demonstrates that improving the work culture and coordinating state resources and strategies can reduce quit rates and attract new people to the profession, yet the problem of nurse overwork and underfunded nurse training calls for national policy.

While more support is needed for programs like Oregon's, the problem will not be solved without addressing the wage gap. The only federal program proposed to address the wage gap was the Nurse Education, Expansion, and Development Act, introduced in 2005. The legislation never made it out of committee. Referred to as the NEED act, the bill has been reintroduced by Senator Richard Durbin (D IL) in February of this year. Our national policy has been more focused on outsourcing nursing education than investing in expanding it in the U.S.[8]

**Advancement in Allied Health Occupations**

Kaiser-Permanente, the nation's largest managed care organization, supports several education and training upgrading programs in partnership with the 27 unions that represent its hospital and other workers. Its programs borrow heavily from 1199C, but are applied to allied health and clerical workers in addition to those in nursing occupations.

Kaiser-Permanente is one of 25 employers participating in the SEIU United Health Workers West & Joint Employer Education Fund. The fund was started in the late 1990s and replicates many of the Philadelphia 1199C offerings. It serves 70,000 health care workers in California, Colorado, Oregon, and Washington. The program offers bridge programs in anatomy, chemistry, microbiology, and nursing to prepare for college-level courses in these subjects needed in nursing and other allied health occupations. In career upgrading, SEIU has recently added a program for licensed vocational nurses to obtain the RN degree at City College of San Francisco.

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[7] Oregon Nursing Leadership Council Strategic Plan, 2005-2008. http://www.oregoncenterfornursing.org/documents/ONLC%20strategic%20plan%20final%205-15-06.pdf

[8] Instead of investing in nurse education and creating good jobs for Americans, we are importing immigrant nurses from the Philippines, India, Nigeria, and elsewhere. The U.S. invests token amounts for educating U.S. nurses while removing caps on hiring foreign nurses. For example, the Nurse Education Loan Repayment Program (NELRP) repays 60 percent to 85 percent of student loans for nurses who agree to practice two years in a facility experiencing a critical staff shortage. The Nursing Scholarship Program provides scholarships and stipends to students in exchange for the same two-year commitment. In fiscal year 2008, the NELRP received 6,078 eligible applications and made 232 2-year awards and 203 3-year awards. Only 172 of the 4,894 eligible scholarship applications were funded. Due to insufficient federal funding, the vast majority of applicants are denied.

In addition to participating in the SEIU fund, in 2007 Kaiser Permanente and its other unions created the Ben Hudnall Memorial Trust for education and training to open education and skills upgrading possibilities to all employees. Like 1199C, project managers work with employees and managers in developing programs and evaluating outcomes. The Fund and Trust provide remedial courses, counseling, and other employment-related services and community and four-year colleges offer the certificate and degree programs, most of which are customized for Kaiser Permanente employees. The trust has sponsored an orthopedic technolgist[9] and other technician programs for hospital workers.

Program completion rate is one of the key indicators of success. The Kaiser Permanente programs have an average 98 percent completion rate. Community college administrators involved in the program note that the Kaiser Permanente student completion rate is more than twice that of other students. A key difference is that the Kaiser Permanente employees are guaranteed a job at end of training. And because of the customization of the program for Kaiser Permanente employees, they start their new jobs without needing to retrain for using various computerized systems. Kaiser-Permanente management is also pleased with the retention rates of employees who advanced through the career ladder program. Eighteen months after training an astounding 89 percent are still in their new jobs. The high retention is saving Kaiser Permanente a considerable amount of money—employers spend about 1 and a half times a position's salary to fill it and provide "onboarding" training.

To date, about 400 employees have been upgraded through the career ladder programs. Because funded with project managers, involvement with employer and union. We had a 98 percent success rate in our programs. Because we had federal and state grants had to do retention.

**Federal Policy Needed to Support Advancement of Entry-Level Health Care Workers**

In *Moving Up in the New Economy* I conclude that government policy is both the key problem and the potential solution to the crisis in nursing care. This is best stated by Steve Dawson, founder of the Paraprofessional Healthcare Institute:

> As the single largest funder of health care, the federal government has in essence created an entire labor market of paraprofessional health care workers—a labor market that would not exist without its funding, a labor market that keeps low-income women in the ranks of the working poor.

[9] Orthopedic technologists fit and adjust canes, crutches and walkers, and provide patient instruction on their use; apply simple braces, prosthetics; perform minor adjustments and repairs to prosthetic and other equipment; fabricate splints and apply plaster and synthetic casts under the direction of an orthopedic surgeon.

> And yet our government has yet to accept responsibility for creating and maintaining literally thousands of poverty-level jobs.[10]

A few special federal training funds have been allocated to improving the quality of nursing home care, but federal policy is contradictory here too. On the one hand, the "cost-containment" guideline of Medicare and Medicaid is responsible for low wages in the health care industry, which in turn reduces the quality of care and is partly responsible for the shortage of direct care providers. On the other hand, the U.S. Department of Labor creates special pools of funds to improve worker training. These demonstration projects, however, cannot compensate for the overall low levels of funding for training and wages.

At least 21 states have adopted what is called a "wage pass through," which requires that a specific amount or percentage of any increase in state Medicaid payments to long-term care providers must be spent on increasing the wages and/or benefits of paraprofessional healthcare workers. The results in terms of reducing shortages and turnover have been mixed at best.[11] States cannot solve nursing home and home health care problems on their own, and they have even less influence over hospitals.

The bottom line is that the nation's investment in upgrading the training of health care workers remains grossly inadequate, and state and federal health care funding is still not enough to create anything approaching self-sufficiency wages.

If public policy were adequate to the challenge, it would set as a national goal not just the expansion of various small programs, but the ideal that all positions in the health care field pay at least the salary of a good paraprofessional. This would require additional public funds, not just for higher pay, but for a coordinated strategy of training, placement, and the subsidy of living expenses so that people could afford to train.

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[10] Dawson, Steven L. and Rick Surpin. 2001. Direct-Care Healthcare Workers: You Get What You Pay For. *Workforce Issues in a Changing Society*. Washington, D.C.: Aspen Institute.

[11] U.S. Department of Health and Human Services (Institute for the Future of Aging Services). 2002. State Wage Pass-Through Legislation: An Analysis. WORKFORCE ISSUES: No. 1. **http://aspe.hhs.gov/daltcp/reports/wagepass.htm.**

Joan Fitzgerald is professor and director of the Law, Policy, and Society program at Northeastern University. She is completing her third book, *Emerald Cities: Linking Sustainability and Economic Development* (Oxford Univ. Press), which addresses the link between climate change strategies and economic development. *Emerald Cities* builds on her 2002 book, *Economic Revitalization: Strategies and Cases for City and Suburb,*(Sage) which identifies strategies for incorporating sustainability and social justice goals into urban economic development planning. Her 2006 book, *Moving Up in the New Economy*, (Cornell Univ. Press) focuses on how to build career ladders for low-income workers in health care, childcare, education, biomanufacturing, and manufacturing. Fitzgerald has published in academic journals such as *Economic Development Quarterly, Urban Affairs Quarterly, Urban Affairs* and the political journal, *The American Prospect.* She is guest editing a special focus issue of the *American Prospect* on greening the recovery. It will be published in April, 2009. Her academic and consulting work has been supported by the John D. and Catherine T. MacArthur, Annie E. Casey, Rockefeller Brothers, Century, and Robert Wood Johnson Foundations. She has also conducted research for the U.S. Department of Labor, the Massachusetts Technology Collaborative, the Boston Housing Authority and other government agencies.

## Subcommittee on Labor, HHS, Education and Related Agencies

## Witness Disclosure Form

**Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.**

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|---|
| Your Name, Business Address, and Telephone Number:<br>Joan Fitzgerald<br>360 Huntington Ave<br>337 Holmes Hall<br>Boston, MA 02115 |
| 1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing. |
| 2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2006?<br>Yes (No) |
| 3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing. |

Signature: Joan Fitzgerald Date: 3/24/09

Please attach a copy of this form, along with your curriculum vitae (resume) to your written testimony.

Mr. OBEY. Ms. Ellis-Lamkins.

Ms. ELLIS-LAMKINS. I am going to try to be thoughtful of your time also, so, Chairman Obey and members of the Committee, thank you for inviting me here. I would also like to say a huge thank you for the introduction from both Mr. Honda and Ms. Lee. Certainly having advocates like them makes it just an exciting trip to be here, but really because of their strength and leadership, we are very proud of them and proud to be their constituents; and to get to be both of theirs is a true honor.

I am here on behalf of Green For All, a national organization dedicated to moving people out of poverty through the green economy. Basically, we think this is a moment in history that we are going to look back and judge ourselves by how we behaved, and the reason is because the economy is going through a transformation. And in the same way that technology transformed the economy, the greening of the economy, the need to conserve energy, the need to save money is going to transform this economy.

The real question for Green For All is will we use that opportunity to move people of color and low income people into this economy, and our belief is that if we are purposeful, we can be sure to make sure that we use this economy and this changing of the economy to make sure people who are often left out are allowed to become part of the economy. So what we are focusing on is specifically green collar jobs. And green collar jobs are well paid, career track jobs that contribute directly to preserving or enhancing environmental quality.

So some people ask us, well, does that mean a green job is where someone uses a broom and is a janitor in a clean green building, is that a green collar job? We say, no, that is a poor job that pays someone; it does not pay someone well. What we are really looking at is what are quality jobs that also make the environment better.

So the question really is green jobs, why now? Well, two reasons. First is the fiscal and the financial crisis. The second is the crisis of global climate change. And I think it is said best by President Reagan's U.S. Federal Reserve Chairman, who said that you can be sure that if nothing is done, the economy will go down the drain in the next 30 years.

Now, for us it is not polar bears that will be the biggest victims of global warming. People will be the biggest victims of global warming; ourselves, our children, and our grandchildren. At Green For All, we think there is a solution to these two problems: to build a green economy strong and inclusive enough to lift people out of poverty; to in effect fight poverty, pollution, and global warming at the same time. We have to be able to create good jobs in basic green industries: renewable energies like wind and solar, advanced biofuels, green building, transportation, waste management, water conservation, and environmental remediation. And we have to be able to recognize that the pathways that these present really will allow the end of a pollution-based economy.

I want to focus on four simple truths about green jobs. First, the job creation potential is enormous. I have to be honest. When we looked at this, we said, well, where are the green jobs? Are there really green jobs that exist anywhere? And what we found is in fact there are, that a broad range of studies have demonstrated that

the renewable energy sector generates more jobs per megawatt of power installed, per unit of energy produced, and per dollar of investment than the fossil fuel-based energy sector.

What we look at is things like waste management. Every time we throw away recyclable consumer waste or building materials, we are throwing away jobs that could have been created. What we have been doing is looking across the Country, because we said we know it is not just California, and what we are finding from the way that we get rid of waste to the way the BeltLine is being built in Atlanta is that there are some clear examples of quality green jobs being created.

Second is that green jobs are not just out in the science fiction movie somewhere, that in fact they are real jobs that we can point very specifically to. When we look at those types of jobs, what we are really looking at is will it actually transform current industries. We sat today with folks who are looking at training programs. What they have said is, look, part of what is happening is just the changing of construction. Part of these jobs will not be new jobs, which is absolutely true. But there actually will be also industries that create whole new jobs, from the way paper is done to looking at window retrofitting. So we are very interested in that.

Three, green jobs are often middle skilled jobs requiring some post-secondary education, but less than a four-year college degree. It will not be a handful of scientists and engineers who build the green economy. Nor will it only be people who live in certain counties in California and drink too much Chablis. It will be pipefitters and machinists and technicians who build the green economy. These can be good middle-class jobs and, most important, accessible to low income, low skilled workers.

Fourth, and perhaps most importantly, is these jobs are difficult to offshore. When we look at the economy's growth, what we are really trying to figure out are what are the jobs that will help produce manufacturing, produce job investment here; and the real potential in green jobs is that it has to be done. You do not get to retrofit a building in China and send it back; it has to be retrofitted here. It makes sense for the materials to be produced here, and it is difficult to transport.

So, obviously, those are four clear truths about the green economy. What scares us is the relying on mistaken assumptions: that fossil fuel energy is abundant and cheap; that pollution is free; and fast and cheap is the same as quality and productivity. And we would make five simple suggestions about what we need to do. And recognizing your time constraints, I want to just go through them very quickly.

First, smart energy and climate policy have to be the foundation of an inclusive green economy. We need a bill that limits greenhouse gas emission and advances aggressive climate solutions. To ensure that the next economic crisis faced by our Nation is not compounded by the type of climate crisis and devastation we experienced during Katrina, where the insufficient resources of low income families trapped an entire community, both economically and environmentally, we need a bill that invests generated revenue to maximize the gain and minimize the pain for low income people and the transition to a green economy.

Second, maximizing impact will require policies at a scale commensurate with the challenge we face. At Green For All, we have been developing a proposal with partners for a Clean Energy Corps. I want to also thank those who voted and helped pass the GIVE Act last week.

Third, job quality in the green economy will not happen without smart public policies that ensure it. From project labor agreements to community benefits agreements, high value contracting standards, it will be clear.

Four, the green economy will not be built without a skilled workforce. I want to thank you, Mr. Obey, your fantastic staff, Ms. Lee, Mr. Honda, and the entire Committee for including $500,000,000 for green job training in the American Recovery and Reinvestment Act. We will be working to ensure, and we also would respectfully ask the Committee to look beyond the next two years of funding provided by the Recovery Act and consider reserving funds in the next year's appropriations bill for the Green Jobs Act authorized in the 2007 energy bill and authored by the Secretary of Labor Solis.

I really want to thank you for giving me the opportunity to be here, but mostly I want to tell you that I promise this is a moment in history, and what we all have to decide is how we want to be viewed in this moment in history. My hope is this is a moment we will look back and say that this Committee invested in, believed in the worker in America and believed that manufacturing and green jobs and preserving the planet was something that we could all do.

Thank you.

[The information follows:]


Phaedra Ellis-Lamkins
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Oakland, California

Testimony before the House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies

Wednesday, March 25, 2009

***Good Jobs and Careers in the Green Economy***

Chairman Obey and members of the Committee, thank you for inviting me here today.

I am here representing Green For All, a national organization dedicated to helping to build an inclusive, green economy – strong enough to lift millions of people out of poverty.

I have been asked to help the Subcommittee understand how the creation of a green economy will help the economic security of America's workers and the competitiveness of our employers.

Let me start by talking about how we define green jobs. Definitions matter: they matter from a policy standpoint because they allow us to maximize the effectiveness of economic and workforce development strategies; and they matter in a political context because the term green jobs, while widely known, is being defined in many ways by many parties. Unchecked, this process will undermine the usefulness of the term and render it meaningless – or worse, obscure its intended meaning.

We articulated a simple but I think useful definition in a report that we issued last year – *Green Collar Jobs in America's Cities* -- with our colleagues at the Apollo Alliance: green collar jobs "are well paid career track jobs that contribute directly to preserving or enhancing environmental quality" ....By this standard "...if a job improves the environment, but doesn't provide a family-supporting wage or a career ladder to move low-income workers into higher-skilled occupations, it is not a green-collar job. Such would be the case with workers installing solar panels without job security or proper training, or young people pushing brooms at a green building site without opportunity for training or advancement."[1]

But why green jobs? Why now?

America confronts two enormous crises right now. The first is the economic crisis that this Congress and the Obama administration are grappling with on a day to day basis. There's little I need to add to the debate around this issue. But I must note that the recession is hitting low-income communities and communities of color particularly hard. This disparity only compounds two long term trends: the extraordinarily high rates of poverty for a country as wealthy as our own – poverty that is unacceptably concentrated among people of color – and levels of income inequality that are as extreme as they've been since we first start gathering reliable data.

The second enormous crisis we face is global climate change. It is not melodramatic to call this the greatest crisis ever faced by humanity. And it is not simply an ecological crisis: Paul Volcker, the chairman of the U.S. Federal Reserve under President Reagan, has flatly stated that "if [nothing is done,] you can be sure that the economy will go down the drain in the next thirty years."[2] Polar bears will not be the biggest victims of global warming. People will be the biggest victims – ourselves, our children, and grandchildren. And as Hurricane Katrina demonstrated, it will be poor people and people of color who are hit hardest.

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[1] See http://www.greenforall.org/resources/green-collar-jobs-in-america2019s-cities, page 3

[2] Associated Press. *Economist Paul Volker Says Steps to Curb Global Warming Will Not Devastate the Economy.* February 6, 2007.

We think there is a solution to these two problems: to build a green economy strong and inclusive enough to lift people out of poverty. To, in effect, fight poverty, pollution and global warming at the same time. We want to build a green economy – but one that Dr. King would have been proud of.

In order to build that economy we need to create good jobs in basic green industries– renewable energies like wind, solar, and advanced biofuels; green building; transportation; waste management; water conservation; and environmental remediation.

Just as importantly, we need to create pathways into these jobs, and the careers they represent, for people who are at the margins, and often at the smokestack end, of the pollution-based economy.

I'd like, today, to talk about how federal policy is needed to create these jobs and ensure that they are both high quality and highly accessible. First let me articulate some of the characteristics of green jobs. The term, as I mentioned, is often used, but rarely with specific understanding of what it means. Here, then, are what I'd call the 4 truths about green jobs.

1. **The job creation potential is enormous.** A broad range of studies demonstrate that the renewable energy sector generates more jobs per megawatt of power installed, per unit of energy produced, and per dollar of investment, than the fossil fuel-based energy sector. It simply takes more work to manufacture, install and maintain renewable energy sources than it does to extract them from the earth. And the amount of work that goes into making a building more efficient is exponentially more work than simply maintaining a wasteful one. This job creation advantage extends beyond the energy sector. Take waste management: every time we throw away recyclable consumer waste or building materials, we're throwing away jobs that could have been created.

In essence, building a green economy represents not just a shift from a fossil fuel based economy to a clean energy economy; it represents a shift to a skilled labor-intensive economy.

2. **Green jobs are not out in a sci-fi future somewhere**. These

are jobs that for the most part already exist, but may need to be refocused on green outcomes. Building a green economy will involve some brand new industries and jobs, but for the most part it will involve transforming the industries and jobs we already have. Whether or not a job is green is not, if I may, black and white; there are many shades of green that evolve as industries change their processes and what they produce.

3. **Green jobs are often middle-skill jobs, requiring some post-secondary education but less than a four-year college degree**. It won't be handful of scientists and engineers who will build the green economy – although obviously these are essential roles. Nor will it only be people who live in certain counties in California and drink too much Chablis. It will be pipefitters and machinists and technicians who build the green economy. These can be good middle-class jobs, and - importantly - accessible to low-income, low-skill workers, who simply need the right training and support.

4. **A lot of these jobs are difficult if not impossible to offshore**. These jobs tend to involve transforming and upgrading the immediate environment, both natural and man-made. You don't ship a building to China to retrofit and ship it back. And building trades jobs are not the only green jobs that are more likely to be made in America. The manufacturing sector, which, as you know, has seen enormous job loss in recent years, could receive a substantial job creation boost from a shift to renewable energy. These are industries which rely on component parts that are very big (like wind turbines) or very fragile (like solar panels) - therefore being harder to transport over long distances .

Those four truths represent the good news. But the bad news is that the promise of green jobs and a green economy – not to mention the liveable planet we must leave for our grandchildren – will be lost unless we change the rules of our economy. Right now, it relies on mistaken assumptions: that fossil fuel energy is abundant and cheap; that pollution is free; that fast and cheap is the same as quality and productivity.

To change these tenets, we need specific policies to ensure that markets for industries that create green jobs are supported, that

these jobs provide family sustaining wages and benefits, and that there are pathways to green economy careers for those Americans who most need them.

Here are several policy recommendations that this Subcommittee might consider to achieve that goal.

1. **Smart energy and climate policy has to be the foundation of an inclusive green economy.** Although energy and climate legislation is not within the jurisdiction of this committee, it is almost certain that at some point in the 111th Congress, the House will vote on a climate and energy bill. This country - and our planet - needs a bill that limits greenhouse gas emissions and advances aggressive climate solutions that are timely enough to avert the worst environmental and economic consequences of global warming. We need a bill that invests generated revenue to maximize the gain and minimize the pain for low-income people in the transition to a green economy.

2. **Maximizing impact will require policies at a scale commensurate with the challenge we face**. Green For All and our partners have developed a proposal for a Clean Energy Corps (CEC), which is an ambitious effort to integrate jobs, training, and service to combat global warming, grow local economies, and demonstrate the employment promise of a clean energy economy. In this era of widespread budget deficits, it makes sense to implement large-scale energy-saving measures on existing buildings – retrofits that can be financed by a revolving loan fund that will replenish itself with the energy savings achieved. In this time of crisis, when Americans are looking for solutions, the CEC can be a signature initiative that captures the imagination of America, unites key constituencies, and motivates millions to act. On that note, I want to thank members of the House for passing the GIVE Act last week, which contains a crucial national service component of the CEC.

3. **Job quality in the green economy won't happen without smart public policies that ensure it**. I'd like to recommend to the Committee a recent report written by our colleagues at Good Jobs

First -- *High Road or Low Road: Job Quality in the New Green Economy.*[3] The report documents the divergence we're seeing between employers in green sectors who treat workers with respect and fair compensation, and those that do not, which includes businesses offshoring production of clean energy products in to pay substandard wages. Fortunately, we have a toolbox of policies that have been honed and tested at the local level -- including community benefit and project labor agreements, high-value contracting, and wage standards – to ensure that the green economy we create takes the high road and not the low road.

4. **The green economy won't be built without a skilled workforce**. I want to thank you Mr. Obey, your fantastic staff, and this entire committee for including $500 million for green job training in the American Recovery and Reinvestment Act. We will be working with our partners to ensure we receive the maximum impact for that investment. We commit to bringing back to this Subcommittee the stories we hear and lessons we learn from our training partnerships, and identifying those that provide the best models for connecting skilled workers to emerging green industries. I would also respectfully ask the Committee to look beyond the two years of funding provided by the Recovery Act and consider reserving funds in next year's appropriations bill for the Green Jobs Act, authorized in the 2007 Energy bill and authored by Secretary of Labor Solis.

Thank you for giving me this opportunity to speak with you today. Your consideration of our efforts – an attempt to bridge two enormous global challenges to the benefit of American working people – is humbling and inspiring. You are in the unenviable position of having to figure out how to solve problems of enormous difficulty and import. Rest assured that Green For All will stand with you in your efforts, and that we stand ready to provide any additional information you seek.

Thank you.

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[3] See http://www.goodjobsfirst.org/pdf/gjfgreenjobsrpt.pdf

## Subcommittee on Labor, HHS, Education and Related Agencies

## Witness Disclosure Form

**Clause 2(g) of rule XI of the Rules of the House of Representatives requires non-governmental witnesses to disclose to the Committee the following information. A non-governmental witness is any witness appearing on behalf of himself/herself or on behalf of an organization other than a federal agency, or a state, local or tribal government.**

Your Name, Business Address, and Telephone Number:

Phaedra Ellis-Lamkins
1611 Telegraph Avenue, Suite 600
Oakland, CA 94612
(510) 663-6500

1. Are you appearing on behalf of yourself or a non-governmental organization? Please list organization(s) you are representing.

I'm appearing on behalf of Green For All

2. Have you or any organization you are representing received any Federal grants or contracts (including any subgrants or subcontracts) since October 1, 2006?

Yes [No]

3. If your response to question #2 is "Yes", please list the amount and source (by agency and program) of each grant or contract, and indicate whether the recipient of such grant or contract was you or the organization(s) you are representing.

Signature: _____ Date: 3/12/09

Mr. OBEY. What I am going to try to do, I am going to try to see how many people I can squeeze in for questions in the next five or six minutes, before we have to go and vote, because when we leave I know we will be gone for at least half an hour, and that will shoot any ability to get questions out. So if I could ask each member to take about three minutes, beginning with Mr. Tiahrt.

Mr. TIAHRT. Well, Mr. Chairman, that is trying to cover a lot of ground in three minutes. Maybe we can get them to return some of this information as a question.

For example, Dr. Fitzgerald, you have come up with some projections that are based on a set of ground rules and assumptions that were not laid out in your presentation. If you could provide those to me, I think it would help me understand your projections a little better.

I know that, for example, borrowing $3,000,000,000,000, as we are going to do this year at the Federal Government level, is going to have an impact on interest rates unless we print the money, like we did last week, when the Federal Reserve printed $1,000,000,000,000. That, in turn, puts more money into our money supply, which I believe drives inflation. And when you combine those two you get unemployment. So I am very concerned about how did you, in your projections, try to adjust a political climate in the future? Because I think there are some things that are hard to see. So if you could provide that to me, I think that would be good.

Dr. Fitzgerald, you mentioned health care having these different opportunities to create a higher wage scale by education and by classification within the jobs. But then you said there is not enough money in the system to raise the wages. So where do we get this self-eating watermelon? How do you create this? And I think my concern is if you look at health care today, 65 percent is privately funded and 45 percent is funded by the Federal Government, either in Medicare, Medicaid, or VA system. And in every case, every doctor, clinic, and hospital that I speak to, cost shifts. They take money they receive from the private sector to cover the shortfalls of government health care.

So as we expand government health care, there is less money available to cost shift. And the only option that we see is what the current doctors in Kansas are doing. Four out of five of them no longer take Medicaid or Medicare patients, any new patients. They are trying to let the current ones go through their life cycle. So if we have less money available to cover the inadequacy of cost, then we have rationed health care.

So my concern is how do you cover this when we are moving towards a rationed health care system? How do you increase the wages for people in health care when there is less money available?

Ms. FITZGERALD. Well, I would certainly support Dr. Krugman in his ideas about what we need to do to reform the health care and reduce administrative costs and put those costs actually into the delivery of the health care system.

Mr. TIAHRT. Well, one of the things he did not cover is that a lot of the 14 percent of administration costs are driven by government regulations. So we have set up this disaster by imposing these government regulations.

You can go to Wesley Hospital in Wichita, Kansas, who used to have a whole floor of beds where people could be treated for problems. Today, that floor has been cleared of the beds and it is a sea of desks, and it is just to handle the paperwork.

The last thing—and hopefully we can come back and finish this—Ms. Ellis-Lamkins, I think you are right about your opportunity in the green jobs, but I think you are wrong in the premise that it is global warming that is driving it. I want to submit for the record testimony of 700 scientists. It used to be 650 scientists. At the last intergovernmental panel on climate change, 650 scientists signed a report that said that the earth is actually cooling. It peaked in 1989 and for the last decade it has been getting cooler.

I know if you talk to Jim Oberstar, he will tell you that in his district, which is Northern Minnesota, the month of January it never got above zero degrees Fahrenheit.

So this is actually testimony of 700 scientists that debunked the claims of global warming. They believe that the earth is actually getting cooler.

[CLERKS NOTE.—The information referred to was supplied and is retained in the Committee files.]

Mr. OBEY. That is only in States populated by Norwegians. [Laughter.]

Mr. TIAHRT. But that being said, I agree that it is a great opportunity. You are on to something that I would like to help with, because I do think there is a wonderful opportunity. For example, we could build a clean technology coal-fired electrical generating plant, and with that, in the carbon sequestration plan, develop a whole new industry related around algae growth. Algae consumes carbon dioxide, emits oxygen, and it is very versatile. We can use it to make more electricity, we can use it for plastics. It has an oil base. You can even make makeup from it. So it is very versatile, and I think you are on to something that we need to expand on and create this opportunity.

Ms. ELLIS-LAMKINS. Well, I appreciate that, and I would like to not focus on our disagreements. So whether you think it is because of global warming or because of business opportunity, I would like to focus on what we agree on. So what would be helpful is to have champions of the Green Jobs Act and to think about how we create some of those opportunities. So I look forward to a discussion that allows people to move out of poverty and we will certainly follow up with your staff so that we can figure out how to make you a champion of those policies.

Mr. TIAHRT. Thank you.

Mr. OBEY. We are going to have to go to vote, and we will return as fast as we can. I would ask members to please come back as soon as the last vote.

[Recess.]

## AFTERNOON SESSION

Mr. OBEY. I was trying to squeeze several people in, so I squeezed Mr. Tiahrt down to three minutes. Let me simply go back to Mr. Tiahrt for another two or three minutes to see what other questions you might have.

Mr. TIAHRT. Thank you, Mr. Chairman.

Dr. Hall, you mentioned utilities declining, if I understood you correctly, in the number of jobs. I guess if you combine that with Ms. Ellis-Lamkins' move to increase green jobs, many of those would be in the area of utilities. And I have often thought we could do simple things like they do in Germany, where they have net metering, and that would encourage people to go out and produce electricity either through solar panels or wind generators. In Kansas we are very interested in wind generators because we have a continuous south wind.

Kasaw [phonetically], in the Oglala Sioux Indian language, means people of the south wind, and, believe me, we are the people of the south wind.

So I think there is actually, in the utility sector, unless you categorize some of those as manufacturing jobs, how would you explain the projection in utility jobs going down?

Mr. HALL. You mean what is behind the——

Mr. TIAHRT. Yes, what is behind the projection? Is it because we have higher productivity in generating power or electricity or other forms of energy?

Mr. HALL. To be honest, I do not know great detail on that one specifically. A lot of what we do, obviously, is we look at trends in employment within the industry. I am not sure——

Mr. TIAHRT. It makes the assumption that utilities are in a more productivity trend, higher productivity trend than we would see, and we expect that to continue.

Mr. HALL. I believe that is so. That is certainly the case with manufacturing. That is part of why we talk about manufacturing jobs declining over time.

Ms. FITZGERALD. I can speak to the utility question a little bit.

Mr. TIAHRT. Please.

Ms. FITZGERALD. I am working on a book on green jobs and career advancement right now.

Part of it is, when you talk about wind or solar, the utilities are purchasers of that power, so that the jobs associated with wind or solar will not be credited under utilities, since they are simply purchasing it.

Mr. TIAHRT. I see. I got something from my power company here in Northern Virginia, Dominion. It is customer connection. It is sign up for green power. In red—and perhaps there is some analogy of this—it says purchase power equal to 100 percent of your monthly electrical usage. The cost is an additional $0.105 per kilowatt hour. For example, if you use 1,000 kilowatts, that is $15 more. You could also purchase blocks at 133 kilowatts at $2, which calculates basically the same cost, $0.105 more kilowatt hour.

Apparently, it is more expensive to generate green electricity. I am a little positive because electrons are not colored. What little I know about electrons, they are not colored. But it does cost more to generate green power at this point.

Ms. FITZGERALD. Let me just give you an example. One is Austin Energy. Austin Energy is a utility in the Austin, Texas area where there is a mandate from the city, a portfolio standard to produce a certain percentage of their electricity from renewable sources. They just signed on to produce a 300 megawatt solar farm that is going to be built. They will purchase that power. They got a fabu-

lous deal, it is about $0.17 a kilowatt. Natural gas is about $0.08 or $0.09. So what they are doing——

Mr. TIAHRT. Retail or wholesale?

Ms. FITZGERALD. That is their purchase cost. And what they are doing is investing in renewable energy in the belief that the cost will go down over time, and there is every reason to believe that; it already has become par in wind. But as much solar as they move to thermal solar and thin film solar, much more likely to move in that direction. So it is more expensive.

So a plan like you mentioned, that Austin has, it is either because you have a very green community and they sign on. But what you are finding is a lot of manufacturers are actually signing on to those green power purchase plans because they are long-term plans. So they will go to X wind farm and say we are going to purchase all your energy over the next 30 years. Then they will lock people in to that price. So that is very appealing as a business to know what that utility cost is going to be over the long term.

So you either get green people who are willing to pay the premium for the renewable energy or you get your big customers, your manufacturing and other institutional customers who like the security of the long-term prices. And sometimes with wind it is actually cheaper over the long run.

Mr. TIAHRT. What I have seen in Kansas, Fort Hays State University, for example, their power rates are determined by the high usage months, which are August and September because of air conditioning. That is when the students come. So they have bought diesel-powered generators and are what they call cost shaving. When they get to a certain usage, these generators kick on and that holds their rates down for the rest of the year.

Ms. FITZGERALD. But that is one way they can deal with this. Another way they could deal with that would be some of the efficiency programs and encourage the universities and others to go to much more efficient systems of air conditioning to shave that peak; and that is what Austin Energy does as well.

Mr. TIAHRT. I guess we will have time later on for another round?

Mr. OBEY. Well, until 1:00.

Mr. TIAHRT. Until 1:00? Okay, well, I think I will yield back.

Mr. OBEY. Mr. Honda.

Mr. HONDA. Thank you, Mr. Chairman.

To Dr. Fitzgerald, just a quick question. It is a training question. Are there small changes that we can make this year to Title 8 training programs to expand opportunities to the CNAs and LPNs without creating new programs? If you would like to look at that and get back to us, we would appreciate it.

Ms. FITZGERALD. Okay.

Mr. HONDA. A general question. We are all looking at the green collar workforce and we are all involved in certain kinds of activities, but on an international level, when we are looking at global activities, and with the current distrust between our Country and China for historical reasons, but also the relationship that we have because of trade and things like that, are there opportunities for the areas that we have influence over to create what might be called a sister city kind of relationship of activities here and linked

with another group in China so that we can start looking at ways to find commonality so that we can start, one, develop confidence with each other, a track record?

And I do not think it needs to be formalized through State Department or anything else like that, but kind of a people-to-people like activities to like activities to start moving this ball towards some international cooperation so that at a certain point in the future, as a Country, we will be ready and have a little bit more work done with people when we are ready to look at a relationship between our Country and China and ways to move forward on this struggle to attack this global warming thing, the greenhouse gases kind of challenge that we have in the future?

Ms. FITZGERALD. Is that for me?

Mr. HONDA. Anyone.

Ms. ELLIS-LAMKINS. It can be for anyone.

Ms. FITZGERALD. You want to go first?

Ms. ELLIS-LAMKINS. Go ahead.

Ms. FITZGERALD. There are a lot of sister city programs, and I do not know that they are very meaningful.

Mr. HONDA. Well, what I was thinking of, the model would be something like that, where you find likes in the other country so you can start developing this relationship and build trust and things like that.

Ms. FITZGERALD. Well, in terms on the green issues—and you may want to speak to this—there is an international organization called ICLEA. I never remember what it stands for, but it is an organization working on climate change and sustainability issues in cities that offers technical assistance, primarily working in Europe, South America, and the United States. And it would be very interesting, particularly because they are building brand new ecocities in China to try to bring Chinese cities into that organization. So I think around the global warming or sustainability issue in cities where there is an organization that probably would be very good in facilitating that.

Mr. HONDA. Are we involved in ecocities also?

Ms. FITZGERALD. Are we involved in ICLEA? It is city-by-city. There are about 850 cities throughout the world that are involved in that, and many area. Is Oakland?

Ms. ELLIS-LAMKINS. I do not know that Oakland is, but San Jose is.

Mr. HONDA. Okay.

Ms. FITZGERALD. I think the real issue with these—I am actually doing some research on these various organizations. Seven hundred some U.S. cities have signed on to the U.S. Council of Mayors Climate Change Agreement, and so what? It does not require them to anything, so what we really need to focus on are organizations on the ground that are working in cities so that these umbrella organizations are meaningful in terms of motivating change.

Mr. HONDA. Well, the question was taking on that activity and finding a like, for lack of a better word, a kindred spirit in China that you can link up to and create this partnership so that people start it before government starts.

Ms. ELLIS-LAMKINS. Mr. Honda, I think it is an excellent question because I think the real challenge is how do you create a spirit

of cooperation among people who want change. And I think there are a lot of groups in China who are also doing like was talked about before, who are trying to do work both around global climate change and also trying to create models. I think there has also been a lot of government investment, certainly, and infrastructure and technology. So I think we both can learn from where investments were made, how to make it easier to be essentially entrepreneurial in spirit.

And in addition is to figure out what are the groups that we can partner with. And we would certainly be happy to send your office a list of groups that we think might be prospective partners in China and also to think about groups on the ground that are doing work here in the United States that are in some of those international relationships.

Mr. HONDA. Great. Thank you.

Mr. OBEY. Dr. Hall, you said that four States right now are at 10 percent or above in terms of unemployment. Which ones are they?

Mr. HALL. They are Michigan, 11.6 percent; South Carolina, 10.4 percent; Rhode Island, 10.3 percent, and California, 10.1 percent.

Mr. OBEY. South Carolina, you say, is among them?

Mr. HALL. Yes.

Mr. OBEY. Okay. And which are the next tier? Which States do you expect that we will see above 10 percent within the next three months or so?

Mr. HALL. It is difficult for me to project data, since we produce the data. It always sort of puts me into a bind because we do collect the data. I can tell you that the trends for all the States up to now have had rising unemployment rates and there has not been pretty significantly rising unemployment rates; all 50 States have risen since the recession started, and there is no real indication yet that that is going to stop.

Mr. OBEY. What would you say are the characteristics of the four or five States that, at this point, have the lowest unemployment levels?

Mr. HALL. It is hard to say because the States seem to have almost characteristic unemployment rates. Some States run generally above average, some run generally below average. I am sure a lot of it has to do with their industry mix, what sort of industries they have got. There has been such a long-run trend, for example, in manufacturing, declining employment in manufacturing. States who heavily invest in manufacturing have generally higher unemployment rates, for example. All the States have gone up because the unemployment has gone up in all industries, just about. So it has been very, very widespread. It is just that some States started from higher levels.

Mr. OBEY. The Brookings Institution recently released a report on middle-skilled jobs which they say constitute nearly half of the U.S. employment, and the report defines these jobs as those that require significant amount of education and training, such as an Associate degree or certificate, but not necessarily a four year Bachelor's degree; jobs like plumbers, machinists, etc. The report seems to support the notion that there are good paying jobs that

do not require a significant post-secondary education, or at least not four years.

What is your reaction to the notion of middle-skilled jobs, whether there is a skill that needs to be addressed today and whether the coming retirement boom will widen the skills gap?

Mr. HALL. That is a good question. Obviously, our projections show job growth at all skill levels, but there are sort of two spots where it really jumps out. I have got a nice chart I can look at here. One is at the very lowest level, a lot of replacement jobs at sort of minimal training level jobs. And then there is a lot of job growth at college education, Bachelor's degree or above. So that does leave a fairly substantial gap in between where the job growth is not likely to be quite as high.

Mr. OBEY. One other question for you. How much does the decline of manufacturing in this Country, in your judgment, add to the gap between incomes in this Country? Do you have any way of assessing that?

Mr. HALL. Not really directly. That is a good question, though, because I think you are right. I think the manufacturing jobs probably do have their share of those in between education levels that you are talking about, those in between jobs, something below a Bachelor's degree and something above minimal training. So I have not studied it, but my guess is that that does contribute.

Mr. FITZGERALD. May I respond to that one? Because I think there is plenty of evidence to show that the decline of manufacturing has contributed to the widening income gap in the United States, and that is why a lot of the green jobs work is so important, because so many of these jobs are in manufacturing. And the representative from Ohio earlier spoke about the businesses in Ohio that could produce parts for the wind turbines. There is a whole organization in Ohio that is trying to make that happen, make the supply chains in manufacturing for wind, for other forms of renewable energy; and time after time, what the manufacturers are saying is we cannot get people that are willing to go into these jobs, these training programs, certificate level or whatever.

So supporting policy in the green area that would support manufacturing has a potential for creating a lot of those middle wage jobs and also the health care. I did not get a chance to talk about it, but those allied health technician positions, most of them are either 9-month to 1-year community college programs, and they pay living wages.

Mr. OBEY. Let me ask either one of you. Let me take the devil's advocate position. There are some people around here and some people around the Country who will pooh-pooh the whole idea of green jobs and they will say that is just the latest fad, that is just the latest label; people are going to shop around this Country and this budget, looking for anything that is labeled green. They will try to associate themselves with it and pull off a piece of the change.

What is your response to that? What would you say to demonstrate that when you are talking about developing green jobs in the economy, that you are taking a hard-headed look at economic realities and not just behaving like you are permanent president of an optimist club or something?

Ms. ELLIS-LAMKINS. Thank you for the question. First, let me apologize for being late; I misunderstood.

Mr. OBEY. No, we got back earlier than we thought.

Ms. ELLIS-LAMKINS. Okay.

I think that is a really important question and I think it is a pretty consistent question when change happens. When new and exciting change happens, people freak out. It is a pretty normal response. You know, we sat with a group of CEOs——

Mr. OBEY. Never in Congress.

Ms. ELLIS-LAMKINS. Never in Congress, thank gosh. But we sat with a group of CEOs in Silicon Valley, and listening to their stories from Google to Hewlett Packard, to thinking about when they made the case that there was something different happening and that technology might transform the way we worked. People disagreed, thought they were crazy, and thought it was something that would only happen in California.

So what I would say to people who say it is not real, is I would say they should look at the examples from solar, where we are beginning to see not only the installation of solar in places like Richmond and Atlanta, but they should look at not only what is being created, but they should think about whether we want to be on the front of innovation.

If you had said, five years ago, you thought U.S. car manufacturing could make a resurgence, but when you look at places like Tesla, one of the only companies that is going to be increasing the numbers of manufacturing jobs in auto making, when you look at companies that are thinking about that, when we have sat with these companies that are ready to grow, we look at Chicago Republic Windows, the workers that stayed in the plant, that was bought by someone who was actually going to use it to do retrofitting as part of the stimulus package.

So what I would say to them is when we look at examples of manufacturing that used to exist, and what we see is not only the commitment to grow, but to be able to increase it, those jobs are going to increase; not just stay where they are, but increase. So the question is will we be ready as a Country for it.

Ms. FITZGERALD. Just to add to that, if we just look at renewable energy, solar and wind, the United States is the innovator of solar energy, and right now, if we looked at both in solar and wind, who are the top 10 producers, we would have maybe one or two companies that are in the United States. We have just let the manufacturing go. And in wind and solar, 70 to 75 percent of the jobs are in manufacturing. And what are we talking about? We are talking about projects in the ground. That is important. But if we are not building them here, we are not going to take advantage of those jobs, and we really have to build that in.

Another example is public transportation. We are talking about expanding subway systems, light rail systems, all of these creating jobs in construction; zero on producing them here. Because there are domestic content, we do a little bit of the assembly. So like we get maybe 10 percent of the value added on this.

So when we are thinking about the stimulus package, let us make sure that we look at how some of these manufacturing jobs

are going to be U.S. jobs; otherwise, we are just going to be paying for manufacturing jobs elsewhere.

Mr. OBEY. Well, to me, one example about which I am the most zealous is the example of new battery technology for the auto industry for cars that we would like to see running on electricity rather than gasoline. I, for the life of me, do not see how our auto industry recovers international leadership unless we are in the forefront of developing new technology that includes new kinds of batteries that will power those new kinds of vehicles, which is why we put over $2,000,000,000 into the stimulus package for that purpose.

What policies should we consider to maximize the earnings potential of the green jobs we are creating, as well as the policies that keep green jobs at home? Any other specific suggestions you have on how to build the focus to do that?

Ms. ELLIS-LAMKINS. I have a couple. You know, I think that there are a couple things that really are important. The one thing that I want to just raise that we hear time and time again in local communities where they are doing excellent work is their concern about Federal preemption when they have good local law. So one thing is what do you think when there are good local standards that are stronger than the Federal regulation? So I would first just raise the issue of figuring out how to recognize good standards at a local level.

The second is there are a lot of good models for this, from community benefits agreements to project labor agreements. The way we have often thought about it is that there is a three-pronged approach: pre-qualification of contractors, standards when there are contracts in place, and enforcement and resources for enforcement. So part of it is also making sure, when there is an investment, there is a way to ensure that the regulations are actually maintained.

In addition, we have got a proposal for the Clean Energy Corps to think about how do you create those jobs, encourage workforce development with that, and to be able to make sure that is funded.

In addition, funding the Green Jobs Act I think will be critically important in the future. Thinking about manufacturing, many cities and jurisdictions across the Country are putting aside millions of square feet to be able to attract manufacturing industrial land and to think about what that strategy will be so that there is a package to be able to make sure that manufacturing happens and that it happens with standards.

I think you made a great point, Chairman Obey, about even the idea of middle class jobs. We have 48,000 apprentices in this Country just alone in the plumbers and pipefitters, and for us to think about how do we make it easier for folks to be able to join those types of programs and how do we ensure that, when there is investment spent through the recovery money, that those jobs are jobs that will continue, not short-term jobs. So thinking about preapprenticeship opportunities so that people move into those jobs.

Mr. OBEY. Dr. Fitzgerald, with respect to health care, you were talking earlier about the need to try to increase wages for people working in the field, and you mentioned nurses, for instance. You know, the general concern in this Country is how we reduce health

care costs, so when you talk about increasing wages in the health care field, that would seem to be counterintuitive. But you mentioned that, in fact, it could help save money or increase quality because of lessening of turnover.

Beyond the turnover issue, how else would you defend the idea that we can afford to provide universal health care with rising wages at the same time that the President is talking about reducing health care costs by health care reform?

Ms. FITZGERALD. Well, first, of course, there is the turnover issue, but there is also the broader level of commitment to employment. So Kaiser Permanente, for example, in the programs they have developed throughout the Country with their 27 unions, one of the things they have really done is return on investment analysis that definitely shows that by investing in your workers and creating opportunities for them to advance lowers costs dramatically in that, for example, to replace a nurse costs about $150,000 in the whole time spent when that position is vacant than when it is filled with someone that needs to learn a whole new system.

So that is one aspect of it.

I think another aspect of it is quality of care. If you have invested in a better trained aide, they are more likely to help reduce, for example, falls, which is a major problem; bed sores, urinary tract infections because people are not taken to the bathroom enough. So that better trained aides and licensed practical nurses deliver better care and actually reduce the health care costs of those facilities that invest in them.

So that is another key area.

And the other is a morale issue so that if people feel invested in and part of the organization, they are part of the process and can help an organization look for ways to cut costs, and nursing homes, it is in the book, can demonstrate that that is the case.

So I would say those are the three key areas.

Mr. OBEY. One last question. Can you elaborate on how much of the nursing shortage and limited nursing career ladder opportunities are due to nursing school faculty shortages? I keep hearing that even if we provide funding for nurses training, we have a bottleneck because often people who are out in the field are making more than people who are on the faculty trying to teach people to be nurses.

How do you see us dealing with that problem?

Ms. FITZGERALD. I would look to Oregon in the longer part of my testimony that talks about different models for making it easier to do the training, whether it is SIM-Man training to replace some clinicals, coordinating and so forth. But, I think the most obvious thing is you raise the wages at the university level. But it is difficult to do, even for community colleges, because they are very expensive programs to run in terms of the faculty-student ratio is much smaller than it is when you can put 500 students in a history class. And throughout the curriculum you have that kind of student-teacher ratio. Plus, there are the clinicals. There is a real shortage of clinical sites. So what you find is a hospital is much more likely to accept clinicals from a Bachelor's degree program than it is from the community college, so you create that bottleneck.

So it has to be dealt with in terms of technological creativity and how we educate nurses. But it just makes perfect sense; no rational nurse is going to make the decision I am going to teach for $20,000 less a year and put in more hours than I would. So I think that kind of legislation that helps the universities subsidize those salaries would be one way to address that bottleneck.

Mr. OBEY. Well, another would simply be if we had State legislators who were willing to meet their responsibilities to their own universities. I know that in my State, when I left the legislature, about 42 percent of the operating cost of the University of Wisconsin was paid for out of the State General Fund financed by the State legislatures. Today, that is down to about 19 percent. They have walked away from their responsibilities to fund the universities at an adequate level. Then they wonder why tuition goes up and it becomes less affordable for kids to go.

Ms. FITZGERALD. Right. That is exactly right.

Mr. OBEY. Mr. Tiahrt.

Mr. TIAHRT. Mr. Chairman, I just want to thank you for a good hearing. I thought it was very interesting, stimulating, and I think we learned a lot. So thank you very much.

And thank you to the witnesses. Appreciate your being here.

Mr. OBEY. Thank you.

Thank you all. Appreciate it. Thanks for coming.

THURSDAY, MARCH 26, 2009.

## NATIONAL INSTITUTES OF HEALTH: BUDGET OVERVIEW/IMPLEMENTATION OF THE ARRA/STATUS OF NATIONAL CHILDREN'S STUDY

### WITNESSES

**RAYNARD KINGTON, M.D., PH.D., ACTING DIRECTOR OF THE NATIONAL INSTITUTES OF HEALTH**
**JOHN NIEDERHUBER, M.D., DIRECTOR, NATIONAL CANCER INSTITUTE**
**STORY LANDIS, PH.D., NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE**
**ANTHONY FAUCI, M.D., DIRECTOR, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES**
**DUANE ALEXANDER, M.D., DIRECTOR, EUNICE KENNEDY SHRIVER NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT**
**GRIFFIN P. RODGERS, M.D., DIRECTOR, NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES**
**PATRICIA GRADY, PH.D., R.N., F.A.A.N., DIRECTOR, NATIONAL INSTITUTE OF NURSING RESEARCH**
**JOSEPHINE BRIGGS, M.D., DIRECTOR, NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE**
**JOHN RUFFIN, PH.D., DIRECTOR, NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES**
**LAWRENCE TABAK, D.D.S, PH.D., ACTING NIH PRINCIPAL DEPUTY DIRECTOR AND DIRECTOR, NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH**

Mr. JACKSON. I would like to welcome Dr. Kington and the institute and center directors who are seated behind him.

At today's hearing, we would like to discuss NIH's implementation of the Recovery Act funding NIH received, the President's fiscal year 2010 budget for NIH to the extent that it has been made public and the status of the longitudinal National Children's Study which many of our Subcommittee members are interested in but which has never received much discussion because President Bush tried his hardest to eliminate it.

Between the omnibus spending bill and the Recovery Act, we were able to provide an $11.3 billion increase for NIH, the largest ever 1-year funding increase to NIH.

I am sure, Dr. Kington, that were Dr. Zerhouni here today he would love to be in your seat these days.

With that kind of increase, the Committee will be watching carefully to be sure that NIH spends it in a way that both stimulate good science to propel our economy and to create high-paying jobs throughout the Country.

We appreciate having some of the NIH institute directors in the front row today. Dr. Kington, you should feel free to have them respond to specific questions if you would like. There is an empty seat to your right, to my left, with a mic for that purpose.

Mr. Tiahrt, are there any comments that you would like to make?

Mr. TIAHRT. Thank you, Mr. Chairman.

I would like to welcome Dr. Kington as well and the National Institutes of Health center directors who are here. Thank you all for coming.

Mr. Chairman, I am particularly glad you scheduled this hearing, given that NIH currently has 33 percent more resources than it did last year. I am interested to know how it is going to be spent.

While I would like to discuss the upcoming budget, it appears that our friends in the Executive Branch may, themselves, not yet know what it contains. That is unfortunate because I know that the Chairman and I both would like to get started in earnest, so we can avoid the end of year crunch that leads to an omnibus bill.

I am always pleased that we are going to be discussing the National Children's Study and some of the problems it has encountered over the last couple of years—problems that, in my view, should never have happened and have jeopardized the entire study.

At any rate, I look forward to the testimony, and I yield back.

## DR. KINGTON'S ORAL STATEMENT

Mr. JACKSON. Thank you, Mr. Tiahrt.

Dr. Kington, we have your written statement. Please feel free to summarize with oral remarks so that you will have adequate time to answer any questions.

We welcome you to the Committee and congratulate you for your ascendancy in this acting role.

Dr. KINGTON. Thank you, Congressman Jackson, and good morning to you and other distinguished members of the Subcommittee. It is an honor and a privilege to appear before you today to discuss the National Institutes of Health's implementation of the American Recovery and Reinvestment Act.

Before I begin, I would like to introduce my NIH colleagues who have joined me: Dr. Anthony Fauci, Director of the Institute of Allergy and Infectious Diseases; Dr. Duane Alexander, Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development; Dr. Josephine Briggs, who is the Director of the National Center for Complementary and Alternative Medicine; Dr. Patricia Grady, Director of the National Institute of Nursing Research; Dr. Story Landis, Director of the National Institute of Neurological Diseases and Stroke; Dr. John Niederhuber, Director of the National Cancer Institute; Dr. Griffin Rodgers, Director of the National Institute of Diabetes and Digestive and Kidney Diseases; Dr. John Ruffin, Director of the National Center on Minority Health and Health Disparities; and Dr. Lawrence Tabak, Acting NIH Principal Deputy Director and Director of the National Institute of Dental and Craniofacial Research.

First, I want to express my sincere gratitude on behalf of the Agency for your support of NIH in the fiscal year 2009 budget and for the continued trust you place in NIH to make the discoveries that will lead to better health for everyone as reflected in the recent appropriation of the $10.4 billion in ARRA and the 3.2 percent increase in the Fiscal Year 2009 Appropriations Act.

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 U.S. territories and on behalf of the public who count on our research to help detect, treat and prevent hundreds of diseases and conditions.

As you noted, I submitted my testimony for the record, and I will try to just highlight key points for you this morning.

As we are all painfully aware, every sector of America is facing challenging times from the drastic downturn in the economy. The biomedical research community has not been spared from this turn of events. It is an unfortunate irony, however, that it comes at the same time that we are seeing extraordinary scientific opportunities for improving health.

This is worrisome not only because it means fewer jobs but also because innovation and a constant influx of new talent are crucial to the Nation's economic success and to a robust biomedical research enterprise. So it is timely that the President and Congress provided ARRA funds to NIH to stimulate the economy and to advance biomedical and behavioral research.

To bring the impact of ARRA down to the individual level, I would like to share with you the following. One of our program directors received an email several days ago in response to news that an applicant's grant application is being considered for funding with ARRA money. Here is an excerpt from the email:

"We gave a termination letter last Friday to my longtime postdoc. His job has been saved. He is going to be thrilled to hear about his change of fortune. I would also like to hire a technician with the new funds since I presently don't have one."

I am certain that similar scenarios will occur throughout the Country over the next two years as we implement the Act.

Your decision sends a strong signal to scientists in the field and to bright young people who may be one day choosing science as a career, that the United States is willing to support outstanding research and outstanding scientists.

Here is only a sampling of the important work that we will support with ARRA funds. For example, we will expand rapidly our understanding of a wide range of diseases and conditions including diabetes, forms of cancer, addiction, glaucoma, heart and lung disease, arthritis, kidney disease and mental disorders. In addition, we will expand our efforts in community-based research with a special focus on minority and under-served populations and make further investments in the potential applications of nanotechnology.

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

It appropriated $8.2 billion to NIH for scientific research.

It allocated $1.3 billion for construction and equipment at our grantee institutions, $1,000,000,000 of that focused on extramural construction and renovation and $300,000,000 to shared instrumentation and large capital research equipment.

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

In addition, $400 million was transferred to NIH from the Agency for Healthcare Research and Quality to support research in comparative effectiveness.

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

NIH is using a nimble approach to investing the money quickly, with the greatest impact. For example, we are in the process of determining which of the highly meritorious applications that we were not able to fund last year would make sense scientifically to fund for the next two years with ARRA dollars.

NIH has already issued a number of new funding announcements. In particular, we have made targeted grants announcements to stimulate research in high priority areas. An excellent example is our announcement this week of four research grant announcements related to autism, a disease that affects so many families in America.

NIH has committed $60 million of research funding to address the differences across the autism spectrum of disorders. Researchers will help develop and test diagnostic screening tools, assess risk from exposures and test early interventions and adapt existing pediatric interventions for this population.

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 Country. For example, we have introduced the Challenge Grants Program, the Grand Opportunity Program or GO Grants, Signature Initiatives and a program to encourage the recruitment of new faculty to conduct research and, finally, a summer program to hire students and science teachers in research laboratories, and I will speak a little bit about a number of these programs next.

For the Challenge Grants, we issued the largest RFA in the history of NIH. This is a shortened version of it, a 220-page document that lists 237 scientific topics in 15 broad scientific areas. We expect to devote at least $200 million to this effort.

The research funded under the Challenge Grants program will fund a number of important topics including advances in biosensors, new approaches to HIV therapy, new research in bioethics, research on health disparities and clinical research, pain management and the new area of so-called theranostics, a combination of the words, therapy and diagnostics, which refers to materials that can both diagnose a condition and treat a condition—so a material that might be painted on a tooth that could both detect a fracture and repair it.

Another new program is the Grand Opportunity Program or the GO Grants. This program will highlight large-scale research projects that accelerate critical breakthroughs, early and applied research on cutting-edge technologies and new approaches to improve interactions among multidisciplinary and interdisciplinary research teams.

NIH is supporting a number of important Signature Initiatives that will support exceptionally creative and innovative projects and programs to address major challenges in biomedical research. The initiatives will cover new scientific opportunities in nanotechnology, for example, genome-wide association studies, Alzheimer's disease,

oral fluids as biomarkers and community-based research just to name a few of the potential topics.

We have also announced an important 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 and provide appropriate start-up packages and to develop pilot research projects for newly independent investigators.

We are also particularly delighted to tell you about our expanded summer program for teachers and students across America. Funds will support short-term summer jobs for high school and undergraduate students as well as elementary, middle, high school and community college science educators in laboratories across the Country and will provide several thousand young people with an opportunity to experience the world of research, and we hope this experience will spark their desire 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 increasing 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.

We will fulfill ARRA's comprehensive reporting requirements including jobs created and preserved, tracking of all projects and activities and trend analyses. To track all of 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 diagnosis, treatments and other public health improvements expected by Congress and the American people.

Because of ARRA funds, there will be more discoveries across the Country next year and many years to come. These findings will yield better understanding of the major diseases and disorders including those that I touched upon here today and hundred more as well as providing keys to allow all of us to live healthier lives.

As I said in my opening comments, we are grateful for your commitment to biomedical research and all the promise that 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 stimulate the economy, we will create jobs, and we will advance science. Most importantly, ARRA will help us contribute to our principal mission which is to make scientific discoveries that will improve the public's health.

I would be pleased to answer any questions, and I will take advantage of the opportunity to call upon my colleagues for a special response to particular topics in their areas of domain.

Thank you again.

[The information follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NATIONAL INSTITUTES OF HEALTH

Implementation of ARRA

Witness appearing before the
House Subcommittee on Labor-HHS-Education Appropriations

Raynard S. Kington, M.D., PhD
Acting Director, NIH

March 26, 2009

Good morning, Mr. Chairman and distinguished Members of the Subcommittee. It is an honor and a privilege to appear before you today to discuss the National Institutes of Health's (NIH's) implementation of the American Recovery and Reinvestment Act (ARRA).

First, I want to express our gratitude for your support for NIH in the FY 2009 budget, and for the continued trust that you place in NIH to make the discoveries that will lead to better health for everyone, as reflected in the recent appropriation of $10.4 billion in ARRA and the 3.2% increase in the FY 2009 Appropriations Act.

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 U.S. 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.

My testimony will be different from testimony that NIH presented in past years, because we are facing unique times. We are in one of the worst economic crises in American history--the worst in my lifetime. It is an unfortunate irony that it comes at the same time that we see great scientific opportunities for improving health. The biomedical research community is not 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.

So, it is timely that the President and Congress provided ARRA funds to the NIH to stimulate the economy and advance biomedical and behavioral research.

I'd like to share with you the following: One of our program directors received an email several days ago in response to news that an applicant's grant application is 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."

We are moving expeditiously 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 two 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.

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 life-style 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 health care 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 us 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 in an accelerated time, 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 identifying and planning to fund those scientifically meritorious applications for two 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 allow for accelerating 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. Several new funding announcements have already been released. In fact, in the first week after enactment of ARRA, NIH announced requests for applications of $1.5 billion.

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 kick start this program, we issued the largest Request for Applications in our history. This 220-page document lists numerous scientific topics in fifteen 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. We expect 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.

- Studies on ethical issues in health disparities and access to participation in research is needed to assess the under-representation in biomedical and clinical research of U.S. minority populations, underserved populations, and populations who may be vulnerable to coercion or undue influence; and to identify barriers to participation in research and to develop approaches for overcoming them.

- Pain research has been greatly hampered by the unreliable nature of self-report based instruments, where we rely on the person in pain to tell us about their condition, which can be highly subjective. The establishment of objective, affordable and reliable pain biomarkers and measurements would advance our understanding of pain mechanisms, provide a basis for improved clinical management of pain, help assess an individual's risk for becoming addicted to opiate analgesics, and establish much needed objective measures of treatment success or failure.

- Development of novel approaches for delivering combined diagnostic and therapeutic agents to appropriate disease sites with high specificity and in adequate concentrations to realize the promise of combined diagnosis and treatment of diseases in a single sitting, hence the hybrid term, "theranostics."

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, 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 that may express at low frequencies but cause greater effect. 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, post-graduate 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.

Under ARRA, the existing framework will be leveraged to document and track projects and activities receiving ARRA funding taking into consideration all additional controls, tests and reports that are called for in the Act and the implementing OMB and HHS guidelines. NIH is working with the Department's Office of Inspector General to facilitate their responsibilities under the Act and to partner, where practical and appropriate, in oversight, review and testing of internal controls pertaining to ARRA funds.

**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.

In the very near future, the President will present the FY 2010 budget request. Our FY 2010 budget will reflect the President's emphasis on increasing research in the areas of cancer and autism, to which we know Congress has shown great attention as well. We look forward to working with the Committee to enact the FY 2010 budget request.

Before concluding, I want to update you on several adjustments and mid-course corrections we are making to the National Children's Study (NCS).

As you know, the NCS is in the early pilot stages and is envisioned as a long-term study to follow children from birth through their teenage years. These studies have a number of factors, assumptions, and estimates. We are actively working to manage this program. Earlier this year, we learned that, if all the potential components of the study were to actually go forward, the most recent total estimate would not be within the spending range expected by the agency.

Studies of this nature and length have cost uncertainty. We strive hard to manage these uncertainties. The NCS is truly of unprecedented size and scope. Once I learned of the potential cost variance, I took the following actions:

- Increased oversight of decisions pertaining to the NCS.
- A former senior NIH scientist, known for his scientific management expertise, was brought in to review the study and advise the NIH leadership on potential actions.
- The NIH Office of Management Assessment initiated a review to ensure we learn from the process and improve study planning.
- We have established a revised two-year plan to outline steps to assess true costs, review the study after the pilot, modify the study to balance science and fiscal prudence as necessary, and apply rigorous scientific review to the final protocol. Final decisions are expected to be made in August 2010.

Once we complete the pilot review and examine the cost data and projects, we will work to ensure the study is fiscally and scientifically responsible; however, there will certainly be adjustments to the scope and/or scale of the study. I am hopeful that with increased oversight and adaptations, the study will go forward and yield important findings about the health of children.

As I said in my opening comments, we are grateful for your trust in NIH and your 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 have also developed brand-new programs, such as the Challenge Grants, to help us do just that. 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.

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

***** Footnotes/Citations ******

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.

Dr. Raynard S. Kington, M.D., PhD.

Dr. Raynard S. Kington, M.D., PhD. was named Acting NIH Director of the National Institutes of Health on October 31, 2008, following the departure of Dr. Elias A. Zerhouni, M.D. Since February 9, 2003, when Dr. Kington was appointed Deputy Director of the National Institutes of Health (NIH), he shared in the overall leadership, policy direction, and coordination of NIH biomedical research and research training programs of NIH's 27 Institutes and Centers with a budget of almost $29 billion and 18,000 employees.

Prior to this appointment, he had been Associate Director of NIH for Behavioral and Social Sciences Research since September, 2000. In addition to this role, from January, 2002 to November, 2002, he served as Acting Director of the National Institute on Alcohol Abuse and Alcoholism.

Prior to coming to NIH, Dr. Kington was Director of the Division of Health Examination Statistics at the National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention (CDC). As Division Director, he also served as Director of the National Health and Nutrition Examination Survey (NHANES), one of the nation's largest studies to assess the health of the American people.

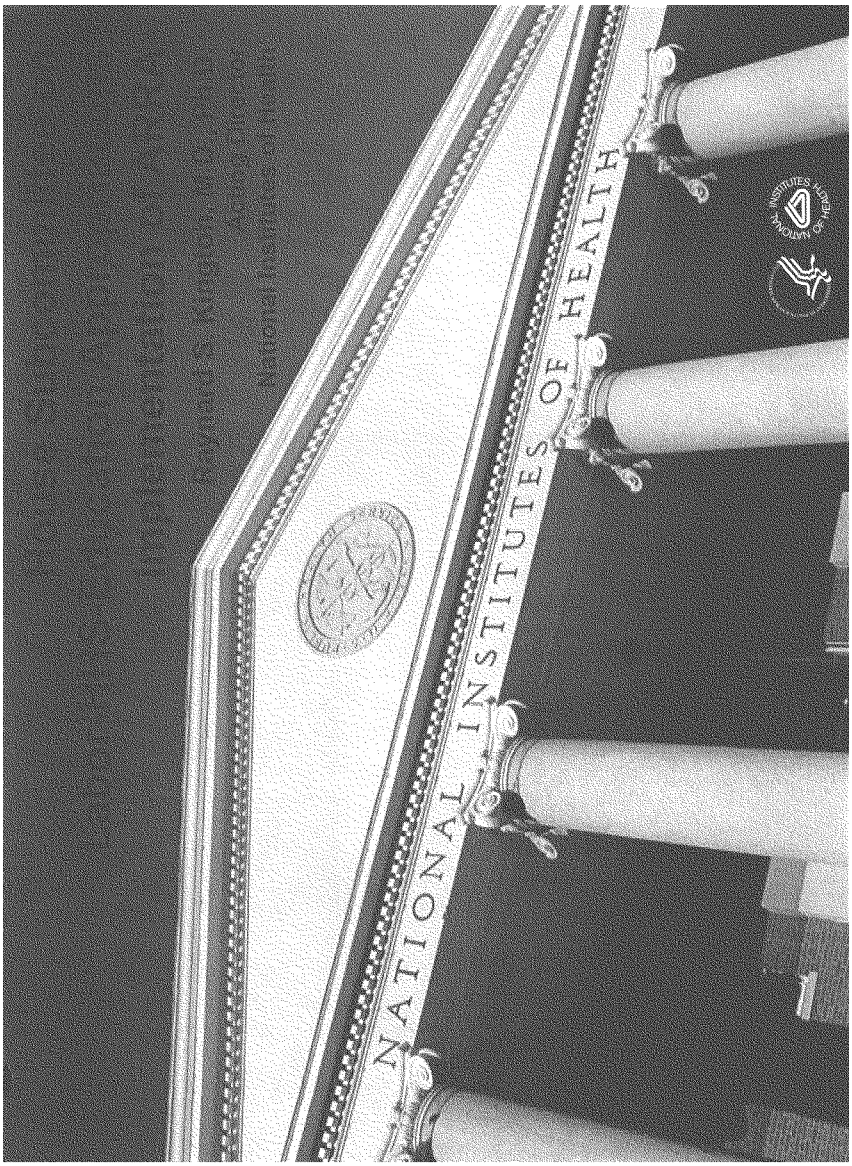
Prior to coming to NCHS, he was a Senior Scientist in the Health Program at the RAND Corporation. While at RAND, Dr. Kington was a Co-Director of the Drew/RAND Center on Health and Aging, a National Institute on Aging Exploratory Minority Aging Center.

Dr. Kington attended the University of Michigan, where he received his B.S. with distinction and his M.D. He subsequently completed his residency in Internal Medicine at Michael Reese Medical Center in Chicago.

He was then appointed a Robert Wood Johnson Clinical Scholar at the University of Pennsylvania. While at the University of Pennsylvania, he completed his M.B.A. with distinction and his Ph.D. with a concentration in Health Policy and Economics at the Wharton School and was awarded a Fontaine Fellowship. He is board-certified in Internal Medicine and Public Health and Preventive Medicine.

In 2006, Dr. Kington was elected to membership in the Institute of Medicine of the National Academy of Sciences. Dr. Kington's research has focused on the role of social factors, especially socioeconomic status, as determinants of health.

His research has included studies of the health and socioeconomic status of black immigrants, demographic correlates of the willingness to participate in genetic research, the relationship between wealth and health status, the health status of U.S. Hispanic populations, and the determinants of health care services utilization.


NATIONAL INSTITUTES OF HEALTH

One Hundred Eleventh Congress
of the
United States of America

AT THE FIRST SESSION

*Begun and held at the City of Washington on Tuesday, the sixth day of January, two thousand and nine*

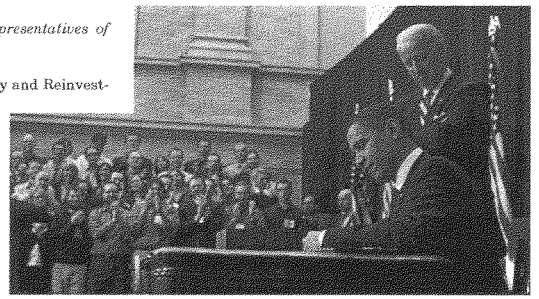
An Act

Making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and State and local fiscal stabilization, for the fiscal year ending September 30, 2009, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "American Recovery and Reinvestment Act of 2009".



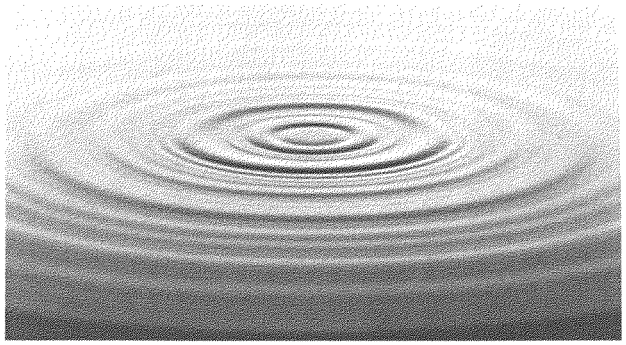
NIH is grateful to President Obama and Congress for the opportunity for NIH to play its part in improving the Nation's health and economy

Raynard S. Kington, M.D., Ph.D.

March 26, 2009

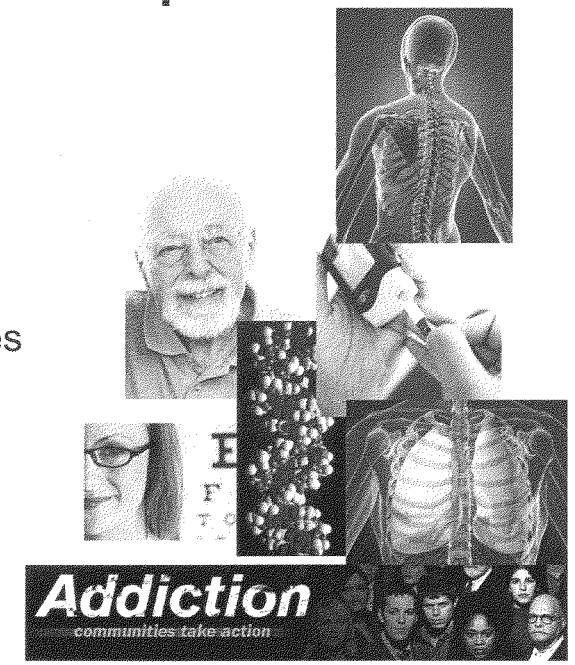
# Funding Impact

- Stimulate the economy
- Create and preserve jobs
- Advance biomedical research

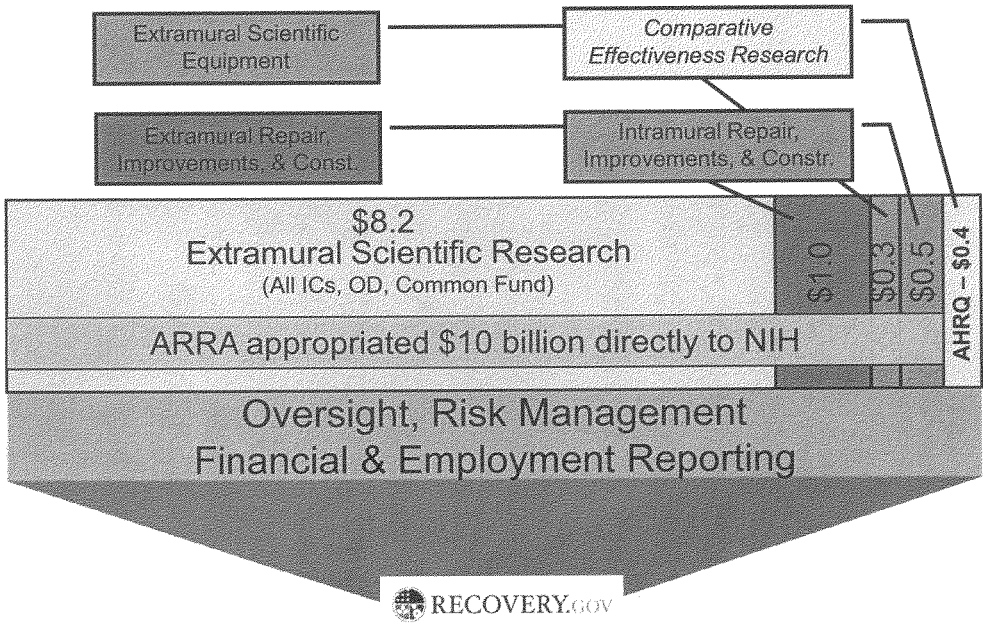


# Biomedical Research supported by ARRA: Examples

- Diabetes
- Cancer
- Addiction
- Glaucoma
- Heart and lung diseases
- Arthritis
- Kidney disease
- Mental disorders



# NIH Allocation of ARRA Funds
## Dollars In Billions



# Scientific Research Approach

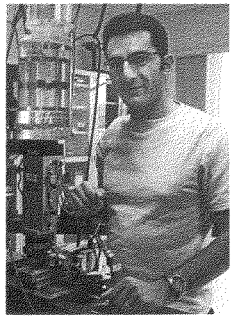
- Stimulate and accelerate biomedical research with existing mechanisms
- Expand science with new programs

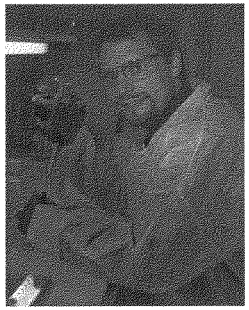
# $60M Grants for Strategic Autism Research

- Research to Address the Heterogeneity in Autism Spectrum Disorders
  - Develop / test diagnostic screening tools
  - Assess risk from exposures
  - Test early interventions / adapt existing pediatric treatments for older groups

# New ARRA NIH-wide Programs

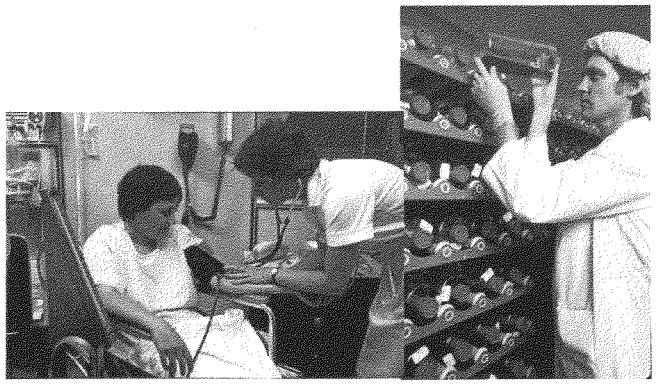
- Challenge Grants
- Grand Opportunities ("GO" Grants)
- Recruit new faculty to conduct research
- Provide summer jobs for high school / college students and teachers to work in science labs





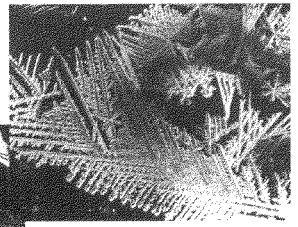
# Challenge Grants

- Challenge Grants (at least $200M total) provide:
  - Priority avenues of research
  - Up to $500K total costs/year for up to two years



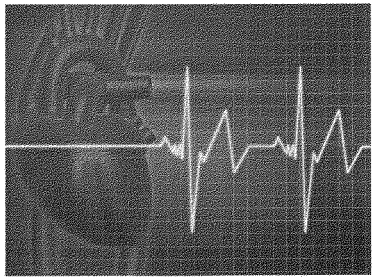
# Challenge Grants
## (Examples)

- Biosensors
- New approaches to HIV therapy
- Bioethics
- Health disparities in clinical research
- Pain management
- "Theranostics"



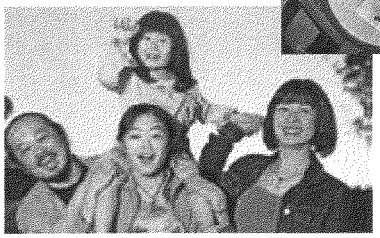
# Grand Opportunity Grants

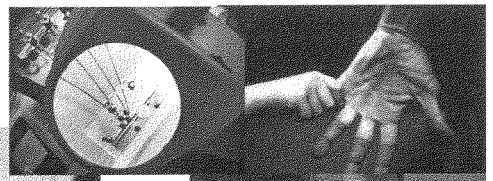
- Grand Opportunity (GO) Grants (at least $200M total):
  - High impact
  - Well defined
  - Large scale



# Signature Initiatives

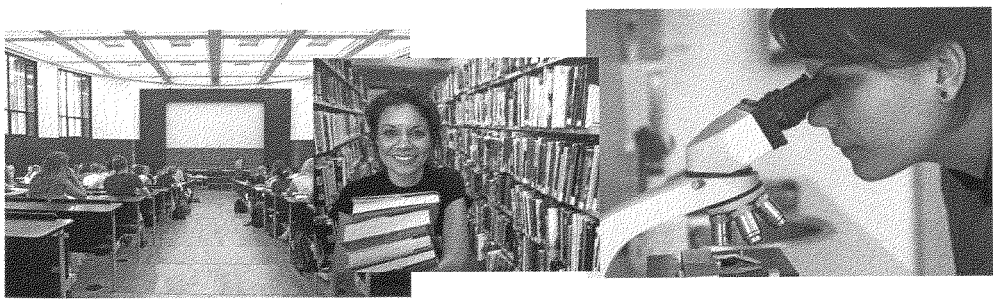
- Support exceptionally creative projects to address major challenges in biomedical research, e.g.:
  - Nanotechnology
  - Genome-wide association studies
  - Alzheimer's disease
  - Oral fluids as biomarkers
  - Large scale sequencing
  - Community-based research





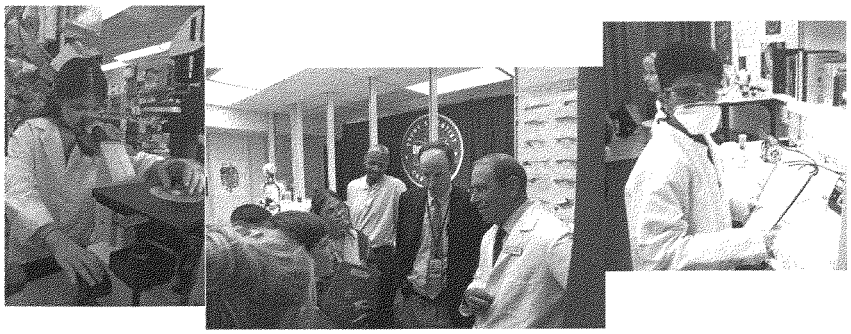
# New Faculty

- Core Centers for Enhancing Research Capacity in U.S. Academic Institutions
  - Newly trained scientists
  - Start-up packages
  - Pilot research projects



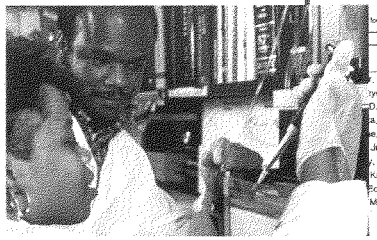
# Summer Jobs in Research for Students and Teachers

- Engage students and educators in research
- Encourage students to pursue research careers
- Provide summer internships at NIH-funded laboratories for science teachers



# Economic Benefits

- Impact
  - Create and preserve jobs
  - Advance biomedical research
- Reporting
  - Financial reports
  - Projects and activities
  - Trend analysis



Principal Investigator/Program Director (Last, First, Middle): Dinauer, Mary C.

**KEY PERSONNEL REPORT**

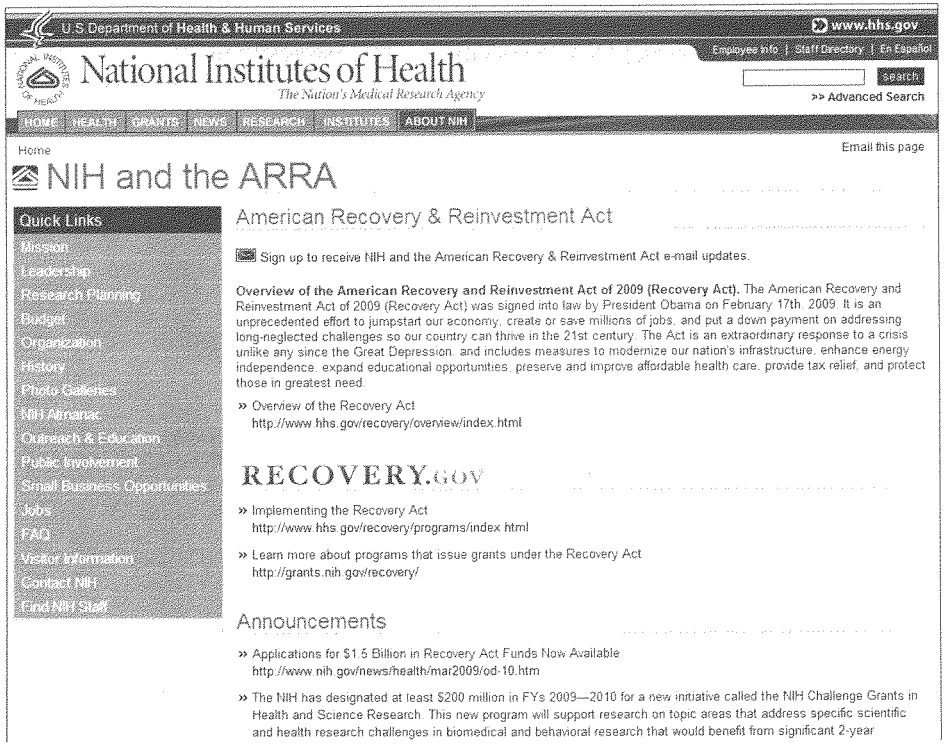
GRANT NUMBER: PO1HL053586-13

form at the end of the signed original copy of the application. Do not duplicate

All Key Personnel for the Current Budget Period (do not include Other Significant Contributors)

| Name | Degree(s) | SSN (last 4 digits) | Role on Project (e.g. PI, Res. Assoc.) | Date of Birth (MM/DD/YY) | Months Devoted to Project: Cal | Acad | Summer |
|---|---|---|---|---|---|---|---|
| , Mary C. | M.D , Ph.D. | | P.I. | 10/31/53 | 3.0 | | |
| yer, Hal | Ph.D | | Project 1 Leader | 11/27/44 | 2.4 | | |
| D, Wade | M.D. | | Project 3 Leader | 07/07/55 | 2.4 | | |
| a, Kenneth | M.D | | Core B Leader | 08/16/56 | 0.6 | | |
| e, Laura | M.D. | | Project 2 Co-Inv. | 12/03/64 | 2.4 | | |
| Jr., David A. | M.D | | Project 2 Co-Inv. | 06/05/66 | 0.6 | | |
| , Sean D. | Ph.D | 5190 | Proj 2 & 3 - Co-Inv | 09/12/72 | 1.2 | | |
| Karen | Ph.D. | 9956 | Core C Leader | 01/11/62 | 1.2 | | |
| Edward | Ph.D. | 9839 | Core A Leader | 07/15/57 | 1.8 | | |
| Mervin C. | M.D | 9749 | Project 2 Co-Inv | 02/12/53 | 1.2 | | |

# http://www.nih.gov/recovery



NIH and ARRA
Stimulating the economy
Creating and preserving jobs
Advancing biomedical research
NATIONAL INSTITUTES OF HEALTH

NIH RESEARCH FACILITIES CONSTRUCTION MODERNIZATION

Mr. JACKSON. Dr. Kington, thank you very much for your testimony.

We are going to try today to adhere as closely as possible to the five-minute rule. I am going to certainly apply it to myself.

I want to thank my colleagues for coming to today's hearing. Chairman Obey, who would normally be chairing the Committee, has found himself in another conflicting scheduling event and expresses his deep regrets for not being here to all of the institute directors, center directors and to you.

The Recovery Bill provided about $1.5 billion for extramural research facilities and NIH campus research facilities. Whether the money is awarded for new construction or renovation, it is sure to generate needed jobs across the Country. What is your estimate of jobs created through this funding?

How critical is it to modernize biomedical research facilities in order to achieve the scientific advances of NIH that have been outlined in the road map?

And, what is the estimated backlog of creating adequate research space?

That is my first series of questions.

Dr. KINGTON. First of all, we anticipate that extramural construction support, which is the $1 billion that will go out across the Country, will allow us to deal with extraordinary backlog on academic campuses throughout the Country in basic renovation and improvements. I believe the estimate was around $9 billion of backlog across campuses across the Country, and this $1 billion is a significant down payment on that large amount of resources that are needed to bring these buildings up to speed. We think that it will have a direct impact on the quality of the research that we support.

And the relatively small amount, the $500 million that will go to support construction on campus, will also allow us to substantially improve the quality of our research buildings and to catch up with the deferred maintenance backlog that we have accumulated.

We have not estimated exact numbers of jobs that will come from the construction dollars, but we can get back to you with estimates. We don't have exact numbers right now.

We have better estimates for the jobs that will come from the research dollars.

JOB ESTIMATES FROM CONSTRUCTION FUNDS

Mr. JACKSON. Can you give us some sense of that?

Dr. KINGTON. We estimate that each of our grants, on average, supports between six and seven jobs either in part or in full. We are in the process of actually doing an even more detailed study to look at the exact numbers that will come from the various mechanisms. That comes from a number of studies that we have conducted by pulling a sample of our grants and looking at their funding patterns.

One of the opportunities with the reporting that will come from this, associated with ARRA, is we will probably have better information than we ever have had about the economic impact of the dollars that we support.

[The information follows:]

CONSTRUCTION JOBS CREATED WITH $1.5 BILLION

Dr. Kington: The estimate number of jobs created or maintained by the $1.0 billion for extramural construction and $500 million to support construction on NIH owned buildings and facilities is an approximation. The exact number will depend on the mix of projects, location, and cost of materials.

The job projection for both the extramural and NIH campus construction projects is based on an industrial labor conversion factor of about 5.5 work years per $1.0 million spent. It is estimated about 8,000 work years can be supported with a total of $1.5 billion of construction funds. If you extrapolate that each work year is equal to one position then it can be inferred the $1.5 billion will support 8,000 positions.

Mr. JACKSON. Dr. Kington, I want to congratulate NIH for a well thought-out plan and for obligating the unprecedented funding increase for fiscal funding for NIH. It provides an unprecedented funding increase for this year and next year, temporarily hiking the number of new grants and success rates, but the prosperity is short-lived. After two years of funding, NIH is back to where it started—low success rates and potentially scant money for new grants.

That is unless the Administration and Congress acknowledge the hole we have dug for NIH and own up to our responsibility to continue stable funding.

I know you would have to be a loyal Administration witness, but can you give us a straightforward assessment of what will happen to NIH scientists in 2011 after the Recovery Act money dries up? How many additional scientists will receive research support under the Recovery Act and how will those scientists be supported once the funding dries up?

Dr. KINGTON. First of all, we have some experience with planning for large influxes in support to our budget, having lived through the doubling and then the not so soft landing that came after the doubling, and we have learned from that experience.

We are much better at estimating the churn of dollars, and with these dollars we have made an effort to limit the impact by limiting our commitments to only the two years of the dollars that come with the Recovery Act. We, however, anticipate that if these dollars actually generate the research advances that we hope they will generate, we will probably have an increase in applications beginning in 2011.

We have done some estimations, and we believe that it may drop the success at least several points below what it has been if we don't have a substantial increase in our budget.

We tried to use these funds wisely, so we can minimize the outyear impacts. But it is inevitable that if the dollars are used successfully, we will generate advances which will, in turn, generate new applications. We are trying to limit that impact, but in some ways it is an indication of the success of the funding to generate new scientific advances.

Mr. JACKSON. Mr. Tiahrt.

Mr. TIAHRT. Thank you, Mr. Chairman.

Welcome, Dr. Kington. I don't think there is any question you guys do wonderful research that has dramatically improved the lives of Americans, and I want to congratulate you on your persistence.

There is some concern on my part about this pig going through the python, if you will, this $10,000,000,000 that is going to be a 33 percent increase to your budget, but it is only for a limited time. Our Chairman and Chairman Jackson here, I think, is right to be concerned about how that is going to be spent.

And I think probably what justifies that concern is the National Children's Study where we started in 2000 to do some good things by tracking 100,000 kids from conception, when life begins, until the natural progress through life. I think it is going to reveal some very interesting things.

But it originally started out to be approximately $3,500,000,000 over a 25-year period, and most of us found that a good plan. Now I am hearing that that cost may actually double. Is that about right?

Dr. KINGTON. Well, we have every plan to bring the cost down, and I can answer in more detail, but we anticipate that the total cost will not be double.

THE NATIONAL CHILDREN'S STUDY

Mr. TIAHRT. The reason there is a concern is if you take this $10,000,000,000 pig going through the python and find out it is really $20,000,000,000 later on, we could shortchange ourselves and our future by having to shut down research or limit it when it could reveal some very profitable things for the life and well being of Americans.

So I would like to know a little bit better about how that $3.5 billion was developed and how it expanded. Did we decide we need to include more children in the study or did we have to hire more people to conduct it?

Did we, after ignoring Kansas, pick up some additional States? Nothing subtle there.

Dr. KINGTON. I am just grateful that we are the python and not the pig. [Laughter.]

The National Children's study is a study of unprecedented size and complexity that is designed to answer extraordinarily important questions about the role of the environment and particularly in the development of children.

This study began out of a working group that identified the scientific need, and then planning was initiated. Over the last five or six years, we have had a number of opportunities to estimate the cost of the study, but we were estimating a moving target because it became clear early on that once we generated a comprehensive sort of wish list of scientific sub-projects that we wanted in the study, it became clear that we would not be able to fund all of those research components, which is not unusual for a large research project.

Mr. TIAHRT. Are you still going through that analysis and so you may be able to limit the increase in cost?

Dr. KINGTON. Absolutely. In fact, we received advice from the National Research Council at the National Academy of Sciences where we were told, advised to have a pause after a period of an extensive pilot when we could analyze the results of the pilot, see what worked, what didn't work, see what the costs were and then to make adjustments.

Mr. TIAHRT. Is that pilot done at the end of this fiscal year or when will your pilot project be complete?

Dr. KINGTON. The pilot project consists of seven vanguard centers. Two are operational now. Five more will come online next month. They will have about a year of operation, and we really need that period of time because the study really is unprecedented.

It is a population-based study. So we are knocking on doors, trying to find women who are of childbearing age, who are likely to become pregnant, follow them through the pregnancy to the birth of the child and then follow the child through to age 21.

Mr. TIAHRT. If you are arranging relationships, I have a couple of gals in my office that would like your help. [Laughter.]

I am being facetious. I am sorry.

Dr. KINGTON. I will resist the opportunity to comment on that one.

What we did know was about maybe three or four years ago we had an estimate of about $3.1 billion. Internal to the study, it became clear at some point that that was an underestimate of the entire package that was being piloted. Now we knew we were going to scale it down some, but it was an underestimate.

A decision was made not to correct the estimates because the feeling was we would have to go back and correct again once we had good information from the pilot study. This was an error in judgment in my opinion.

We have now corrected that error in judgment. We are re-estimating costs. We are having a number of steps in the review of the activity including much greatly increased review from the Office of the Director.

Mr. TIAHRT. Excuse me. I almost out of time, so I apologize for interrupting you.

I think you are on the right track by reassessing the study. In any government program, allowing it to grow beyond its original intent is a great temptation. So I would encourage you to keep it within the original scope because you had a great idea.

Let's complete that idea rather than risk jeopardizing it by expanding it too big and getting it killed because of the size.

Thank you, Mr. Chairman.

Mr. JACKSON. Thank you, Mr. Tiahrt.

I have been informed that we are expecting a fairly lengthy series of votes sometime between 12:30 and 1:00. These will be the first and last votes of the day but, again, potentially lengthy. And so, I am grateful to members who are honoring the time.

I thank you once again, Mr. Tiahrt.

Mr. Honda.

## HEALTH DISPARITIES AND EQUAL ACCESS BILL

Mr. HONDA. Thank you, Mr. Chair.

Welcome, Doctor. Your written testimony is very good, and I really appreciate its detail and being succinct.

The area I am concerned about is the area that you took a lot of pain to discuss, and that is the communities of color and the disparities. Hopefully, in your discussion and your research and your thinking, Asian American populations are included in there be-

cause I think that is a myth out there, that the communities don't have any problems.

When we disaggregate the community, you know that there will be different communities with very serious problems. So, in part of your work hopefully, that will be some of the direction.

We had a bill in the last session. I believe it was H.R. 3014. It is the Disparities and Equal Access Bill. Essentially, what we wanted to do was look at all the gaps in our health system from research to delivery systems, services at the clinical level, community level—many of the areas which you have discussed in your paper here.

I was wondering whether, number one, in the last fiscal year out of the $30 billion that was allocated for NIH, I believe it was $2 billion or $3 billion was set aside. Two billion dollars was set aside to study the disparities, and I was wondering what kind of work was done as a result of that.

Two, where in your studies was there some matching in the desire that we provide services based upon our bill, figuring out whether if you are already doing it, what parts of it, what parts of the bill are being addressed.

And then, three, in the future, how will you be looking at that in anticipation of a bill being passed or not being passed? In the direction, whichever you want to go to, there is a parallel there, an equal desire.

So I was wondering whether you could comment on those questions.

Dr. KINGTON. Thank you for the question. This is an extraordinarily important area for the Agency and for the American people.

First, I point out the trends for our expenditures in health disparities. We, as you noted, estimated that about $2.6 billion of our budget in 2008 was devoted to health disparities research.

We have defined disparities populations, and we certainly acknowledge that many Asian sub-populations have extraordinary health care problems. There is great heterogeneity across subgroups, and that is a theme that cuts across many projects of research supported by multiple institutes and centers including the Minority Center.

Mr. HONDA. May I just interrupt for a second?

Dr. KINGTON. Sure.

Mr. HONDA. For purposes of the future, if that would be articulated, that would be greatly appreciated because I think once articulated and written down then we know that exists and we pay attention to it. Thank you.

Dr. KINGTON. We will articulate it in our strategic plan, and I can go on to that topic. We are in the process of starting a second wave of our strategic planning process. It is led by Dr. Ruffin, and Dr. Ruffin may want to comment.

We try to integrate health disparities research across the entire Agency. Although the Minority and Health Disparities Center clearly has the lead, we feel that it is important that every single institute and center understand that they own part of this problem.

I see, and I can personally tell you that every single institute and center director sees it as a priority. It was a priority under Dr.

Zerhouni, and it is also a priority under our ARRA dollars. You may note that in this large compendium of topics one of the 15 priority areas was health disparities research.

We anticipate receiving many important applications and funding them under ARRA. I think that you will see in our portfolio we have everything from very basic research all the way through research on systems and how minority groups and health disparities populations fare within our health care systems, and I think that you will continue to see that broad continuum of research at the Agency.

And, Dr. Ruffin may want to comment as well.

Mr. HONDA. Thank you.

Mr. RUFFIN. I think that the last iteration of the strategic plan, as Dr. Kington stated, while it had been slowed getting through the process because there was a lot of different stages that it had to go through, I can say that 100 percent of the institutes and centers at NIH did not let that process of clearance slow them down. Many of those issues and initiatives that are listed there in that plan have already been initiated.

I think those of you who may have participated and were present in December at our summit meeting where there was somewhere in the neighborhood of about 4,400 people. The purpose of that summit was to give the ICs—the institutes and centers—an opportunity to report on where we are with the various projects that we have going on within the ICs at the NIH, the institutes and centers.

I think that what was revealed at that summit is the magnitude of research in all of those areas that you just mentioned that are now underway.

Mr. HONDA. Thank you.

Mr. JACKSON. Thank you, Mr. Honda.

By the way, I like the idea that when Dr. Kington invokes your name if you would just step up to the mic. It saves us a considerable amount of time, and there may or may not be a second round. But the distinguished institute heads and directors have traveled a great distance to participate, and to the extent to which they can participate, we would be grateful.

Mr. Rehberg.

Mr. REHBERG. Thank you, Mr. Chairman.

Could you expand a little bit more on the 14,000 grant applications?

One of the problems that I have, and I have maybe been critical of my own party from time to time, we always say we want to balance the budget except keep your hands off Homeland Security and Defense, and that is where you end up with the $500 toilet seats and $200 hammers. When you are not paying attention, somebody is going to be padding a budget.

When you have an influx of money like $10,000,000,000 and all of a sudden you go: Oh, goody, goody, goody. Now we can just expand what we were doing. These may have been meritorious. However, they didn't make the cut before. All of a sudden, they are back on the table again.

Give us some confidence that, one it is going to stimulate the economy as intended, two, that you are not just going to be throw-

ing money at new projects that hadn't made the list before and, three, why not just use the money for an expansion or a continuation of those that you found to be meritorious in the first round rather than trying to spend it on let's say two-year projects and then coming back before the Committee and saying, well, now you have to have a maintenance of effort because we have begun these very important projects when, however, they didn't make the cut before.

Dr. KINGTON. Very good questions.

First of all, it is important to recognize that those 14,000 applications were reviewed and found to be scientifically meritorious. We received many more applications that were not funded. This was the top, right below our funding level.

But it is also important to recognize that that is in the context of flat budgets. Over the last six years, the NIH budget has essentially been flat, and we have lost about 17 percent purchasing power. So there was a great deal of pent-up demand.

We believe that many of those projects can be funded for two years, and all of them have been found to be scientifically of high quality and have been reviewed by our councils. But that is not the only way that we are using these dollars.

Many institutes and centers are also committing equal amounts, if not more, to supplement existing grants and contracts as you suggested. These are projects that are already ongoing in which we are either accelerating or we are expanding to address new areas for existing contracts. We released two solicitations for requests for those supplements, and that will be a major part of this portfolio

We have three big buckets. One is the funding of grants that were on the table but were very high quality, and if we had had funds we would have been perfectly comfortable funding them because they were of high scientific quality. The second is supplementing existing grants and contracts through either an administrative process or a competitive process in which we solicit requests. And the third is the new grant programs such as the Challenge Grants and GO awards which are only for two years.

Mr. REHBERG. And your deadline on that is what?

Dr. KINGTON. The deadline?

Mr. REHBERG. Of this various process of the spending.

Dr. KINGTON. We have started. We have released the supplement requests, announcements for administrative supplements and competitive supplements. We have released the Challenge Grants. We hope soon to release the GO Grant application RFAs.

So we are substantially down the track a bit on this, and I actually think we have elaborate time tables actually to make sure that we can get the applications, review them and fund them beginning in 2009.

We are absolutely confident that we have the infrastructure and the reserve to, one, fund really good science and, two, fund it quickly.

JOB ESTIMATES FROM ARRA FUNDS

Mr. REHBERG. What is your number on new jobs created with your $10 billion?

Dr. KINGTON. It depends upon the distribution across those pots. We can give you an estimate. As I said, each grant we believe supports between six to seven jobs in part or full.

We can get back to you with the exact dollar estimates.

Mr. REHBERG. I want not just exact dollar but exact job.

Dr. KINGTON. Excuse me. The exact number, yes.

Mr. REHBERG. Because the stimulus was billed as a jobs creation. It got morphed into a job maintenance somewhere along the line once they realized that it was going to be very difficult to create as many jobs as were promised. So I want an exact number that you anticipate, jobs that will be created with your $10 billion.

Dr. KINGTON. We will give that to you, and it is required under the reporting requirements of the Act.

[The information follows:]

JOBS CREATED WITH $10.0 BILLION

Dr. Kington: The estimate number of jobs created or maintained by the $10.0 billion provided to NIH in the Recovery Act is an approximation; the exact number will depend on the mix of grants or contracts awarded. The Act provided $8.5 billion for scientific research and equipment, $1.0 billion for extramural construction and $500 million to support construction on NIH owned buildings and facilities.

The traditional NIH scientific grant type is called an R01, for which a study indicates each award supports 6 to 7 part or full positions. NIH estimates the $8.5 billion funds will support around 7,000 research project grants and contracts of which, about 4,000 should be R01 type grants. We project these R01's should support 24,000 to 28,000 positions in part or in full across the Nation. NIH does not have the data available to estimate the job creating impact of the remaining 3,000 grants and contracts that are not R01's. The job projection for both the extramural and NIH campus construction projects is based on an industrial labor conversion factor of about 5.5 work years per $1.0 million spent. It is estimated about 8,000 work years can be supported with a total of $1.5 billion of construction funds. If you extrapolate that each work year is equal to one position then it can be inferred the $1.5 billion will support 8,000 positions. Although NIH does not have the data to generate comprehensive estimated job projections, we will continue to work to develop and provide them.

Mr. REHBERG. I understand that. Thank you.

Mr. JACKSON. Thank you, Mr. Rehberg.

Ms. Roybal-Allard.

Ms. ROYBAL-ALLARD. The National Children's Study is a study that is extremely important for communities such as the ones I represent that are overrun with freeways and every kind of unwanted project that you can imagine. So, if I may, I would like to direct my questions to Dr. Alexander who I believe oversees the studies.

Is Dr. Alexander here?

Dr. ALEXANDER. Yes.

Ms. ROYBAL-ALLARD. Okay. Dr. Alexander, first, I would like a little bit of a clarification of the response to Mr. Tiahrt's question because I have heard that some concern has been raised about the many variables that you are piloting in the National Children's Study. The concern is that it may double the budget is what I have heard.

Can you explain what the reasons are for so many variables and do you share that concern in terms of doubling of the budget?

Dr. ALEXANDER. When we made the decisions to go ahead with the pilot study that was very broadly encompassing of many of the

ideas, not all, that had been proposed for inclusion in the study, we did it for several reasons.

First, we felt that the best way to decide what the content of the final protocol for the main study would be, would be based on experience in testing in the field of the various ideas, possibilities of different approaches for recruiting subjects, different approaches for collecting data, et cetera. The best way to get that information was to actually test it in the field.

There was never any anticipation that we would double the size of the study or even massively increase it. However, the study itself was conceived as a public-private partnership. So, in addition to the Federal funds available from the appropriation, we also anticipated that things that could not be incorporated into the protocol funded by the appropriation might be picked up by other interested parties, other components of the government, other government agencies, the private sector, industry, foundations, advocacy groups, whatever.

We wanted to have an identification of things that were useful to do but did not make the cut, if you will, of inclusion within the protocol within the financial constraints that there would be, and we would hope many of these other things might be picked up by these other sources.

Therefore, it was advantageous, in addition to trying to pick the best things for the final protocol, to include more things so that we might be able to offer these up to expand the reach of the study and really fulfill its purpose much more extensively than just the appropriated dollars would be able to do alone.

Ms. ROYBAL-ALLARD. Also, many parents have concerns about enrolling their children in clinical studies, and this is particularly true of ethnic and minority groups who could benefit greatly from this study.

Could you please tell the Committee what is being done to recruit and to retain racially ethnic and culturally diverse children and what your contingency plan is to support study sites that do not achieve the targeted minority enrollment rates that you are anticipating?

Dr. ALEXANDER. Yes, those are very important issues that the study has tried to address from the beginning. First of all, the study itself is one that looks like America. We have rejected the approach, based on the best scientific advice we could get, of a convenience-based sample in favor of a nationally representative sample so that the children included will come from an appropriate proportional representation of their representation in the population.

There will be representation from all racial and ethnic groups, socioeconomic status groups, geographic distribution, et cetera.

Ms. ROYBAL-ALLARD. Doctor, I am sorry to interrupt, but my question really is what kind of outreach are you going to have in order to assure that you get the diversity that you are seeking?

Dr. ALEXANDER. Okay. Very good. Let me get to that.

That then has been also an effort we have made from the beginning. The outreach includes presentations to organizations that represent minorities across the spectrum—Hispanic organizations, African American organizations, whatever. We have presented sev-

eral times to the National Medical Association and have their endorsement and so forth.

We have also charged each of the sites with a broad effort in community outreach. Each of them has a person on their staff directed toward community outreach and reaching people in the community, both directly as well as through the media, through their community leaders and organizations and so forth. So that is being done.

In addition, we have publicity that has preceded our entry into the field in the sites where the study is being done.

We also have efforts underway to be sure that if we have difficulties in the field we are able to deal with them. We have sensitivity training being done for all the people who are doing the interviewing.

And, our oversight center will be looking at our minority recruitment efforts to be sure that we are making our goals. If we are not, then we are prepared to step in and increase the efforts in the sites or to increase efforts at supplementing by over-sampling in other areas.

Ms. ROYBAL-ALLARD. Doctor, I am just hoping that there will also be forms and applications and presentations in appropriate languages and that the research teams themselves will be culturally and linguistically competent.

Dr. ALEXANDER. They are. In fact, virtually all of the documents for the public are in English and Spanish, and we have seven different languages for the consent process.

Ms. ROYBAL-ALLARD. Thank you.

Mr. JACKSON. Let me just indicate also that I have just received an update that the votes are likely to come now, the final votes of the day, between 11:30 and noon. So the extent to which we have questions of Dr. Kington and the extent to which we have questions for institute heads or directors, please feel free to incorporate them now as the first round might be in fact our only round.

Mr. Ryan.

Mr. RYAN. You are running a very tight ship, Mr. Chairman.

Mr. JACKSON. It is all we have.

Mr. RYAN. It is all we have. That is right. [Laughter.]

Thank you very much.

I have had the opportunity over the past couple of months to get involved in some different programs that are going on around the Country.

I went out to the University of Wisconsin at Madison and met with Dr. Richard Davidson out there who is doing a significant amount of brain research. One of the issues that he is trying to deal with and I think a lot of people around the Country are trying to deal with, whether it is in the field of health care or in the field of education, is how our society at this point in time is dealing with stress and the ripple effect that stress has throughout our communities, throughout our health care system, throughout our education system.

So I have a couple of questions basically along the line of basic behavioral research, science research that you are doing but also some more specifics as far as how we can start within our health care system, within the research that you are doing, as we learn

more and more about the functions of the brain, what we can do to prevent and teach people how to control their levels of stress so that we are not dealing with these chronic symptoms that are weighing down our health care system.

There is also major science now backing in schools that these kids that come to school, they have problems at home. They have problems with their family. They are dealing with a significant amount of stress before they get into the classroom, and the brain research is showing that in these kids the part of their brain that they need for working memory, for good decision-making is all being affected by the levels of stress they are having to deal with.

So I have two or three questions. One, initially, probably would be for Dr. Briggs, I think. So, come on up.

What research have you supported and are currently supporting on the application of low-cost behavioral interventions such as mindfulness-based stress reduction on health care utilization?

Dr. BRIGGS. Congressman, I am delighted at your interest in this question. This is indeed a very exciting part of our scientific portfolio. We have a very robust set of superb applications dealing with mindfulness, stress reduction and their impact on disease.

Dr. Davidson's program is supported by us as a center, and he is doing very interesting fundamental neural work on the impact of meditation on the brain.

In addition, we are looking at some very practical applications of these methods such as effect of mindfulness on post-traumatic stress disorder, effect on eating and metabolic disorders and effect on the management of pain.

As I think this Committee is well aware, management of chronic pain, and as all of us as doctors know very well, management of chronic pain is very difficult, and these interventions show substantial promise in that arena. It is a very active area in our portfolio.

Mr. RYAN. My next visit is on Monday. I will be out at the University of Massachusetts Center for Mindfulness, and I invited Representative Kennedy to come on over and help meet with some of the folks over there. Jon Kabat-Zinn started that about 30 years ago, and that is dealing with managing chronic pain.

I think this is another area that we really need to get into.

What research are you supporting on behavioral interventions that can start early in life, so, preschool, first grade, to promote emotional and social skills to help deal with these levels of stress in a lot of these kids—basically, the emotional and social intelligence that our kids are really required, not only required to have but need to be competitive in a global marketplace?

Dr. BRIGGS. This is an area of great promise. NCCAM has a relatively small portfolio in mindfulness in children, but I agree with you, it is an area of great promise.

We are a small part of the NIH. We are only 0.4 percent of the NIH budget. But we are very careful to partner with areas like OBSSR in the development and support of the behavioral research. It is a very promising area.

PHYSIOLOGICAL FACTORS AFFECTING ORGAN SYSTEMS

Mr. RYAN. Okay. Well, you can answer this in writing but about the research you are supporting, focusing on identifying how psychosocial factors can get under the skin and affect organ systems, both for health and illness, if you can get back to me because I know the hammer is coming down from the Chairman here real soon. I am starting to sweat.

Dr. BRIGGS. We would be glad to give you that information.

[The information follows:]

## PSYCHOSOCIAL FACTORS AFFECTING ORGAN SYSTEMS

Dr. Briggs: In general, what research support is occurring for research focused on identifying how psychosocial factors can "get under the skin" and affect organ systems important for health and illness? What research is occurring on how mental factors as they are expressed in the brain affect physical health and illness?

Scientific evidence suggests that psychosocial factors such as acute and chronic stressors, optimism, depression, hostility and social isolation influence physiology and thus, health and disease. NIH supports both solicited (via Funding Opportunity Announcements) and investigator-initiated research to improve our understanding of the biological and behavioral mechanisms underlying these effects. Selected examples of ongoing programs, initiatives and individual projects include the following:

- ***BIOLOGICAL MECHANISMS OF PSYCHOSOCIAL EFFECTS ON DISEASE (BIMPED).*** The National Cancer Institute (NCI) has used the biological mechanisms of psychosocial effects on disease (BiMPED) as a programmatic framework to cultivate the discovery of biological pathways that mediate influences of biobehavioral factors on cancer growth. BiMPED strives to support transdisciplinary research that bridges basic cancer biology and biobehavioral science to advance our fundamental knowledge of the extent and specificity by which central nervous system regulated factors like stress, chronic depression, and social support might regulate tumor biology.

- ***NIMH RESEARCH ON ACUTE PSYCHOLOGICAL STRESS AND TRAUMA*:** The National Institute of Mental Health (NIMH) has an active and rigorous portfolio examining the impact of uncontrollable and unpredictable acute stress. It includes research on basic biology, as well as treatment-related research. On-going and planned activities include studies using state-of-the-art research methods, ranging from molecular biology to cognitive neuroscience and functional brain imaging to characterize the brain mechanisms by which stress increases an individuals' vulnerability for mental illness.

- ***MIND-BODY RESEARCH:*** Numerous NIH Institutes, Centers and the Office of Behavioral and Social Sciences Research (OBSSR) support *Research on Mind-Body Interactions and Health*. This initiative encourages research in three specific areas: 1) how cognitions, emotions, and/or personality (e.g., beliefs, attitudes, and values; modes of thinking) affect physical health; 2) how health beliefs, attitudes, and values are developed, maintained, and/or changed; and 3) how stress influences health. Projects currently supported under this initiative include studies of stress, depression and cardiovascular disease; biological processes that may link caregiving stress to the development of metabolic syndrome, and the subsequent decline in functional and cognitive status; race/ethnicity, psychosocial and environmental stressors and cellular aging; interplay of conscientiousness (and its genetic and environmental antecedents) with social environmental factors, such as socioeconomic status, on health-related behaviors, physical health, and longevity.

In addition, the National Center for Complementary and Alternative Medicine (NCCAM) is building the evidence base for the use of complementary and alternative medicine (CAM), including mind-body interventions such as meditation, acupuncture, and yoga to promote health and wellness and reduce stress. NCCAM's portfolio of mind-body research ranges from basic and translational studies to efficacy and effectiveness research. Research supported includes investigations into how the body reacts to and processes stress, and the role of mind-body medicine, such as meditation, in reducing post-traumatic stress disorder, anxiety, insomnia, and in improving outcomes in inflammatory bowel disease and diabetes. Promising data from NCCAM-funded research are providing clues into the biological mechanisms of acupuncture's role in human's pain perception and control; how meditation may make information processing in the brain more efficient; and the role of mind-body medicine in management of chronic pain, including osteoarthritis and back pain. One NCCAM-funded research project recently demonstrated that tai chi, a traditional Chinese form of meditative exercise, may help older adults avoid getting shingles by increasing immunity to the virus that causes it and boosting the immune response to the vaccine that protects people against it. In FY 2009, NCCAM will support additional mind-body research under its new initiative, *Effectiveness Research – CAM Interventions and Chronic Back Pain*. Overall NIH support for mind-body research was estimated to be $567 million in FY 2008.

- ***Yale University Interdisciplinary Research Consortium on Stress, Self-Control, and Addiction:*** This goals of this NIH Common Fund (i.e., Roadmap)-supported consortium include: 1) bringing together leading biological, behavioral and social scientists to examine the mechanisms underlying self-control and addictive behaviors 2) conducting programmatic, team-based collaborative research to understand the processes underlying stress and self control that promote and maintain compulsive smoking, drinking and overeating; and 3) developing new social, behavioral and pharmacological preventive and treatment strategies to decrease stress, increase self-control and prevent and decrease addictive behaviors.

- ***EARLY EXPERIENCE, STRESS, AND NEUROBEHAVIORAL DEVELOPMENT CENTER:*** This NIMH-supported center at the University of Minnesota will conduct several studies to better understand early life stress. Specifically, the center will study: 1) the transition of maltreated toddlers into foster care; 2) the childhood development of institutionalized children adopted into families, and 3) the wellbeing of rhesus monkey infants who experience early adverse care. The studies will provide critical first steps towards understanding the brain and behavioral effects resulting from early adverse care, and will inform the development of effective intervention strategies for this vulnerable population.

Mr. RYAN. Yes, my stress level is going up right now.

But just to say thank you and that over the course of this budget and next year's budget this is something that I am going to be extremely focused on and hopefully get you some more money because I think this can end up in the long run saving our health care system, our education system, tons and tons—and our criminal justice system, tons and tons of money.

Dr. BRIGGS. This is an area that we also hope to be able to look at in the comparative effectiveness arena.

Mr. RYAN. Great. Thank you.

Mr. JACKSON. Mr. Kennedy.

Mr. KENNEDY. Thank you, and I appreciate those questions very much.

I do have a number of questions about neuroscience and the brain and look forward to getting to those, but I fear that we don't have enough time today but look forward to future hearings.

I do want to ask Dr. Kington if he could present the President of the United States with the top half-dozen most promising opportunities to fund research that would transform the outcomes of various diseases in terms of the research and its production of viable cures.

I have had numbers of scientists in my office to talk about the deficit in these research grants that you have heard the concern about all over today in this Committee and how that whether it is muscular dystrophy or if it is brain science or if it is another illness and that if we had more peer review science.

We are leaving so much of it on the table because we don't have enough funding, that if we had more of it out in clinical trials, that we would be moving it forward so much that we could really make a marked difference in people's lives.

What I think we could make such a difference in this Country in terms of funding this Committee properly is if the President of the United States went to the American people and he said: This is the deal. If we had these dollars, we could literally expand the lifetime of people with this illness, with this illness, with this illness.

We could literally find a cure for Alzheimer's. It would shorten the time that we could find a cure for Alzheimer's in this period of time.

We could literally shorten the period of time that we could come up with a cure and find a cure for autism.

We could literally make the progress we need to make on Parkinson's disease and shorten the time that we need to have a cure for some of these other illnesses.

I think that is the way we capture the public's imagination. It is not over jobs. It is not about jobs. This is about changing the quality of people's lives.

I have had it put to me so poignantly on so many occasions in my office, that it just gets me wild when I think to myself that we can't get it across the American people that their dollars, just a minuscule amount of dollars in comparison to the total budget, could be transforming their health care—transforming it—and, furthermore, cutting the amount of dollars that we are going to have to expend in overall future health care dollars.

You heard the other day in terms of the Alzheimer's folks who were in town the other day. We spend so many dollars treating Alzheimer's patients when if we just found a cure, and the research dollars we are spending on Alzheimer's is minuscule. It is pennies compared to the dollars we are spending on actual treatment.

So, if you could comment just basically on that premise that we are spending dollars on treatment of Alzheimer's and on treatment of autism. Autism is now 1 in every 142 boys that are born have autism. Yet, research is like pennies in Alzheimer's and autism compared to the treatment of these diseases and why it is that we should be spending money on the research because the research is prevention. It is like real dividends paid if we invest in the research.

Could you talk about that?

Dr. KINGTON. Well, we certainly share your passion for NIH as a good investment for the American people primarily because of its impact on health. All of us live healthier lives and longer lives because of the advances certainly over the last several decades.

I think that each of us could generate a list of diseases, whether it is Alzheimer's or many other neurologic disease, cancer, musculoskeletal diseases, infectious diseases and HIV, the obesity epidemic. We could run down the list of areas of important scientific opportunity and enormous public health challenge.

We believe that over the course of this Agency we have been a good investment. So I will be discreet and say that we share your enthusiasm for this Agency.

Mr. KENNEDY. What I am asking for is I need, we need to get concrete here. We can't be all over the board. We need the President of the United States to offer up your top, most promising research in the pipeline and send out because the American public can only handle a couple of really specific examples that we can digest in the public medium.

I am asking you, can you get it to the President, so he can put it in a speech and capture the American public's attention on this?

Dr. KINGTON. Well, your point is well taken. We will think about whether or not we can get an opportunity to do that.

Mr. KENNEDY. Okay. Well, I would encourage you to do that because it is good for your budget.

Dr. KINGTON. That, I can't respond to. [Laughter.]

Mr. JACKSON. Ms. McCollum.

MESOTHELIOMA RESEARCH

Ms. MCCOLLUM. Thank you, Mr. Chair.

I am going to set a little bit of a background here. Mesothelioma kills as many as 10,000 people each year in the United States. When I am using that term, I am also going to include other asbestos-related diseases.

Millions of Americans are exposed to asbestos, including military personnel and approximately 1.3 million employees on the job in construction and general industry according to OSHA.

Now many people are going to be surprised that the use of asbestos, a known human carcinogen, has no established safety threshold level for exposure, and it is not banned for reimportation into the United States. So it currently comes back in products.

Worldwide, the World Health Organization estimates that 90,000 people die each year from asbestos-related lung cancer.

So, last year, to try to see where the scientific community was on pulling all the information together, I put in some report language and it was as follows: The Committee is concerned about the progress and the research and the efforts to address mesothelioma and other asbestos-related diseases and, therefore, requests a complete report of all NIH-related intramural and extramural projects and grants related to mesothelioma and asbestos-related diseases.

Are you prepared at the time or can you get back to me shortly on the progress on research efforts to address mesothelioma and other asbestos-related diseases through NIH? Who could take the leadership in coordinating what is going on out there on this disease?

Dr. KINGTON. We would be happy to get back with you with a much more detailed presentation about the status of our current portfolio and where we think are the important scientific opportunities. As you point out, this is a relationship that has been known for some time now, and it is something that we can do something about.

It is an important problem, and we will get back to you.

[The information follows:]

MESOTHELIOMA RESEARCH

Dr. Kington: Mesothelioma is a disease in which malignant cells are found in the sac lining of the chest, the lining of the abdominal cavity, or the lining around the heart. Most commonly linked to exposure to asbestos, this disease usually remains asymptomatic for many years until detected at a later stage. This limits treatment options and results in poor rates of success. Few active therapeutic options are currently available, and patient outcome is invariably dismal in the short term. NCI is committed to finding new treatment options and funds a broad research portfolio in which several areas show promise.

Mesothelin, a protein present in limited amounts in normal tissues but highly expressed in many cancers, makes an attractive candidate for cancer therapy. Three mesothelin targeted agents are in various stages of clinical evaluation in patients.

NCI scientists are conducting a clinical trial of SS1P, an immuno-toxin targeting mesothelin, in combination with pemetrexed and cisplatin for the treatment of newly diagnosed pleural mesothelioma. The trial is based on previous laboratory studies showing synergy between SS1P, taxol, and other chemotherapeutic agents.

Researchers at NCI have completed a phase I clinical trial of MORAb–009, an anti-mesothelin monoclonal antibody and vaccine, in patients with mesothelin expressing cancers. A multi-institutional phase II clinical trial of MORAb–009 with chemotherapy in mesothelioma is set to begin with NCI as the lead institution. MORAb–009 was developed as a collaborative effort between NCI and Morphotek Inc.

NCI is also participating in a clinical trial of a mesothelin tumor vaccine (ANZ–207) for the treatment of patients with mesothelioma who have failed standard therapy.

The Cancer Therapy Evaluation Program of the Division of Cancer Treatment and Diagnosis (DCTD) supports four active phase II clinical trials under a contract with several cancer research institutions within the U.S. Two additional phase II trials have been approved and will be active in 2009. These studies are testing novel targeted agents for mesothelioma, including molecules that inhibit the formation of blood vessels in the tumors. Almost 100 mesothelioma patients have been treated so far in these trials.

NCI has awarded a grant to the University of Pennsylvania to study immunogene therapies for malignant pleural mesothelioma. Included in this program is a phase II clinical trial combining immunotherapy, chemotherapy, and surgery. This program is expected to produce findings that will be incorporated as novel mesothelioma therapies.

The Radiation Research Program of DCTD has awarded a grant to the University of California, San Francisco, to develop radio-immunotherapies for mesothelioma tu-

mors using nanotechnology for specific targeting of mesothelioma tumor cells. This has the potential to create far-reaching applications in radio-immunotherapy, particularly in high-potent treatments for malignant mesothelioma.

The Cancer Diagnosis Program of DCTD has awarded a grant to the University of Washington to gain a better understanding of the immune response to ovarian cancer using an assay to detect mesothelin. Although not specifically directed to mesothelioma, it is expected to impact mesothelioma therapies since it is studying a target shared by both diseases.

NCI has awarded to grants through the Small Business and Innovation Research and Small Business Technology Transfer Programs to study mesothelioma treatments. One grant is seeking to improve the delivery of small interfering RNA (siRNA)-based therapeutics targeted for the treatment of malignant mesothelioma. The other grant is seeking to develop functional gene therapy vectors as a treatment mode for mesothelioma.

Ms. MCCOLLUM. I would appreciate that.

Mr. Chair, there are many opportunities out there, I know, for researchers who are looking at moving forward on this, including at some of our universities which are facing great struggles in that right now.

Angels dare to tread with picking out what is the most important disease to study. The reason why I said to kind of find out what is going on and who is collaborating and coordinating on this is quite often because military personnel are involved in this here too. So I am going to lay out a little more challenge perhaps.

I see the NIH as being the lead organization in the United States with what the Department of Veterans Affairs is doing, what our universities are doing, what other research groups are out there doing. Somebody has to pull this all together.

We have limited dollars, and people are coming up here. Mr. Kennedy just pointed out some great, great opportunities to improve the quality of lives for people, individuals and their families with Alzheimer's, with autism. We have to get really smart with the dollars that we have in health care.

I think people look to you, and I want to look to you as being the leaders in telling us, the Congress, how we can go forward and working in cooperation with you in setting up good examples of how not only basic research but peer review studies, as has been pointed out, and funding grants and applications can have long-term benefits.

With that, I yield back, Mr. Chair.

Mr. JACKSON. Thank you, Ms. McCollum.

Just before I recognize Mrs. Lowey, I received an update. Votes are expected between 11:20 and 11:40. These will be the first and last votes of the day, potentially a very lengthy vote series.

I have a number of questions, Dr. Kington, that have been presented by Chairman Obey and the Committee that we would like to submit for the record and would like a detailed response to those questions.

Dr. KINGTON. We would be happy to answer.

Mr. JACKSON. Mrs. Lowey.

### IMPACT OF TOXIC CHEMICALS ON HEALTH AND DEVELOPMENT

Mrs. LOWEY. Thank you, Mr. Chairman.

The fact that I had to be at a hearing next door has certainly not defined my passionate interest in what you are doing at the NIH, and I am delighted to have the opportunity to have an ex-

change with you, and I look forward to continuing the dialogue. Thank you.

For years, I have been concerned about the impact of toxic chemicals on health and development particularly in the womb and throughout childhood. Some scientists believe these endocrine disrupters can alter cell development and organ function, negatively affecting one's health throughout a lifetime.

More than 12 years ago Congress passed legislation that I authored, requiring EPA to screen and test chemicals and pesticides for possible endocrine-disrupting effects. Unfortunately, EPA has moved slowly, which is the understatement of the year, in developing techniques to identify disrupters.

While I understand that NIH has a program to study the impact of endocrine disrupters on humans, there are still many gaps in our knowledge on this issue.

I know that Dr. Linda Birnbaum, the new Director of the NIEHS, National Institute of Environmental Health Sciences, isn't here today. But I would like you to comment on activities within NIH when it comes to studying endocrine disrupters.

What is being done?

How can we enhance this research?

Would NIH be willing to convene a panel of stakeholders to develop a plan for research moving forward? How much funding would be required for this?

How will the National Children's Study specifically study endocrine disrupters' impact on children's health and development?

If you can respond and share any additional information, that would be helpful.

Dr. KINGTON. Thank you. As you noted, Dr. Linda Birnbaum is our new Director. She is a world-renowned toxicologist and actually comes from the EPA.

I know they have a substantial investment of over $30 million in endocrine disrupters, both at NIEHS and the National Toxicology Program which is run jointly with NIEHS.

They have also been a leader in the area of EPA analysis, and their monograph on that topic is also available now. And they are working closely with the FDA on a number of these issues, and the EPA.

I know that Dr. Birnbaum is considering having a workshop as a planning exercise to do exactly what you suggested—to bring together scientists and constituencies to come up with a reasonable sort of next step plan, both in identifying research gaps and, we hope, to inform our decisions about allocation of resources.

I know this is a priority topic for her. We can give back much more detail about what we are doing in terms of specific activities, and there is a substantial portfolio precisely because this is such an important public health challenge.

Mrs. LOWEY. Well, let me thank you very much. As I mentioned, I began working on this when scientists came to talk to me about it.

And I have been so concerned about the impact of wrapping food in plastics. Recently, many mothers of newborns have been concerned about the impact of the bisphenol A, I believe it is, plastic

bottles. So I do hope that there is an urgency at the NIH to finally address these very serious issues.

Dr. KINGTON. It is certainly a priority.

Just as another example of ways that we are trying to help develop informed policy about this, we have started an initiative with the FDA in which we will take existing NIH studies that have biologic samples that can be analyzed to look at the relationship between BPA, bisphenol A, and various health outcomes. We are hoping that by using existing data sets and existing studies, we can develop quickly more information that will help inform some of FDA's decision-making.

Mrs. LOWEY. Well, thank you.

It has also been widely acknowledged in the medical and scientific communities that this generation of children may face a lower life expectancy than their parents due to increased obesity and decreased physical activity.

I would be very interested in whether the National Children's Study will look at what factors, both genetic and environmental, might contribute to increased incidence of obesity, and I would be interested to know because there is another issue that many of us have been talking about for a very long time and not that there hasn't been attention given to it.

I see the red light is on. Maybe you can just respond very quickly. What research is NIH doing on this topic?

Dr. KINGTON. It is certainly a priority. It is among the most important problems facing our population with the potential of having substantial detriments in health as a result of this aging cohort that is becoming adults, carrying with them the weight of overweight and obesity and all of the health implications that come with that.

I know that it is one of the topics that is to be studied in the National Children's Study, and we also have a range of community-based interventions that are being developed as well, particularly targeted toward activity in children as adolescents when they begin to develop their health habits for their lives.

So it is an important topic. We can give you a lot more detail about the full portfolio of investment in that area.

Mrs. LOWEY. Thank you.

I just want to say, Mr. Chairman, that we have been having these hearings for a long time, and Dr. Fauci just gets in better shape and better shape. He looks younger every time.

Dr. KINGTON. It is because of NIH research that he looks so good. [Laughter.]

Mrs. LOWEY. Thank you.

Mr. JACKSON. Let me thank you, Chairwoman Lowey.

We have time for a brief second round requested by the Minority, but let me first acknowledge and recognize for five minutes under the first round, Ms. Lee.

Ms. LEE. Thank you very much, Mr. Chairman.

I apologize for being late. So, if the question is redundant, please forgive me.

I am looking at your testimony, and I will definitely read it. It is very good to see you.

Dr. KINGTON. Great to see you.

OUTREACH FOR MINORITIES IN RESEARCH PROFESSIONS

Ms. LEE. Thank you for being here. And all of the NIH directors and staff, thank you for the work that you are doing to advance research and quality medical care which your research, of course, is allowing us to do.

Also, I appreciate the urgency and the diligence that NIH is putting into using the funds that we provided in the economic recovery package.

I am particularly concerned—I am sure you know that—that as we dole out these funds that we are especially mindful and assured of the fact that they will benefit all segments of our diverse population. We are all aware and we know that it has been very difficult for minorities to break into the research professions and compete for NIH grants.

So I just want to just ask you with regard to the specific funds with regard to diversity, how you plan to ensure diversity among the new investigators that will benefit from the funding in the economic recovery package and also if you have specific, I guess, outreach efforts for African American, Latino, Asian Pacific American and Native American and other racial minority groups represented among these investigators.

Are you coordinating these efforts among the institutes?

And, finally, extramural research facilities, I want to make sure that minority-serving institutions such as Meharry Medical School know about funding opportunities and are able to compete for these funds because we are at the beginning and at the dawn of a new day now. So I would like to see some of the past history, for whatever reason, of lack of diversity, lack of inclusion be rectified and corrected as we move forward in this new era of change.

Thank you very much.

Dr. KINGTON. Well, it is certainly true that we believe that it is essential that we have a diverse workforce in order to achieve our goals of the next generation for science. If we don't do it, we won't make the progress that we need to make. I think we try to focus on integrating approaches throughout the various programs.

One area that I think has great opportunity is our summer program for summer jobs. This is an opportunity for thousands of students to work in labs in the Summer of 2009 and the Summer of 2010. We are just developing an outreach program, and the highest priority is to reach out to students who are from under-represented minorities and other diverse backgrounds as well as from geographically diverse areas as well.

This is a great opportunity. We are just planning it now and working collaboratively across the institutes and centers. In terms of the construction, all of the institutions will have opportunity to prepare proposals.

We have $1 billion that is being devoted. Obviously, we will make a significant effort to ensure that there is a reasonable spread of those funds across types of institutions and across the Nation. So I think we are aware of a lot of these issues.

And some of the institutes are specifically targeting their training programs and their diversity programs for additional resources. For example, the National Center for Research Resources which

funds the RCMI program, which is a target program to support research centers at minority institutions and which has a base of about $300 million will get about $70 million more dollars through supplements.

So we are trying to use all the mechanisms that we can use to make sure that we are diverse, both scientifically and geographically and along other dimensions as well.

We, of course, have a continued problem with the pipeline, and that is a real issue in terms of assuring that we have diversity at every stage of the career development process. It is very clear that the diversity that we are seeing at the high school level is not translating to the diversity that we see at the level of principal investigators of grants.

We are, in particular, interested in funding a program that will encourage diverse and creative approaches, new approaches to addressing some of these problems. We know that there are models that work, but it has been a real challenge for the scientific community as you are well aware.

There isn't a magic bullet, but we are committed to trying new approaches.

Ms. LEE. Thank you.

Mr. JACKSON. Ms. Lee, thank you.

I understand that we have time, and it has been requested for an abbreviated second round. I am going to limit members' comments, if they don't mind, to three minutes.

I believe we do have time before the series of votes begins, and I am going to show some leadership by example on that three minutes.

Let me first begin by saying I want to change my focus to the National Center for Research Resources. In the American Recovery and Reinvestment Act of 2009, the Congress made an investment in the research infrastructure of our Nation's universities and colleges by placing $1,000,000,000 in an extramural facilities account at NCRR which had not been previously funded since fiscal year 2005.

I want to further make you aware that the Public Health Service Act says the following: "Up to $50 million, the director of the Center shall make available 25 percent of such amount to" emerging centers of excellence.

Since this program has not been funded in so long, I want to remind you that these institutions such as Meharry Medical College, Morehouse School of Medicine and Charles Drew University, which focus on eliminating health disparities, which is a priority for the NIH.

Can you assure me that NIH will follow the letter of this law in the way it distributes the funds of this competitive grant program?

Dr. KINGTON. We will follow the letter of the law. I am not familiar with that specific part of our law, but we will go back and review it, and we will follow it to the letter.

Mr. JACKSON. The reason I am putting this question in the record is because I wanted to familiarize you with it and put it on your mind that because we have expectations in this Committee that the law be followed.

Also, I want to congratulate the NIH for organizing an impressive summit on health disparities in December. In particular, I want to commend Dr. Ruffin and the Center on Minority Health and Health Disparities—would you please take your seat—for their vision and leadership in planning such an important conference.

The summit was a major accomplishment for the National Center for fulfilling the spirit of the law by bringing together all the institutes and centers at NIH and other Federal agencies around health disparities, but this is the type of leadership and coordination that the National Center is charged with and must continue to demonstrate with your support and the cooperation of the institutes, Dr. Kington, and the centers.

At the summit, you announced the creation of the Health Disparities Intramural Research Program at the National Center. It is good to know that the research into health disparities is becoming more prominent at NIH's campus under the leadership of the National Center.

I am always concerned about the support and resources of the National Center to effectively carry out its leadership responsibilities for minority health and health disparities at NIH. What additional resources have you given or planned to give to the National Center to start its intramural program or enhance its coordination?

I would like you to answer it very quickly and then, Dr. Ruffin, if you would comment, and then Mr. Tiahrt is recognized.

Dr. KINGTON. First of all, I had the pleasure of actually announcing that program at the summit. We think that is a great need, and it is an interesting model, a new model that I think some of the other institutes may follow as well in seating scientists across institutes and centers and having, if you will, sort of a virtual network across the institutes and centers rather than starting a new stovepipe.

I think that is a great model. It has been fully supported by Dr. Zerhouni and Dr. Michael Gottesman, the Intramural Program Director, and we worked collaboratively with Dr. Ruffin to develop it. We will continue to support it.

Mr. JACKSON. Dr. Ruffin.

Mr. RUFFIN. As you know, most of our effort, not being a disease-based center but a trans-NIH center, that much of our success depends upon our ability to work collaboratively with all of the institutes and centers at NIH. And so, with the intramural program, we will continue that effort and work across NIH to make sure that this comes across the way we intend it to be.

Mr. JACKSON. Thank you.

Mr. Tiahrt for three minutes.

COMPARATIVE COST AND COMPARATIVE EFFECTIVENESS IN RESEARCH

Mr. TIAHRT. Thank you, Mr. Chairman.

I noticed in your written testimony, Dr. Kington, that you have been tasked with doing comparative effectiveness research and received $400 million to do it. Will this include comparative cost effectiveness in research?

Dr. KINGTON. The definition for comparative effectiveness research was defined in the legislation, although there is a range of definitions.

We identified that as one of the priority areas within the Challenge Grants Program. If we receive high quality applications that meet the definition for comparative effectiveness research that include cost, we will fund them. We may not fund them with the $400 million set aside. That will depend upon the ultimate decisions about the definition that will apply to that pool of funds.

Mr. TIAHRT. So you are not certain at this point whether cost comparative research will be part of it? It could be?

Dr. KINGTON. It could be.

Mr. TIAHRT. My concern is this, and I hope that you don't fund it.

I just spoke recently with a young lady named Jenny Jobe. She has an immune deficiency. When she turned 65, Medicare denied her current medication and put her on something that was more cost-effective.

It gives her headaches. It gives her backaches. She has an upset stomach, and it doesn't work. Because of it, her immune system can't fight off a lot of the common things that we are able to disperse.

My point is that cost comparative research will lead to rationed health care. Medicare is rationed health care today. She is a good example. There are many other examples.

Medicaid does the very same thing.

As we approach what people will call universal health care or single payer health care or national health care, it will become rationed health care very easily. I think it will anyway.

But if you go to cost comparative or cost-effectiveness research, it will lead directly to that path, and people who have very serious diseases will be denied the best treatment.

With the oncoming of the genome mapping, the DNA now that each of us possess, which is unique to all of us, allows us individual treatment. But cost-effectiveness research will lead away from that individual treatment and group us in aggregates. My concern is that these aggregates will not be able to meet the needs or the science that we have today.

Dr. KINGTON. Well, certainly as a physician who practice internal medicine I certainly understand the concern that any policy effort might severely restrict choices in whatever way, but comparative effectiveness research doesn't necessarily lead to that.

Mr. TIAHRT. Right.

Dr. KINGTON. Comparative effectiveness research can provide useful information to commissions, to patients and providers to make better decisions about what works, under what circumstances, for which patients and might actually complement the movement that you noted toward personalized medicine. So they are not necessarily opposing.

We believe that comparative effectiveness research will increasingly integrate information at a much more detailed level, at the individual level and can be used to help make better decisions for everyone. But I certainly recognize the concern.

Mr. TIAHRT. Thank you, Mr. Chairman.

And thank you, Doctor.

Mr. JACKSON. Mr. Honda for three minutes.

Mr. HONDA. Thank you, Mr. Chairman.

A real quick question on climate change and the kind of work that we are doing. Is there any thought being done on using some of the funds—even though if it is a two-year project, I know it will have continuous impact—in looking at climate change, its impact on immigration patterns and then ultimately spreads of diseases and things like that, working with NASA, NOAA and some of the others, CDC? Is there any thought or are there any grants that would be addressing that arena?

Dr. KINGTON. First of all, the public health community is becoming increasingly aware of the potential impact of climate change on health, and it is potentially extraordinary—everything from increasing heat waves and individuals who are vulnerable to high temperatures such as the elderly at risk of heat strokes to changes in ecologic systems that might, for example, increase the transmission season for vector-borne diseases such as diseases carried by mosquitoes all the way through to drought and malnutrition.

We have begun a process of assessing what our own portfolio is in the Agency. The Fogarty International Center is actually chairing a working group of individuals from across the Agency to look at what our current investments are and to think about new investments.

Certainly, this is an important scientific area, and it could be eligible for funds either through existing grants or newly submitted grants as a result of ARRA dollars. So it can be funded under ARRA dollars. Thus far, it has not been an explicitly articulated area of focus, but researchers can submit under many of the initiatives and can submit their own ideas for ARRA dollars.

This is an important scientific area. Again, though, I think we are at the early stages in terms of the research community in understanding what the big needs are. Many of the institutes already have large portfolios. NIAID, Dr. Fauci's institute, deals with many of the infectious diseases, and I am certain would be able to fund research related to this.

I don't know if you would like to comment.

Mr. HONDA. Yes, I would hope that we would be anticipatory rather than reactionary. I think that knowing the information that we have at hand and using computer-assisted predictions, that your NIH has a role in trying to figure out what it is that we can anticipate.

Dr. KINGTON. We agree.

Mr. JACKSON. Mr. Ryan for three minutes.

BASIC BEHAVIORAL AND SOCIAL SCIENCE BLUEPRINT

Mr. RYAN. Thank you, Mr. Chairman.

I understand from some press accounts that you asked two of your institute directors, Jeremy Berg and Richard Hodes to come up with a basic behavioral and social science blueprint. Could you provide the Subcommittee with some more details on this initiative and when you expect the effort to be completed?

Dr. KINGTON. Of course. As you know, there has been a running discussion at the Agency about how best to support basic behavioral and social science research. There is no question that this is important for many of our major areas of focus at the Agency. Certainly, lots of prevention hinges on changes in behavior, and basic

behavioral and social science research informs how we understand these behaviors occur and how we develop interventions to prevent bad outcomes.

I think there was a decision made that I fully support, that rather than putting all of this area into one unit at the Agency, it is so important for so much of the Agency's mission that it should be spread across the entire Agency. This is a challenge we have had for many areas like this—obesity, the neurosciences—where we know there are important scientific opportunities that cut across the structure of the Agency.

So we are following a model that we developed. We use it in obesity. We also use it for the neurosciences blueprint, where we form a high level of leadership. In this case, as you pointed out, co-directed, co-chaired by Dr. Berg and Dr. Hodes of the Aging Institute but also populated by institute and center directors, in which we look for strategic opportunities to build areas of research where there are gaps and that have the potential to affect the missions of multiple institutes and centers.

The expectation is we will have both a core funding at the institutes and centers, and there will be a pooled funding as well. This is just getting started now and will be playing out over the next year, but then the blueprint will set the stage for research over several years.

I think this is the right approach. Dr. Berg and Dr. Hodes are committed to making this work. We have seen it work before. Stay tuned. You will see major changes.

Mr. RYAN. Also, in the report language that we had in 2009, we asked for a progress report by March 1st of this year, I think, asking you to use the Division of Program Coordination, Planning and Strategic Initiatives as the central headquarters to do this. So, if you could give us some insight as to what the report will entail.

I just say I think a lot of people in the field, whether it is stress reduction or mindfulness or social and emotional learning or behavioral science, in many instances are doing this already. I think it is our responsibility as policy makers to try to break down these walls and get it into the prevention side of our health care plan, with the insurance industry and what we are doing here.

So I appreciate what you are doing. Any assistance we can be, we want to be helpful.

Dr. KINGTON. Can I just note that one of the areas in the Challenge Grants is behavior change and prevention? So that is one of the fifteen areas that is targeted.

Also, in our Transformative RO1 Program that is designed to fund really creative and innovative research, we also specifically ask for applications on the science of behavior change. So I assure you it is at the top level of consciousness of the Agency.

Mr. RYAN. That is not locked into one institute?

Dr. KINGTON. No.

Mr. RYAN. That is across the board.

Dr. KINGTON. The common fund and across the Agency.

Mr. RYAN. Okay. Great. Thank you.

Mr. JACKSON. Votes are coming now. We do have time to finish this round of questioning, provided no other members enter the room.

Mr. Kennedy, then Mrs. Lowey, then Ms. Lee for three minutes.

COORDINATION FOR TBI AND PTSD

Mr. KENNEDY. If Dr. Landis could come up.

I would like to thank Dr. Kington.

I really want to thank my colleague, Mr. Ryan, for his focus on behavioral health.

I want to focus on the Institute of Neurological Disorders and ask Dr. Landis, in light of the soldiers coming back from Iraq and the traumatic brain injury—360,000 of our soldiers suffering from traumatic brain injury—can you talk about the coordination that is going on between NIH, DOD, the VA and to what extent that we can get all the brain science together, neuroscience research and brain research and how that research can, interrelated, work to benefit psychiatric disorders?

Mr. LANDIS. There is a significant effort in NINDS to look at Traumatic Brain Injury (TBI) at the cellular, molecular level all the way to understanding changes that may occur in brain structure and brain connectivity.

NINDS, as the lead institute for that, has worked very closely with the Veterans Administration and with the DOD to make sure that there is not duplication but that there is actually good gap analysis, and programs have been targeted to specific topics. Towards that end, we have been working in workshops with diagnosis of TBI, definition of what actually brain changes occur, coming up with common data elements that would allow us to do clinical trials.

Of particular interest is a very new effort coordinating with USUHS, Uniformed Health Services Institute, the Naval Hospital—and, as you know, Walter Reed will be moving out to the Naval Hospital—with the NIH to come up with a very innovative program to look at TBI and Post Traumatic Stress Disorder (PTSD) and better ways to treat it. So I think there is a lot going on.

[The information follows:]

COORDINATION FOR TBI AND PTSD

Dr. Landis: The new Center for Neuroscience and Regenerative Medicine (CNRM) is explicitly designed as a coordinated program of NIH and the Uniformed Services University of Health Services (USUHS). A Memorandum of Understanding spells out in detail how the center will operate as a cooperative venture. In keeping with that agreement, Dr. Kington appointed a steering committee that includes the directors of NIMH, NINDS, the NIH Clinical Center and General Sutton of the Defense Center of Excellence for TBI. The research will help the soldiers at Walter Reed and National Navy Medical Center using the extraordinary neuroimaging resources at the NIH Clinical Center and the collective efforts of 162 investigators from USUHS and from several NIH Institutes. Plans are moving forward for research on diagnostics, biomarkers, neuroprotection, regeneration, and rehabilitation, as well as patient recruitment, informatics, and other critical areas.

More generally, there is extensive coordination of research on TBI and PTSD within NIH and among NIH and the Department of Defense, the VA, the CDC, and other federal agencies. At NIH, NINDS, NIMH, and the National Center for Medical Rehabilitation Research, which is within NICHD, each have major TBI or PTSD programs, and other Institutes participate as appropriate. A Federal Interagency TBI Research group informs federal agencies of one another's efforts and facilitates coordination. A September 2008 meeting of the group discussed goals, priorities and funding for TBI research across many agencies including the NIH, four components of the DoD, the VA, CDC, SSA and others. Other trans. agency workshops have focused on TBI Classification in October 2007, Combination Therapies for TBI in Feb-

ruary 2008, on Neurological Consequences of Blast Injury in April 2008, Trauma Spectrum Disorders: Effects of Gender, Race, and Socioeconomic Factors in August 2008, and Advancing Integrated Research on Psychological Health and TBI: Common Data Elements in March 2009. The NIH is working closely with CDC on the activities specified in the TBI Act of 2008, including studies on how to improve tracking of TBI in former military personnel and on the effectiveness of interventions. There are many other interactions among the staff of the various agencies, including, for example, sharing of expertise and knowledge on review panels and on advisory boards for clinical consortia. For many years, the NINDS intramural research program has conducted very important work with the VA and DoD on long term neuropsychological outcomes of TBI in Vietnam veterans, and now the memorandum will further enable that research to extend to veterans who served in Iraq and Afghanistan.

Finally, at the broadest level, the NIH Blueprint for Neuroscience Research coordinates the efforts amoung the 16 NIH Institutes, Centers and Offices that support neuroscience research. Just as the NIH Roadmap for Medical Research addresses roadblocks that hamper progress across all of medical science, the Blueprint takes on challenges in neuroscience that are best met collectively.

The Blueprint has developed working groups on specific cross cutting issues, brought the scientific community together in scientific workshops, funded grants and contracts through specific initiatives, developed tools and resources to help all neuroscientists, and generally fosters communication and a culture of cooperation within the NIB and the neuroscience community.

Mr. KENNEDY. Is it being run out of NIMH because NSF told me there is a blue kind of an unofficial organization of brain science kind of being done through NIMH, or coordinated.

Mr. LANDIS. There is a coordinated effort. So, NINDS has responsibility for TBI, NIMH for PTSD, and we recognize that the same changes in brain structure may underlie both, and we are working very closely together to maximize our understanding of brain plasticity to make a difference for soldiers who are coming back with both of those disorders.

Mr. KENNEDY. I would just like if you could get me what is going on in terms of coordination.

Mr. LANDIS. Absolutely. I will give you a detailed answer for the record.

[The information follows:]

ASTHMA AND ALLERGY DISEASES

Dr. Insel: The National Institute of Allergy and Infectious Diseases (NIAID) continue to build on its longstanding and successful research efforts into the causes, pathogenesis, diagnosis, treatment, and prevention of asthma and allergic diseases. NIAID vigorously pursues research on asthma and allergic diseases by supporting investigator-initiated projects, intramural research, cooperative clinical studies, networks of research centers, and demonstration and education research projects. The ultimate goal of NIAID's asthma and allergic diseases research programs is to develop more effective therapies and prevention strategies.

An important example of the many NIAID initiatives in asthma and allergic disease research is the NIAID-supported Inner-City Asthma Consortium (ICAC), which evaluates the safety and efficacy of promising immune-based therapies to reduce asthma severity and prevent disease onset in inner-city children. The ICAC is conducting several large clinical studies of asthmatic children and adolescents. These studies are testing the safety and efficacy of experimental treatments for asthma with an emphasis on factors that contribute to asthma severity in inner-city environments. Another ICAC study of more than 500 children enrolled since birth examines the environmental conditions and immunological responses that contribute to the development of asthma and allergies in the first years of life. Since the 1970s, NIAID has supported the Asthma and Allergic Diseases Cooperative Research Centers, a network of 15 academic research centers located across the country. These Centers currently are conducting studies of the roles of infections, pollution and allergens in the development and severity of asthma. The Centers also are conducting three clinical studies in asthma, allergic rhinitis (hay fever) and sinus disease. Two additional studies are exploring the links between genetics and asthma. Recently,

NIAID and several other NIH Institutes have established a public-private partnership with the Merck Childhood Asthma Foundation to define and prioritize asthma outcomes, information will be used in future clinical studies. These outcomes will provide the standardization needed to conduct meta-analyses and draw more meaningful conclusions from the results of independent studies.

Another important component of the NIAID research program is in the area of food allergy. the Consortium of Food Allergy Research is conducting a study with more than 500 infants to identify factors associated with allergies to peanuts, milk, and eggs. Five clinical trials currently are underway in the consortium to evaluate the safety and efficacy of experimental approaches to treat food allergy. The NIAID-sponsored Immune Tolerance Network currently is conducting a clinical trial with more than 600 infants at high risk for developing peanut allergy to determine if eating peanut-containing foods starting in infancy will prevent this disease. Another NIAID-supported network, the Atopic Dermatitis and Vaccinia Network, is identifying the immunologic changes that contribute to atopic dermatitis (an allergic disorder commonly known as eczema) and to the heightened susceptibility to infection in individuals with this disorder.

Recently, NIAID and U.S. Food and Drug Administration co-organized a meeting of experts to identify safe approaches for developing new treatments for food allergy. A report and the recommendations of this meeting will be published this year in the Journal of Allergy and Clinical Immunology. Lastly, NIAID is leading an effort to develop clinical practice guidelines for the diagnosis and management of food allergies, involving an independent evidence-based review of the literature, guidelines writing by an expert panel, and review and oversight by a coordinating committee of more than 30 federal agencies, professional societies and patient advocacy groups.

SELECTED DISEASE RESEARCH AND EPSCOR

Mr. KENNEDY. In terms of, Dr. Kington, if you could just get me what is going on in terms of research on the asthma, ADHD, allergies and autism and whether states with EPSCoR receive any additional consideration for applying for stimulus funds, that would be terrific.

Dr. KINGTON. We will prepare the response.

[The information follows:]

## ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Dr. Insel: Attention Deficit/Hyperactivity Disorder (ADHD) is a mental disorder linked with attention problems, impulsivity, and hyperactivity. ADHD is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity. NIMH is committed to supporting research on all aspects of ADHD, including discovering its potential causes and genetic risks; understanding its developmental trajectory; and developing improved diagnostic tools and effective interventions. With treatment, most people with ADHD can be successful in school and lead productive lives.

Research on the biology of ADHD has included both genetic and neurobiological studies. During the past year, data from the first genome wide association study of ADHD became available to the scientific community for analysis and comparison with previous genetic findings. While there have been several robust genetic findings in previous studies, this is the first opportunity to examine genomic variation across the entire genome in a large population of patients with ADHD. The data from this study will be an important resource for gene discovery in the coming years. Longitudinal neuroimaging research from the NIMH Intramural program recently reported a striking delay in cortical maturation in children with ADHD. Between ages 5 and 15, the maturation of the prefrontal cortex is delayed by roughly three years in children with ADHD relative to age-matched controls. Current studies are exploring the effects of treatment on the rate of cortical maturation.

Ongoing NIMH-funded research is examining a number of intervention and service delivery approaches for families of children with ADHD. Several ongoing studies focus on the utility of alternatives to medication for families with very young children with ADHD. These studies include a project comparing a standard parent management training intervention to a novel home-based approach developed in the United Kingdom for treatment of preschool-aged children, and another study comparing alternative deliver formats, specifically individual- versus group-parenting interventions, to identify families of preschoolers who might require a more intensive, individualized treatment format. Another study with young children focuses on establishing whether varying intensities of behavioral treatment delivered in home and school settings can reduce the need for medication and improve functioning of children with ADHD.

Additional projects test novel interventions or novel treatment delivery approaches for school-aged children. One study examines an integrated multi-setting psychosocial treatment intervention specifically targeting youth whose ADHD symptom profile is characterized predominantly by inattention. Research projects exploring novel service delivery approaches include a study to develop and pilot test an integrated, dyadic intervention for depressed mothers of children with ADHD; a pilot study exploring a novel parent training program specifically designed to engage fathers and teach them evidence-based approaches for improving the behavior of children with

ADHD; and an evaluation of a family-school intervention that promotes a collaborative approach to target both home and school behavior. A recently completed project addressed the dearth of interventions for adolescents by testing a developmentally appropriate school-based intervention targeting behavior and academic performance among middle-school students with ADHD. Additional projects focus on the comparative effectiveness of pharmacological approaches for treating children in order to maximize both efficacy and safety.

In an effort to promote research in ADHD gap areas, NIMH sponsored two workshops in 2007. The first workshop aimed at evaluating the current state of knowledge concerning long-term (i.e., adolescent and adult) efficacy and effectiveness outcomes in ADHD. The second workshop explored novel treatment approaches to neurodevelopmental disorders, including ADHD, and strategies for promoting the development of innovative therapeutic approaches. As a result of these two efforts, NIMH has seen a significant increase in investigator-initiated studies addressing these areas. Additionally, in FY09 NIMH released a Request for Applications (RFA) entitled, Novel Interventions for Neurodevelopmental Disorders. The Institute expects projects to develop novel behavioral/cognitive interventions for ADHD resulting from this effort to be underway soon.

**AUTISM SPECTRUM DISORDER**

Dr. Insel: Because of the urgent need to better understand the causes of Autism Spectrum Disorder (ASD) and develop treatments for these serious and disabling disorders, Congress passed and the President signed the Combating Autism Act (CAA) of 2006 (P.L. 109-416) on December 19, 2006. The CAA emphasized the need for expanded research and improved coordination among federal programs and agencies focused on ASD. The NIH has many ongoing research projects and programs that are making considerable progress in implementing the research-specific portions of the CAA. NIH-supported ASD research covers a wide variety of topic areas, including: diagnosis; basic biology; behavioral, cognitive and motor learning; speech, language, and sensory neurobiology; potential causes; treatment; prevention; epidemiology; and, outcomes of ASD across the lifespan. Of note is the NIH Autism Centers of Excellence (ACE) program, which comprises 11 centers and networks that are conducting a broad array of ASD research projects.

Shortly after the completion of the Interagency Autism Coordinating Committee (IACC) Strategic Plan for ASD Research, the American Recovery and Reinvestment Act (Recovery Act) of 2009 (P.L. 111-5) was enacted, enabling the NIH to jumpstart implementation of objectives in the Strategic Plan. The objectives span several key scientific areas, including discovery of biomarkers; development of novel interventions and new tools for ASD screening; establishment of ASD registries to support large-scale effectiveness trials; understanding of genetic and environmental risk factors; elucidation of immune and central nervous system interactions; development of model systems for research; and, enhanced research on services that can help people with ASD across the lifespan. The NIH is using Recovery Act funds to support several new initiatives with autism-focused components through the Challenge Grants in Health and Science Research Program. The NIH has also allocated approximately $60 million in funds from the Recovery Act to solicit grant applications for research relevant to the heterogeneity of ASD. These initiatives directly address many objectives in the Strategic Plan.

The NIH is also contributing to research infrastructure to support an expanding ASD research effort. Through investments in the National Database for Autism Research (NDAR), the NIH is making considerable progress in addressing the complex data sharing needs of ASD researchers, which is a cross-cutting theme highlighted in the IACC Strategic Plan for ASD Research.

**EPSCor CONSIDERATION FOR ARRA FUNDS**

Dr. Kington: The National Center for Research Resources (NCRR) supports the Institutional Development Award (IDeA) program, which is equivalent to the EPSCor programs of several other agencies. The program currently funds grants to institutions in 23 states and Puerto Rico in order to increase the states' capacity to conduct biomedical research.

NCRR plans to advance its existing programs through the support provided by the American Recovery and Reinvestment Act (ARRA) of 2009. IDeA-state institutions are being encouraged to apply for administrative supplements to their existing awards to accelerate the scientific tempo of their research grants. These additional funding opportunities for the IDeA-state institutions include, but are not limited to: expansion of translational research activities; research workforce recruitment, training, development and dissemination; and support for pilot projects and collaborative community engagement.

Separately, research project grantees (supported by most other NIH institutes or centers) are being encouraged to identify NCRR Center resources, such as IDeA grantees, with which they could establish strong collaborations to speed or strengthen their research. These grantees may submit revision award applications to their original awarding IC and the applications will be competitively reviewed for support with ARRA funds.

IDeA-state institutions are also encouraged to apply for additional ARRA funding available through NCRR's research facilities improvement (construction and renovation) program and the shared instrumentation grant program. These programs will give additional consideration to ensure that there is adequate geographic distribution of ARRA funding.

Mr. JACKSON. Mrs. Lowey for three minutes.

CROSS CUTTING RESEARCH

Mrs. LOWEY. Dr. Kington, you and I agree that peer reviewed medical research is at the core of NIH's mission. Peer review grants to doctors and scientists throughout the Country are absolutely critical to make progress in finding a cure for treatments for thousands of diseases and disorders.

But I understand that about $800 million of NIH's stimulus funds will go to the Office of the Director for various research grants on various diseases. Can you share with the Committee what your priority areas are for these funds?

How many new grants do you expect to be funded?

And, will you be able to use any of the stimulus funds to place a few big bets on promising but risky research that you would not have been able to pursue otherwise?

Dr. KINGTON. We are in the early stages of planning for the entire allocation of $800 million, but we are focusing precisely on those areas—areas that cut across the mission of institutes and centers, areas where an infusion of large dollars can move a whole field ahead and riskier investments.

So we have committed $200 million toward the Challenge Grants Program, again targeted to those specific areas.

We have committed $100 million to the Grand Opportunities Program which we anticipate and under which we will receive many creative, large grant applications.

We won't make the final decisions of allocation until we see what institutes and centers have done because then we can decide, look at the entire portfolio and see what gaps there are.

We are also funding the summer program for students from the Office of the Director. That is $21 million, right now, and it may go higher if we get more applications.

So we have made those commitments for about half. The other half are waiting until we have a better idea of what the commitments are of the institutes and centers, and then we can make decisions about which initiatives we will fund.

We generally won't fund at an individual grant level, but we will fund specific institutes' and centers' initiatives that have broad application and cut across the mission of institutes and centers. We are making those decisions, and we will try to complement the decisions of institutes and centers.

Mrs. LOWEY. Thank you very much.

Mr. JACKSON. Ms. Lee for three minutes.

SICKLE CELL TESTING

Ms. LEE. Thank you very much.

Could I ask Dr. Rodgers to come forward just a minute, please? Let me just thank you, first of all, and the National Institute of Diabetes and Digestive and Kidney Diseases for responding with regard to the whole issue of sickle cell anemia and the validity of the A1c test.

I just wanted to know. First of all, I think the public awareness campaign to educate the public about that was effective, and it was very good, and I just needed an update from you on the status of

laboratories and physicians and others who need to know this information. Do they all know now or do we need to do more? What is going on?

Dr. RODGERS. Well, thank you for the question.

The question relates to using hemoglobin A1c. I think that you posed to me two years ago that some were using that to actually diagnose diabetes and it was particularly confounding in patients that had hemoglobin variance such as sickle cell trait.

While A1c determination is certainly not the standard at the moment for diagnosing diabetes, it certainly is very important for monitoring the course of disease because it gives the average value of glucose control in the preceding two to three months.

At the time that you asked me the question, there were about 20 various assays for measuring hemoglobin A1c, and unfortunately 6 of that 20 were unreliable, gave unreliable results in individuals that had sickle hemoglobin or other variants.

The NIH did, with your prompting, develop this education campaign which got out the message to individuals, to physicians as well as the general public, and it has been quite effective in diminishing the utilization of those unreliable methods in those areas.

We have ongoing funding to a national glyco-hemoglobin standardization program out of the University of Missouri that continues both looking at the final remaining assays as well as getting the message out not only in this Country but worldwide because of course there are many more people in other areas of the world that have hemoglobin variants than in the United States.

So your prompting that question, I think, has had a major impact.

Ms. LEE. Thank you very much and thank you so much for your responding so quickly to that because many, many people were being, I think, mistreated as a result of that.

Dr. RODGERS. Thank you for your interest.

Mr. JACKSON. Let me remind members that they may submit questions for the record which will be provided to Dr. Kington for an appropriate response to the Committee in writing.

I want to thank the members' indulgence as well as Dr. Kington for allowing me to chair my first Labor, Health and Human Services Subcommittee.

[Applause.]

Mr. JACKSON. And, to all of the distinguished scientists, chairmanships around this place are very hard to come by. It has taken me 10 years to sit in this seat.

I am reminded by Chairman Obey that I long one day to have my picture hanging in this austere body, and Chairman Obey reminds me that members of Congress usually get hung before their pictures do. [Laughter.]

The Committee is adjourned.

SCIENTIFIC PRIORITIES

Mr. Obey: Dr. Kington, I realize that NIH may not have had much discretion in the Administration's decision to propose a specific 2010 funding level -- $6 billion – for cancer research at NIH. But Presidential budgets historically have avoided choosing winners and losers in disease research. I agree with that. I've always felt that Members of Congress should avoid favoring certain research areas and instead that we should leave those questions to the peer review process. But the only mention of NIH research in the budget framework is the promise on cancer research. I don't take a back seat to anyone in my support of cancer research funding. Too many of my family members and friends have fought the cancer battle. But isn't it true that research in one area often produces unexpected benefits in another? And if one disease area is highlighted at the expense of others, don't we lose those serendipitous discoveries?

Your budget's special treatment of cancer research funding has already set off the "disease wars". We're being besieged with questions like "What about heart research? What about Parkinson's? What about Alzheimer's?" Why should Congress cast aside a successful system for allocating NIH resources based on scientific merit in favor of a political judgments made by the President and OMB?

Dr. Kington: Because cancer research involves the dissection and understanding of perhaps the most basic functions of human cells-cell growth and differentiation, cancer research will always produce many serendipitous discoveries. Such discoveries involving the most basic properties of human cells are likely to benefit a wide range of areas of disease research across the NIH.

In addition, cancer research also involves technology development that will benefit research in a number of disease areas. For example, cancer research includes the development of advanced imaging technologies to refine diagnosis and, therefore tailor treatments. Such advances in imaging technology will benefit research on many diseases including Alzheimer's Disease and Parkinson's, just to name a few.

Cancer research also involves developing technologies for targeted treatments that involve micro-systems that deliver drugs only to the disease site. Once again, the development of such targeted therapy modalities, including systems that can penetrate the blood-brain barrier to deliver drugs to brain tumors as well as other brain cells involved in a range of neurological disorders, will benefit the development of treatment strategies and possibilities for numerous diseases.

NIH will work with the President and the Congress to ensure that cancer research resources are allocated responsibly, effectively, in accordance with peer review principles, and on the basis of sound science.

## THE NATIONAL CHILDREN'S STUDY

Mr. Obey: Dr. Kington, the National Children's Study has been described as a landmark study that will be able to detect environmental-genetic interactions because of its sample size, study length, and careful design. Dr. Alexander, head of the Child Health Institute, has said that:

"The principal benefit of a large scale, long-term study like the National Children's Study is that it will uncover important health information at virtually every phase of life. Initially, it will provide major insights into disorders of birth and infancy, such as preterm birth and its health consequences. Ultimately it will lead to a greater understanding of adult disorders, many of which are thought to be heavily influenced by early life exposures and events."

I recognize that the study has had cost overruns, which is hardly surprising in a study that has no parallel in NIH longitudinal research. But how can you consider "pausing" and perhaps even terminating a study that is so important? Isn't it worth the extra money, amortized over two decades, to be sure we get valid results? How much money will have been wasted if the study is terminated?

Dr. Kington: Mr. Chairman, the "pause" you described creates a sufficient period of time before the initiation of the full study in order to better evaluate the myriad of possible tests and questions that could eventually make up the main study. We believe that the best way to decide on the final content of the actual protocol for the study is to test in advance a number of questions and to assess the feasibility, acceptability, and costs of each element. This approach will allow us to complete the development of a efficient study design that will still answer core questions about the influence of the environment on children's health and development, being mindful that we are spending the taxpayers' dollars.

Through fiscal year 2008, expenditures on the NCS totaled $234.1 million. In addition, Congress appropriated *up to* $192.3 million for fiscal year 2009.

Mr. Obey: Can you provide us assurances that the study will be continued?

Dr. Kington: Current plans call for the one-year pilot study to be completed by May 1, 2010. At that time, a revised protocol will be assembled by NCS staff and study investigators, with greatly heightened oversight by the Office of the NIH Director. It will contain the most important science necessary to address the important study hypotheses, with assurance that the approaches tested are feasible and acceptable to the participants. The goal is to make adjustments such that the final proposal protocol is as close as possible to the $3.1 billion planned for the study. That protocol will be reviewed by the NCS Federal Advisory Committee. In addition, we will seek input from an expert panel convened by the National Academy of Sciences, which will advise the NIH on whether the study at that cost level will yield sufficient scientific advances for the study to be continued.

Mr. Obey: In coming years, the Committee will want assurances that new management structures and oversight are in place to prevent the study's early missteps. What will be different in terms of the management leadership and budget development for the study?

Dr. Kington: The review that is being conducted is identifying managerial issues, the situations that caused them, and ways to avoid them in the future. The corrective measures that will be put in place will assure confidence in the management leadership and budget operations of the study. Again, under any scenario, the oversight of this study will be substantially increased.

Mr. Obey: I'd like a copy of the review that the NIH Office of Management Assessment conducted for the Children's Study. Will you be able to provide that to us?

Dr. Kington: NIH will provide you with the review when it has been completed by the Office of Management Assessment.

## STEM CELL GUIDANCE

Mr. Obey: Some opponents of stem cell research have advocated that NIH permit only the use of stem cell lines created from "spare" embryos from fertility clinics. If the executive order guidance limits the source of stem cell lines to those created from "spare" embryos, how restrictive will that be to scientific opportunities in the field, now and in the future?

What other guidelines is NIH considering to ensure that stem cell research is conducted in an ethical manner?

Dr. Kington: NIH is currently working on Guidelines to govern NIH funding of stem cell research as required by the President's Executive Order. We expect to release final Guidelines within the 120 time frame called for by the Order. The Guidelines will address research that is both scientifically worthy and responsible

## ARRA AND COMPARATIVE EFFECTIVENESS RESEARCH

Mr. Obey: NIH received $400 million in the Recovery Act to conduct comparative effectiveness research. The comparative effectiveness research provision in the Act has attracted criticism that I find inexplicable. Somehow conducting research to learn which treatments are more effective was translated into the spectre of socialized medicine.

As just one example of comparative effectiveness research conducted by NIH, the National Institute of Mental Health (NIMH) has supported two studies comparing new drugs that treat schizophrenia to older, less expensive drugs. NIMH reported that not only are the newer drugs no more effective for either children or adults, but they have

potentially serious side effects. That is the kind of comparative effectiveness finding I hope gets out to families without delay.

Dr. Kington, can you describe the types of research you expect NIH to support with the $400 million in the Recovery Act? What are some of the major comparative effectiveness questions NIH feels it is important to pursue?

Dr. Kington: The American people are eager to have access to reliable and unbiased information regarding which drugs and treatments work, and which ones deliver the greatest benefit. CER is not about rationing and cost controls. It is about supporting the highest quality research to learn which treatments and strategies are the most effective for preventing and treating disease. CER has the potential to clarify which drugs and other kinds of treatments, or combinations of treatments work best, and for whom. This new knowledge can help doctors and patients make the optimal medical decisions, regardless of type of healthcare organizational setting. CER will enable doctors to offer the right treatments to the right patients at the right time in the right settings.

NIH has a distinguished history of supporting landmark CER studies. In 2002, the Diabetes Prevention Program study showed that exercise and lifestyle changes yielded substantially better health and economic outcomes than did medication alone or placebo. This study revealed that type 2 diabetes can be delayed or prevented altogether in older patients who control their weight, eat a healthy diet and take an evening walk five days a week. Also in 2002, the Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial confirmed earlier hints that diuretics, also known as "water pills"—the least costly drugs used to lower blood pressure—were as or more effective than newer, more costly medications. In 2005, the Clinical Antipsychotic Trials of Intervention Effectiveness trial concluded that an old drug, clozapine, was less expensive and no less effective than newer drugs used to treat schizophrenia. In 2006, the Strategies for Management of Anti-Retroviral Therapy, a large, international clinical trial, showed clearly that using anti-HIV drugs continuously to keep the amount of virus in the blood as low as possible was far better than episodic treatment guided by low immune cell counts.

The ARRA has provided NIH with $400 million to support medical research that compares the benefits, risks, and costs of alternative treatments and that address management or prevention of particular medical conditions. To most efficiently target this funding to the most "ripe" areas of opportunity the NIH Director has established a CER Coordinating Committee (CER CC). The NIH CER CC will consult with the Federal Coordinating Council for CER, which was authorized by and established pursuant to the ARRA. The NIH CER CC will:

- Provide advice re CER-related initiatives, expenditures, program implementation.
- Initiate a CER portfolio analysis, and establish a CER Fingerprinting Subcommittee to enable NIH to track CER-related projects and funding.

- Create a new Challenge Grant category for CER studies.
- Develop a long term vision for enhancing CER, including integrating personalized medicine, advancing research methods, instrumentation and informatics, and identifying cutting-edge CER priorities.

PUBLIC ACCESS POLICY

Mr. Obey: Dr. Kington, I'd like you to update us on public access. I was pleased that we were able to make the public access provision permanent in the omnibus bill. It seems as if many sectors are moving in the direction of requiring researchers to make public the journal articles describing their taxpayer-funded research. I understand that the Massachusetts Institute of Technology just announced it will make its research available to the public free of charge, becoming the first U.S. University to mandate the policy across all departments. Yet, despite this broad movement, we continue to hear grumblings from some quarters. The Judiciary Committee has reintroduced a bill this year, H.R. 801, the Fair Copyright in Research Works Act, which would prohibit NIH from requiring researchers to provide their manuscripts to the Library of Medicine. Does NIH have a position on H.R. 801?

Dr. Kington: The Administration does not have a position on H.R. 801. However, NIH strongly supports the current public access policy and would be concerned if obstacles were in place that would impede the progress we have made towards transparency, accountability and effectiveness of the NIH investment.

NIH has been able to make tens of thousands of papers publically available on PubMed Central (PMC) through the Public Access Policy. PMC contains approximately 1.8 million articles, most of these submitted by publishers that have been participating in PMC since 2000.

PMC papers are heavily accessed. On an average weekday, some 400,000 users retrieve over 650,000 articles. These users, the public, include patients, doctors, educators, and scientists at universities and small businesses. Access to NIH supported papers on PMC increases the likelihood that all of these groups will use the NIH investment to increase their productivity, efficiency and quality.

Articles on PMC also serve as a gateway to tremendous scientific knowledge. Bibliographic references in PMC articles link to other full text articles at the National Library of Medicine (NLM) and thousands of journal sites. There also are nearly 60 million links from PMC to related data about biological sequences, genes, small molecules and more, creating a unique resource for American scientists. The breadth and interconnectivity of NLM databases can lead to discoveries that a reader may not have made otherwise.

Mr. Obey: Could you update us on the increases you have seen in the number of articles describing NIH-funded research that are being released to the public through the NIH Library of Medicine since the mandatory policy went into effect?

Dr. Kington: The Policy is off to a promising start, and NIH has made considerable progress towards full compliance. The NIH Public Access Policy requirement went into effect April 2008. Compliance has increased almost 250% since the requirement took effect. It has jumped from 19% of our target estimate 80,000 papers per year arising from NIH funds during the voluntary policy to almost half of the target estimate of papers arising from NIH funds at the end of 2008, and our collection rates continue to increase. This is a positive beginning to the requirement due in large part to cooperation from NIH awardees and publishers.

Compliance with the policy continues to improve. In January and February 2009 we collected over three times as many manuscripts as we did in January and February 2008, before the requirement took effect. Currently, we estimate that nearly half (47%) of NIH funded papers are ready to post to PubMed Central. This is slightly less than our success rate of 56% that we projected last fall, as the revised estimate of 47% represents only the NIH-supported papers that were published after April 2008, when the requirement took effect. The previous estimate was based upon submissions received during April to August 2008, which we later learned included many papers published prior to April 2008.

Mr. Obey: Have you seen any evidence that publishers are losing money because of the public access policy?

Dr. Kington: The NIH Public Access Policy provides publishers with three significant protections: (1) A 12-month delay period that allows publishers to display and print a paper exclusively, before PubMed Central (PMC) can make a version of that paper publically available; (2) The final published paper, as it appears in the journal, need never be posted to PMC; (3) NIH Investigators may continue to charge any publisher related expenses to their NIH awards.

We are not aware of any harm caused by the mandatory policy, or by the voluntary policy that was in place from 2005 to 2008. In 2008, the year the policy was implemented, and the economy plummeted, commercial scientific publishing nevertheless enjoyed major profit increases. Industry analysts forecast double-digit profit growth for Scientific, Technical and Medical (STM) publishers (http://www.iwr.co.uk/information-world-review/news/2238077/stm-growth-takes-hit). For example, Elsevier reported a 21% increase in profits in 2008. (http://business.timesonline.co.uk/tol/business/industry_sectors/media/article5768684.ece)

## VULVODYNIA

Ms. Lowey: The Committee has repeatedly called on NICHD to expand research efforts on vulvodynia, yet only eleven grants have been made in the past nine years and only three in the last three fiscal years. This is especially discouraging given that a NICHD-funded study found that 16% of American women suffer from this serious women's pain condition and that 40% who seek medical care remain undiagnosed after multiple consults.

Please summarize your plans for fiscal years 2009 and 2010, including the use of stimulus funds, to increase federally funded research efforts on vulvodynia?

Dr. Kington: NICHD sponsors a current Program Announcement (PA) to encourage research applications on the etiologies and potential interventions for vulvodynia, which comprises a range of pain-related conditions. Applications continue to be submitted under this PA, including some that will be considered during the Institute's June Council meeting.

Because one issue facing scientists interested in pursuing research related to vulvodynia is a lack of specific knowledge about these conditions on standing study sections, NICHD plans to issue a Program Announcement with Special Review (PAR) in FY 2010; this will ensure a well-informed review panel. This PAR will permit applications for large (R01), small (R03) and conference (R21) grants.

NICHD also has reached out to the Canadian Institutes of Health experts in pelvic pain to discuss potential partnerships on the PAR and other initiatives. These discussions are ongoing. Moreover, vulvodynia was specifically included as one of NICHD's Challenge Grant Areas: Translational Science, Pelvic Pain (emphasis areas: vulvodynia, uterine fibroids and endometriosis); successful applications will receive funding for two years under ARRA.

NICHD also has partnered with the NIH Office of Research on Women's Health to promote public education, through joint sponsorship of the ongoing *Vulvodynia Awareness Campaign,* and more recently, participating in the Work Group on Pelvic Pain Syndromes at ORWH's women's health research agenda-setting meeting in March 2009.

## BORDERLINE PERSONALITY DISORDER

Ms. Lowey: Borderline personality disorder (BPD) is a relatively recently recognized severe mental illness. Last year, an NIH study described a 5.9% lifetime prevalence for BPD.

How many investigator-initiated research grants directly related to BPD are currently being funded? How do current and historical levels of BPD research compare with levels for other severe mental illnesses like bipolar and schizophrenia disorders?

Are you taking any steps to encourage more grant applications related to BPD?

Dr. Kington: Borderline Personality Disorder (BPD) is a serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image, and behavior. Reported prevalence estimates have been variable. NIMH is committed to supporting research on all aspects of this disorder, including discovering its potential causes and genetic risks; understanding its developmental trajectory; and developing improved diagnostic tools and effective interventions. NIMH currently funds 27 investigator-initiated grants on BPD research. The following table exhibits the historical changes in NIMH funding for BPD research in comparison to schizophrenia and bipolar disorder research.

NIMH Funding (dollars in thousands)

| | FY 2004 | FY 2005 | FY 2006 | FY 2007 | FY 2008 |
|---|---|---|---|---|---|
| Borderline Personality Disorder | $6,719 | $7,048 | $5,922 | $6,697 | $6,010 |
| Schizophrenia | $318,589 | $327,016 | $335,021 | $327,707 | $205,332 |
| Bipolar Disorder | $86,888 | $103,731 | $101,457 | $121,653 | $120,720 |

In order to help fulfill goals of the American Recovery and Reinvestment Act (the Recovery Act) to help stimulate the economy through support of biomedical and behavioral research, NIH recently announced the opportunity for investigators and U.S. institutions with active research grants to request up to two years of supplemental funding. NIMH has identified areas of interest in accordance with its goal of accelerating mental health research as described in the Institute's Strategic Plan. BPD was specifically emphasized, along with several other major mental disorders, as part of an effort to obtain biomaterials and biological measures which could be used to identify predictors of outcome, moderators of treatment response and adverse effects, or mediators and patterns of treatment effects.

In addition to this Recovery Act initiative, over the past decade NIMH has entered into partnerships with private entities to promote BPD research, and to disseminate significant research findings. The Institute co-sponsored a series of meetings to increase scientific interest and engagement in BPD research with the Borderline Personality Disorder Research Foundation. In addition, NIMH has worked with the National Education Alliance for Borderline Personality Disorder (NEA-BPD) and the TARA National Association for Personality Disorder. The NEA-BPD has taken a lead role to foster activities, including national and regional meetings, to promote awareness of BPD, and to disseminate significant research findings to clinicians, researchers, and patients and their families. The TARA National Association for Personality Disorder has worked to promote awareness of BPD, disseminate research findings, and foster outreach, education, and support for individuals and families affected by BPD. Both organizations are members of the NIMH Alliance for Research Progress--a group of

patient and family advocates representing national voluntary organizations that meet twice a year with the NIMH Director and staff to discuss NIMH-funded research and priorities.

## CHRONIC KIDNEY DISEASE

Ms. Lowey: Chronic Kidney Disease (CKD) affects up to 13% of the US general population. The roots of CKD's major causes in adults - diabetes and hypertension - first present in childhood and adolescence. About one-third of children with CKD are born with abnormal kidneys/urinary tracts. Scientists require support to initiate effective interventions in childhood to prevent or treat hypertension and precursors of diabetes, as well as find cures and more effective treatments for kidney disease in childhood. Otherwise, Medicare spending on ESRD will continue to increase and more children and adolescents will undergo evaluation and treatment for early signs of progressive kidney disease and precursors to renal failure and cardiovascular diseases. Additionally, approximately 20,000 children will be born with congenital kidney abnormalities while 2,000 infants will die from genitourinary disease; and 1.2 million children under the age of 7 will develop urinary tract infections that can permanently damage kidney tissue.

Given the implications of failing to address CKD in children, what is the status of research at NIH with respect to pediatric kidney disease and what is your vision for its future?

Dr. Kington: Within the NIH, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) leads the Federal research effort on pediatric kidney disease. The NIDDK supports a broad range of investigator-initiated clinical studies of kidney disease in children and adolescents. Research areas currently funded include pediatric transplant infections and outcomes; primary prevention of hypertension in obese adolescents; the genetics of and various therapeutic approaches to focal segmental glomerular sclerosis; and non-invasive diagnostics for IgA nephropathy.

In addition to these studies, the NIDDK supports the *Study of Chronic Kidney Disease in Children (C-KiD),* an observational study of 560 children ages 2-16 with mildly to moderately impaired kidney function. The goals of *C-KiD* study are to determine the risk factors for progression of pediatric chronic kidney disease, and to examine its impact on neurocognitive development, risk factors for cardiovascular disease, and growth. The NIDDK is also supporting a study of vesicoureteral reflux in children to determine whether antibiotic treatment prevents urinary tract infections and kidney scarring in children with reflux. This study, the Randomized Intervention for Children with Vesicoureteral Reflux *(RIVUR)* trial, has the potential to help researchers and physicians better understand how to care for the numerous children who are diagnosed each year with reflux and urinary tract infections. The NIDDK also supports an interdisciplinary Center of Excellence in polycystic kidney disease (PKD)-related research, with a specific emphasis on autosomal recessive PKD (ARPKD).

These research projects are complemented by NIDDK-initiated scientific and planning meetings to identify research opportunities to improve the lives of pediatric patients living with chronic kidney disease.

GLOMERULAR DISEASE

Ms. Lowey: African Americans are 4 times more likely to be diagnosed with end stage renal disease, and in some cases, such as focal segmental glomerulosclerosis (FSGS), the second leading cause of renal failure in children, nearly 5 times the number of African Americans are likely to develop FSGS than Caucasians. Additionally, due to FSGS nearly 19,300 Americans are suffering from end stage renal disease.

What initiatives is NIH currently undertaking to examine kidney diseases, including rare diseases such as FSGS which have a disproportionate impact on African Americans?

Dr. Kington: With the *FSGS Clinical Trial (FSGS-CT),* the NIH's NIDDK has formed a collaborative network of U.S. research centers that is testing the effectiveness of two different treatment regimens in children and young adults who have steroid-resistant FSGS of unknown origin. The FSGS-CT has randomized 138 participants, of whom 35 percent are African American. This is the largest randomized trial of FSGS ever conducted. Ancillary studies are evaluating immunosuppressive medications, anti-proliferative medications; the genetics of the patients in the FSGS trial to determine whether there is a difference between those who respond to treatment and those who do not; and proteins in the urine to determine whether there is insight to be gained regarding prognosis.

The NIDDK is also supporting two observational cohort studies of racially and ethnically diverse patients with chronic kidney disease in general. The *Chronic Renal Insufficiency Cohort (CRIC)* study is designed to improve our understanding of the relationship between chronic kidney disease (CKD) and cardiovascular disease. It is following approximately 3,600 men and women with chronic kidney disease. CRIC is the largest cohort study of CKD ever conducted, and 46 percent of the participants are African American. The *C-KiD* study, which I have previously mentioned, is studying CKD in pediatric patients. Five hundred sixty patients have been enrolled; overall, 21 percent are African American, but among those who have been diagnosed with glomerular disease, 41 percent are African American.

In another avenue of research, a team of NIDDK intramural scientists, along with another team of NIH-supported investigators, recently discovered that genetic variants around the *MYH9* gene are major contributors to the excess risk of non-diabetic kidney disease among African Americans. Scientists are also studying additional genetic factors that may be associated with the development of FSGS and investigating a protein called permeability factor, which has been found in some patients with the disease. The identification of such risk factors and possible biomarkers will not only

provide opportunities for further understanding of mechanisms of disease in FSGS, but also may provide avenues for discovery of new disease therapies.

NIDDK also supports kidney disease education and outreach programs through its National Kidney Disease Education Program (NKDEP). Several of NKDEP's outreach efforts and materials are tailored for African Americans. Together, NIDDK's research program represents a multifaceted effort to understand FSGS and other kidney diseases in all patient populations.

NEUROBLASTOMA RESEARCH

Mr. Jackson: Dr. Kington, for the past two years the Subcommittee has encouraged the National Cancer Institute to expand research on a devastating pediatric cancer called neuroblastoma. Unlike other pediatric cancers, survival rates for children battling high-risk neuroblastoma have remained unchanged at about 20%. Clearly this is unacceptable and I am committed to raising the profile of this orphan disease. Can you or the NCI Director briefly comment on neuroblastoma and provide for the record a detailed account of what NCI is doing to make progress in this area?

Dr. Kington: The NCI research activities for neuroblastoma described are organized around specific research programs that have a substantial neuroblastoma component and that contribute to NCI's overall goal of improving diagnosis and identifying treatments that improve survival.

The Children's Oncology Group (COG) develops and coordinates cancer clinical trials at over 200 member institutions throughout the United States and at sites in Canada, Europe, and Australia. In 2008, COG opened a phase III randomized trial of single vs. tandem myeloablative consolidation therapy for high-risk neuroblastoma. A high priority trial for COG is evaluating the role of the chimeric antibody 14.18 in high-risk neuroblastoma patients following myeloablative therapy and stem cell transplant. The NCI manufactured the antibody so that COG could definitively evaluate this neuroblastoma-targeted agent. In 2008, COG researchers reported that genes on chromosome 6p22 are important in the development of neuroblastoma and also identified activating mutations in the ALK oncogene as the primary cause of familial neuroblastoma and as present in approximately 10% of sporadic neuroblastoma cases. This discovery has immediate clinical implications, as small molecule ALK inhibitors are already under clinical evaluation.

An important component of NCI's research effort for neuroblastoma is the Childhood Cancer TARGET (Therapeutically Applicable Research to Generate Effect Treatments) Initiative. The goal of the Initiative is to identify and validate therapeutic targets for childhood cancers. The Neuroblastoma TARGET Project, or Translational Genomics in Neuroblastoma Consortium, will perform specialized genetic analysis and sequencing of 100 genes from 300 neuroblastoma tumors. The data collected through the Neuroblastoma TARGET Project will be made rapidly available to the research community so that any potential therapeutic targets identified can be quickly studied for their clinical relevance.

The COG Phase I/Pilot Consortium includes a subset of COG institutions and is responsible for expeditiously developing and implementing pediatric phase I and pilot studies. NCI's support of this Consortium allows new agents to be introduced in the pediatric setting with close monitoring of unanticipated toxicities and with state-of-the-art pharmacokinetic evaluations to determine whether children metabolize and excrete the agent in a manner similar to adults. New studies in the COG Phase I/Pilot

Consortium are evaluating agents for which preclinical activity against neuroblastoma has been observed.

The objective of the NCI-supported Pediatric Preclinical Testing Program (PPTP), a comprehensive program to evaluate new agents against childhood solid tumor (including neuroblastoma) and leukemia models, is to identify novel agents that have the potential for significant activity when clinically evaluated against selected childhood cancers. To date, over 20 agents, both standard and experimental, have been tested for their activity against the PPTP's neuroblastoma models. Several agents have been identified as having activity against the neuroblastoma preclinical models.

The NCI-supported New Approaches to Neuroblastoma Treatment (NANT) Consortium is a group of 13 university and children's hospitals with strong neuroblastoma research and treatment programs. The NANT Consortium focuses on new therapies for neuroblastoma patients who no longer respond to standard treatments. New agents that look promising in NANT testing can then be studied by COG to more definitively test their therapeutic benefit for children with neuroblastoma.

Use of genetic markers could improve diagnostic accuracy and open the way for genetic-based therapies. NCI scientists have identified a gene expression signature that alone can diagnose neuroblastoma, and investigators have also found 19 genes that can be used to predict survival for individual neuroblastoma patients. Additionally, by comparing gene expression in low stage vs. high stage neuroblastoma, investigators discovered that low stage and high stage neuroblastomas are biologically distinct diseases, rather than the same disease along a severity spectrum. This work is the first biologic data to corroborate an evolving paradigm shift in therapy for neuroblastoma, and the practical implication is that therapy for these two patient groups should be fundamentally distinct.

Several clinical trials for neuroblastoma patients are underway at the NCI. Researchers recently identified a safe dose of the drug ABT-751 and discovered that children with neuroblastoma treated with ABT-751 had a three-fold-longer interval without tumor progression than patients with other types of cancer. Currently, a new dosing form for use in small children is being investigated and a nationwide phase II trial of ABT-751 has been initiated to validate the ability for this drug to delay progression of neuroblastoma. In addition, NCI is enrolling patients in a clinical trial of treatment that incorporates a tumor vaccine and autologous cell therapy for patients with newly diagnosed or late recurrent neuroblastoma.

## MITOCHONDRIAL RESEARCH

Mr. Jackson: Dr. Kington, there seems to be growing interest in the area of mitochondrial disease and dysfunction, and a growing recognition that more research is needed in this area. The NIH last year included mitochondrial research ("functional variations in mitochondria") as one of its research focus areas under the Transformative Research (T-R01) grants announced in September. Additionally, numerous institutes

within the NIH, including the National Cancer Institute, the National Heart Lung and Blood Institute, and the National Institute of Neurological Disorders and Stroke, are participating in various endeavors related to mitochondrial research. Can you provide the committee with information for the record concerning current research activities relations to mitochondria, some of the interesting developments and hypotheses related to mitochondrial disease research, what the NIH sees as the future direction for research in this area, and what specific steps will be taken in 2009 to promote mitochondrial disease research?

Dr. Kington: Mitochondria are one of the most complex and important components of cells and their defects have long been suspected to play an important role in the development and progression of a variety of diseases, including cancer and neurological diseases. Proper functioning of human mitochondria is critical to normal cellular function and metabolism, as evidenced by specific mutations in mitochondrial genes that result in increased severity of disease. Up until now, estimates of mitochondrially-associated disease rates have held steady at about 1-in-4000 people, but a study published in 2008 in the American Journal of Human Genetics concluded that 20 times that number have genetic mutations that potentially cause mitochondrial disease (this translates to at least one in 200 healthy humans).

More than 40 years ago the first patient with a mitochondrial disease was described. Although much of the evidence linking mitochondrial DNA mutations and certain diseases is unequivocal, there is still a compelling need to comprehensively determine and characterize the extent to which mitochondrial DNA mutations and aberrations affect the pathology associated with diseases. In addition, comparatively few epidemiological studies of mitochondrial disorders have been conducted and thus the full extent of the problem in general populations remains unknown. For the vast majority of patients presenting with clinical signs of mitochondrial disease, the specific underlying causes remain unknown.

To address these challenges, the NCI is involved in several significant activities. NCI participates in three active funding opportunity announcements aimed at supporting research in the area of mitochondrial diseases. One of these funding initiatives was released in April 2008 and solicits projects from the scientific and clinical communities that propose to develop and validate new mitochondrial-related biomarkers for cancer. The remaining funding announcements center more on the indirect effects of mitochondrial defects. NCI also supports mitochondrially-directed research projects through investigator-initiated awards such as R01s.

Recognizing that a clear opportunity exists to determine the direct effects that specific mitochondrial alterations play in cancer, the NCI is exploring new approaches that would significantly improve our understanding of the direct effects of mitochondrial changes on cancer pathology. We believe this could be achieved through an integrated approach that combines much of what has been discovered in the field of mitochondrial genes, proteins, and metabolites.

To specifically support an integrated, consolidated, and informed approach to the study of mitochondrial disease, the NCI has accomplished the following:

- Sponsored a Mitochondrial Symposium that was held at the NIH on Jan. 9-11, 2008. This symposium was sponsored by 11 ICs and 2 NIH Offices, and showcased a plenary lecture on clinical proteomics.

- Served as the lead organization in the successful implementation of the new trans-NIH Roadmap initiative titled "Functional Variation in Mitochondria."

- Hosted a seminar in conjunction with the NIH mitochondrial interest group by a prominent mitochondrial researcher to discuss the pivotal roles of mitochondria in cancer.

The National Institute of Neurological Disorders and Stroke (NINDS) is also addressing the challenges of mitochondrial disease. NINDS supports a broad portfolio of research to understand the role of mitochondria and mitochondrial dysfunction in neurological diseases and to test potential therapies that target mitochondrial pathways. This includes studies of rare disorders caused by mutations in mitochondrial genes or in genes that directly affect mitochondrial function, including Friedrich's ataxia, Leigh syndrome, and certain types of epilepsy, myopathy and peripheral neuropathy. Other NINDS-supported research focuses on the role of mitochondrial dysfunction or mitochondria-mediated oxidative stress in neurodegenerative diseases such as Parkinson's disease, Huntington's disease, and amyotrophic lateral sclerosis (ALS), and in cell damage or death that occurs after stroke, epileptic seizures or traumatic injury to the brain or spinal cord.

In June 2008, NINDS, the National Institute of Mental Health, the Centers for Disease Control and Prevention, the Federal Drug Administration, and the Department of Health and Human Services held a workshop entitled "Mitochondrial Encephalopathies: Potential Relationships to Autism?" (www.ninds.nih.gov/news_and_events/proceedings). At the workshop, invited panelists considered their clinical experience as well as published research findings suggesting mitochondrial involvement in autism. They also discussed difficulties in diagnosing mitochondrial disease, known or potential triggers, and research needs to better understand how and to what extent mitochondrial disease contributes to autism.

## IMPROVING MITOCHONDRIAL DISEASE RESEARCH

Mr. Jackson: The National Heart, Lung, and Blood Institute has held working group and other meetings related to mitochondrial dysfunction and cardiovascular disease. Following these meetings, recommendations were identified to strengthen mitochondrial research including: adopting a systems biology approach, promoting cross-disciplinary research, developing improved tools and models, and centralizing data from various institutes regarding mitochondrial disease research. Many of these recommendations have trans-NIH implications and would seem appropriate for

consideration by the Office of the Director. Please indicate what the NIH could do to implement these and any related recommendations to improve the effectiveness of NIH research on mitochondrial disease?

Dr. Kington: Through the efforts of the NHLBI and other NIH components, the NIH has made substantial progress towards implementing the primary recommendations of the workshop held in July 2007 on "Modeling Mitochondrial Dysfunction in Cardiovascular Disease".

For example, Recommendation 1 urged support for the integration of genomic and proteomic data to enable improved understanding of diseased cardiovascular phenotypes. NIH actions in response to the recommendation include:

- Highlighting the main Integrative Mitochondriome Project (IMP) goal of assessing functional variation in mitochondria in disease as a key area in the NIH-wide Roadmap Transformative R01 Program.
- Preparing for release in May 2009 an open RFA, "The Role of Cardiomyocyte Mitochondria in Heart Disease: An Integrated Approach," that relates directly to the recommendation
- Supporting trans-disciplinary systems biology research on the role of mitochondrial metabolism in sudden cardiac death through the program "Exploratory Programs in Systems Biology".

Recommendation 2, which proposed development of new technologies for improved measurement of mitochondrial function, is also being addressed through the RoadMap Transformative R01 program solicitation of efforts to develop new tools and technologies for improved measurements of mitochondrial function in health and disease.

Finally, progress has also been made with respect to Recommendation 3, which proposed establishment of an open-source mitochondrial knowledge base for data and computational tools. In July 2007, the NHLBI convened a group of interested investigators to establish community-supported standards for mitochondrial proteomics data sharing and the Institute is now supporting a new award through a program titled "Predictive Multi-scale Models of the Physiome in Health and Disease" that requires data and model sharing and is working to make the data and models available to the community.

These efforts to date, along with future efforts across the NIH, can be expected to increase markedly our understanding of the role of mitochondrial dysfunction in cardiovascular disease and to help foster the development of new, more effective approaches to treat them.

Mr. Jackson: Dr. Kington, as you know, African Americans are 4 times more likely to be diagnosed with end stage renal disease, and in some cases, such as focal segmental glomerulosclerosis (FSGS), the second leading cause of renal failure in children, nearly 5 times the number of African Americans are likely to develop FSGS than Caucasians. Additionally, due to FSGS nearly 19,300 Americans are suffering from end-stage renal disease. What initiatives is NIH currently undertaking to examine kidney diseases, including rare diseases such as FSGS which have a disproportionate impact on African Americans?

Dr. Kington: With the *FSGS Clinical Trial (FSGS-CT),* the NIH's NIDDK has formed a collaborative network of U.S. research centers that is testing the effectiveness of two different treatment regimens in children and young adults who have steroid-resistant FSGS of unknown origin. The FSGS-CT has randomized 138 participants, of whom 35 percent are African American. This is the largest randomized trial of FSGS ever conducted. Ancillary studies are evaluating immunosuppressive medications, anti-proliferative medications; the genetics of the patients in the FSGS trial to determine whether there is a difference between those who respond to treatment and those who do not; and proteins in the urine to determine whether there is insight to be gained regarding prognosis.

The NIDDK is also supporting two observational cohort studies of racially and ethnically diverse patients with chronic kidney disease in general. The *Chronic Renal Insufficiency Cohort (CRIC)* study is designed to improve our understanding of the relationship between chronic kidney disease (CKD) and cardiovascular disease. It is following approximately 3,600 men and women with chronic kidney disease. CRIC is the largest cohort study of CKD ever conducted, and 46 percent of the participants are African American. The *C-KiD* study, which I have previously mentioned, is studying CKD in pediatric patients. Five hundred sixty patients have been enrolled; overall, 21 percent are African American, but among those who have been diagnosed with glomerular disease, 41 percent are African American.

In another avenue of research, a team of NIDDK intramural scientists, along with another team of NIH-supported investigators, recently discovered that genetic variants around the *MYH9* gene are major contributors to the excess risk of non-diabetic kidney disease among African Americans. Scientists are also studying additional genetic factors that may be associated with the development of FSGS and investigating a protein called permeability factor, which has been found in some patients with the disease. The identification of such risk factors and possible biomarkers will not only provide opportunities for further understanding of mechanisms of disease in FSGS, but also may provide avenues for discovery of new disease therapies.

EFFORTS TO REDUCE STROKE MINORITY HEALTH DISPARITIES

Mr. Jackson: I remain concerned that blacks have almost twice the risk of an initial stroke compared to whites. And compared to whites, blacks have a 1.3 times greater rate of nonfatal stroke and a 1.8 times greater rate of fatal stroke. Please tell this Committee what progress the NIH is making in preventing stroke in minorities and in individuals at especially high risk of stroke.

Dr. Kington: Health disparities in stroke incidence and outcome are of great concern to NIH. To understand the causes of these differences, NIH supports studies that are identifying genetic and modifiable risk factors in minority populations that contribute to the increased incidence of stroke. For example, the National Institute of Neurological Disorders and Stroke (NINDS) currently funds the Reasons for Geographic And Racial Differences in Stroke (REGARDS) study, an observational study of 24,000 participants designed to explore the role of geography and race on risk factors, incidence, and mortality for stroke. REGARDS investigators have found that blacks are more likely to exhibit stroke risk factors including hypertension, diabetes, smoking, and markers of heart disease. Blacks are also less likely to have controlled blood pressure even when they were on anti-hypertensive drugs. The National Heart Lung and Blood Institute (NHLBI) also supports population-based studies of risk factors for cardiovascular diseases, including stroke, as well as clinical trials of interventions that would lead to reduced stroke incidence, such as lowering blood pressure and controlling diabetes.

Several groups are also looking at risk factors in Hispanic Americans, which also exhibit a higher incidence of stroke than whites and are at higher risk for hemorrhagic stroke. Data from the NINDS-funded Northern Manhattan Study, for example, have shown that the metabolic syndrome, a condition where several vascular risk factors are expressed in combination, predisposes for stroke and is more prevalent in Hispanic Americans. An NHLBI contract (with co-funding from NINDS, the National Institute on Diabetes and Digestive and Kidney Diseases, the National Institute of Environmental Health Sciences, and other NIH Institutes) is studying the prevalence and development of general disease, including stroke and cardiovascular risk factors, in 16,000 US Hispanics. Results will provide a bounty of epidemiological data that will help understand the causes of stroke in this population.

NIH also supports studies aimed at improving stroke prevention and treatment in minority communities. For example, in 2007, NINDS funded a Stroke Prevention/Intervention Research Program focused on a diverse community of the District of Columbia. The program is composed of three projects, focused on: 1) exploring the impact of a multilevel educational intervention on the number of patients treated with the clot-buster drug tPA; 2) assessing the impact of an aggressive strategy to prevent recurrent stroke; and 3) evaluating the prevalence and significance by race and ethnicity of small chronic brain bleeds in individuals with intracerebral hemorrhage. All of these studies will benefit underserved and minority populations, and as a whole, this program will foster collaborative, innovative and effective research strategies to

reduce the burden of stroke in populations historically at increased risk from this disease.

Education about the symptoms of stroke and the importance of calling 911 is crucial to ensure delivery of time-sensitive treatments that may save lives and improve functional outcomes, but data from a 2005 survey administered by the CDC has shown that blacks and Hispanics were less aware than whites of this information. NINDS continues to promote stroke awareness and the need for urgent action through its "Know Stroke" public education campaign. The Institute has developed targeted and audience-tested education materials in English and Spanish for minority communities and has partnered with the CDC through the "Know Stroke in the Community" program to identify and enlist the aid of "Stroke Champions" and "Promotores de Salud" who will educate minority and other at-risk communities about the signs and symptoms of stroke. Since its inception in 2004, the program has identified more than 150 Champions in 11 cities who have delivered stroke education messages and materials to hundreds of thousands of people in communities across the United States.

NIH is aware of the increased burden of stroke on minority communities and strives to improve its efforts to eliminate this disparity. It is worth noting that as part of its broader strategic planning effort, this year NINDS will commence a health disparities planning exercise that will examine the Institute's programs and performance related to the reduction of neurological health disparities and the recruitment and retention of a diverse research workforce.

## CONTROLLING HIGH BLOOD PRESSURE AND HEART FAILURE

Mr. Jackson: Dr. Kington, I read with interest an article on the results of the National Heart, Lung, and Blood Institute's Coronary Artery Risk Development in Young Adult study that showed African-Americans develop heart failure before the age of 50 at a rate 20 times that of whites in this age group. I understand that this research demonstrated the seriousness of high blood pressure in young adulthood, particularly uncontrolled high blood pressure, in developing heart failure later in life. Please tell this Committee what the NIH is doing to control high blood pressure and heart failure, particularly among African-Americans.

Dr. Kington: The Coronary Artery Risk Development in Young Adult (CARDIA) is but one of many seminal studies supported by the National Heart, Lung, and Blood Institute (NHLBI) that have together provided us with a comprehensive understanding of the epidemiology of high blood pressure and the efficacy of various approaches to treat it. The CARDIA study was capable of providing us with the results you mentioned because it was designed to include equal numbers of African Americans and whites when it was initiated by the NHLBI in 1985. It has previously provided essential information on risk factors for hypertension and changes in blood pressure over time, and has now highlighted the high prevalence of its serious consequences.

Because of knowledge gained through CARDIA and other NHLBI epidemiology studies with high African Americans representation, the NHLBI has recognized the importance of supporting community outreach efforts to improve hypertension treatment and control in African Americans. For example, the NHLBI created the "With Every Heartbeat is Life" (WEHL) program that uses community health workers to improve the delivery of heart health education to the African American community. The WEHL 12-lesson curriculum, which includes a hypertension education component, relies upon hands-on demonstrations, skills-building activities, handouts, heart healthy recipes for popular cultural dishes, and quotes by African Americans to motivate community members to make changes in their lifestyles to improve heart health. The NHLBI has also recognized the importance of strategic partnerships in disseminating messages about heart health to African Americans and has developed partnerships with the Department of Housing and Urban Development (HUD), the Health Resources and Services Administration (HRSA), and the Association of Black Cardiologists (ABC). HUD and the NHLBI are working with 10 of HUD's HOPE-VI public housing sites across the nation on projects with the theme, "Improving Public Health in Public Housing."

The NHLBI has also supported research to develop new approaches to control hypertension in the African American community. One recent example is a program titled, "Interventions to Improve Hypertension Control Rates in African Americans," the objectives of which are to determine the best approaches to improve treatment of hypertension. The results from the program, which will be published starting next year, will provide the basis for future efforts to improve blood pressure treatment and control among African Americans.

Finally, the NHLBI has supported the research that has provided the scientific underpinning of many current practice guidelines, all of which strongly recommend the prevention of heart failure by early and aggressive medical and non-pharmacological treatment of hypertension, diabetes, and obesity, conditions that are all too common in young African-Americans. The NHLBI will soon begin a new clinical trial to determine if lowering systolic blood pressure to below the current widely accepted target of 140 mm Hg target is beneficial. Because the study will include over 25 percent minority participants, mostly African Americans, it should be able to tell us whether such a lower treatment approach is especially beneficial for African Americans.

## COORDINATION AND FUNDING OF HEALTH DISPARITIES RESEARCH

Mr. Jackson: Dr. Kington, I wrote the bill that elevated then the Office of Research on Minority Health to the National Center on Minority Health and Health Disparities at the National Institutes of Health. The NIH has made health disparities one of its priorities on the roadmap. However, the role of the National Center has not increased to fulfill the intention of the legislation which states, "The Director of the Center shall act as the primary Federal official with responsibility for coordinating all minority health disparities research and other health disparities research conducted or supported by the National Institutes of Health." I understand the Center only has a budget of

approximately $200 million, wilting in comparison to other Centers and Institutes like Human Genome Institute with $500, National Center for Research Resources at over $1 billion, or the National Cancer Institute at nearly $5 billion. What can I do as a legislator to make sure the intent of the law, which I read to you, is practiced at NIH in terms of coordination and funding of health disparities research?

Dr. Kington: The issue of health disparities is a priority for the NIH, and the *NIH Health Disparities Strategic Plan* underscores the commitment of the Institutes and Centers to health disparities. The NIH will carry out the intent of the law under the leadership of the National Center on Minority Health and Health Disparities (NCMHD)

ELEVATION OF NCMHD TO INSTITUTE

Mr. Jackson: I understand that there is a hierarchy at NIH, where Institutes generally have more prestige and grant making authority than Centers. I want to make you aware that it is my intention to drop a bill this Congress which elevates the National Center on Minority Health and Health Disparities to an Institute. Does the NIH have an official statement or response to this issue?

Dr. Kington: Mr. Jackson, your leadership on the issue of health disparities has always been valued by NIH and remains an asset in the national discussion of this important issue. Health disparities continue to affect major segments of the U.S. population and the subject is a priority area of research at our Agency. Your question has enormous implications for the overall direction of science and NIH. The mechanisms for organizational change were addressed in the NIH Reform Act, which provides for a reasonable process for examining the Agency's research structure which might lead to organizational changes.

The NIH Reform Act of 2006, the landmark legislation affirming the importance of NIH's vital role in improving the Nation's health, added new tools to maximize NIH's effectiveness, including new authorities to enable the Director of NIH and the Directors of the Institutes and Centers to make organizational changes following a public process and certain approvals. With this law Congress also established the NIH Scientific Management Review Board (SMRB) to conduct periodic organizational reviews and make recommendations regarding the use of such authorities. The intent of these provisions is that before organizational changes are made to the structure of NIH, an examination takes place in a deliberative manner that explores the need and anticipated value of such changes. For example, the scientific potential of the field could be reviewed and a determination made if there is a compelling scientific justification for changing an institute from a center to an institute. The first meeting of the SMRB will take place in April, 2009. It is NIH's position that before changes to the structure of the NIH organization take place, we take advantage of this Congressionally-created process that provides for thoughtful consideration of proposals such as this with opportunities for input from the scientific community, the public, and others as to whether the state of the science merits a change taking place.

INCREASED SUPPORT FOR RCMI'S

Mr. Jackson: So many times, Dr. Kington, your predecessors have come before this Subcommittee and our Full Committee and have told this membership that funds for NIH will be applied equally amongst the Institutes and Centers. However, I just want to receive your assurances that when funds are applied throughout the Centers and Institutes that the Research Centers at Minority Institutions (RMCI) will receive an increase at NCRR, which would bring more minority scientists into mainstream research and enhance studies of minority health.

Dr. Kington: The RCMI program, administered by the National Center for Research Resources (NCRR), is receiving approximately an eight percent increase in FY 2009. The budget for the program in FY 2008 was $52.5 million and the estimated budget for the program in FY 2009 is increasing to $56.7 million.

NCRR also plans to advance its existing programs through the support provided by the American Recovery and Reinvestment Act (ARRA) of 2009. RCMIs are being encouraged to apply for administrative supplements to their existing awards to accelerate the scientific tempo of their research grants. These additional funding opportunities for the RCMIs include, but are not limited to: expansion of translational research activities; research workforce recruitment, training, development and dissemination; and support for pilot projects and collaborative community engagement. For example, through these administrative supplements, RCMIs can improve technologies and cyber-infrastructure to support research collaborations and expand multi-site project management and data management support through the RCMI Translational Research Network (RTRN).

Separately, research project grantees (supported by most other NIH institutes or centers) are being encouraged to identify NCRR Center resources, such as RCMI grantees, with which they could establish strong collaborations to speed or strengthen their research. These grantees may submit revision award applications to their original awarding IC and the applications will be competitively reviewed for support with ARRA funds.

RCMI institutions are also encouraged to apply for additional ARRA funding available through NCRR's research facilities improvement (construction and renovation) program and the shared instrumentation grant program.

TUBERCULOSIS RESEARCH

Ms. Roybal-Allard: Dr. Kington as you know despite the view of many that tuberculosis is a disease of the past, it continues to be an issue here and now in the United States. Currently, the latest drug developed to treat TB was developed over four decades ago and the most common diagnosis methods are a century old coupled with the advent and expansion of drug resistant TB, including 83 cases of extensively drug resistant TB in the United States costing up to $500,000 to treat one case. TB is also one of the leading causes of death among those infected with HIV/AIDS globally, but is often more difficult to treat due to drug interactions between TB medication and anti-retrovirals. What initiatives is NIH currently undertaking to increase our understanding of TB?

Dr. Kington: The National Institute of Allergy and Infectious Diseases (NIAID) is the lead institute of the National Institutes of Health (NIH) for the conduct and support of research on tuberculosis (TB), including multidrug-resistant (MDR) and extensively drug-resistant (XDR) TB, and is currently the leading global funder of biomedical research on TB. NIAID coordinates its TB research activities with other components of NIH, including the National Heart, Lung, and Blood Institute, the Fogarty International Center, and the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development.

NIAID supports an extensive and robust TB research portfolio, including fundamental studies of TB and its causative agent, *M. tuberculosis (Mtb)*; translational studies which apply basic science findings to the identification and development of candidate drugs, vaccines and diagnostics; and clinical studies to evaluate new interventions and improved regimens of existing drugs. In NIAID-supported laboratories and clinics around the world, researchers are actively pursuing new drug development, preclinical models to better select the most promising new drug candidates, clinical studies to evaluate new regimens to treat drug-resistant TB, and immunotherapy as a strategy for treating TB.

Through its extramural research programs, NIAID also supports an array of public-private partnerships to develop new tools to control TB. For example, NIAID scientists were instrumental in the development of SQ109, a promising TB drug candidate; a Phase 1b clinical trial of SQ109 is currently being planned and will be conducted at an NIAID-supported contract site. In 2008, NIAID joined the not-for-profit Lilly TB Drug Discovery Initiative to help coordinate resources and facilitate new drug development for MDR TB. This collaboration seeks to make research resources, particularly expertise in medicinal chemistry, available to the research community to accelerate the development of new drug candidates.

NIAID also supports contracts to provide investigators with critical reagents for biomedical research, *in vitro* and animal models for testing candidate drugs and vaccines, preclinical development services to bring the most promising candidates into clinical testing, as well as a clinical trials infrastructure to conduct studies in the United

States and abroad. Additionally, the Tuberculosis Research Unit (TBRU), established in the mid-1990s, is working toward a better understanding of the host/pathogen interaction; developing biomarkers for *Mtb* infection, disease and immune protection; and researching the mechanism of action of the existing Bacillus Calmette-Guérin (BCG) TB vaccine.

NIAID TB research initiatives that have recently begun or are in the process of being awarded include a systems biology program aimed at better understanding the various phases of TB disease; the establishment of a Clinical Diagnostics Research Consortium to test early-stage diagnostics in TB-endemic countries; and grants to study the pharmacology of existing drugs against TB.

NIH also supports the development and evaluation of diagnostic tools, therapeutics and vaccines for people who are co-infected with HIV and *Mtb;* NIAID's TB research efforts are coordinated with its extensive research portfolio on HIV/AIDS. Several studies are planned or underway to examine when to start antiretroviral therapy in co-infected individuals, to evaluate new diagnostic tools, to examine the immunologic interaction of HIV and *Mtb* coinfection and to understand better the interaction of both existing and experimental anti-TB treatments with anti-HIV medications. In addition, NIAID scientists are leading several ongoing studies at the NIAID International Centers for Excellence in Research in India and Africa that aim to elucidate the reasons for the high TB incidence among people with HIV/AIDS. These studies already have provided insight into the immune response to latent TB.

## AMERICAN RECOVERY AND REINVESTMENT ACT

Ms. Roybal-Allard: This February, after five years of declining NIH funding, NIH received $11.4 billion in Recovery Act and FY09 omnibus funding. We all appreciate that NIH needs this funding, and I know we can use it well to create jobs, pursue scientific opportunity and advance public health. However, I am concerned about the cycle of boom and bust for NIH. We doubled the funding at the beginning of this decade, but then we entered a five-year period in which, adjusted for inflation, NIH lost nearly $6 billion or 17% of its purchasing power.

Are you concerned, Dr. Kington, that two years from today after the ARRA funds have been spent we will repeat NIH's post-doubling history? Should we try to invest in NIH's *base* in fiscal years 2010 and 2011 so that, when Recovery Act funding has been spent, we don't halt all the tremendous progress in medical research that I know this infusion of funds will lead to? Have you made a calculation of what NIH might need over the next two years so that we can sustain the investment that we are making with Recovery Act funding and assure the greatest yield in lifesaving medical science for the American people?

Dr. Kington: Under the Recovery Act NIH received a total of $10.4 billion. I am excited that these resources will help stimulate the economy and scientific discovery. Yes, it is important to note that like all scientific investments, these funds will create

demand within the research community to further build on this progress. NIH has been proactive and doing all it can to minimize the effect of any perceived boom and bust cycle on the research community.

NIH is determined to seize the opportunity afforded us by the infusion of ARRA resources to develop a nimble approach to investing the money quickly for the greatest impact. This opportunity is too important for us to conduct "business as usual" and demands that we employ the best possible approaches to ensure timely progress with the most efficient and effective use of resources.

NIH estimates it will spend about $5 billion in each of 2009 and 2010 using Recovery Act appropriations, which were intended as one-time infusions for scientific research and related activities. Funding decisions for most discretionary programs, including NIH, are made on an annual basis. Therefore, 2011 decisions have not yet been made.

SCLERODERMA

Ms. Roybal-Allard: Last year the subcommittee received compelling testimony from a 12 year-old girl from my district bravely battling scleroderma. As you know, scleroderma is a devastating and often deadly autoimmune disease that causes significant pain and suffering. The fact that there are no FDA approved therapies for this disease leads me to think we would benefit from an expansion in this area. Could you please provide an update on promising research being supported by the NIH on scleroderma?

Dr. Katz: Scleroderma is a disabling autoimmune disease characterized by hardening of tissues in many parts of the body, including skin, internal organs and blood vessels. In as many as 70 percent of patients with this disorder, there is scleroderma-related lung impairment, which is difficult to treat and may lead to death. Although scleroderma is more common in women, the disease also occurs in men and children. It affects people of all races and ethnic groups.

Several components of the NIH support research on scleroderma, to better understand what causes this disease and how best to treat it. For example, the NIH-supported Scleroderma Lung Study demonstrated that oral administration of cyclophosphamide for 12 months modestly improved pulmonary function in patients with scleroderma-related lung disease. NIH-funded researchers are also working to develop a composite response index for patients with one kind of scleroderma called diffuse systemic sclerosis. This tool will capture information on organ involvement in scleroderma and patient response to treatment. Such an index is crucial in developing new treatments for this disease and evaluating the outcomes of clinical trials.

In other efforts, research conducted at an NIH-supported Center of Research Translation is examining the molecular basis of scleroderma to understand its underlying causes using functional genomics and gene networks, building on the earlier

finding of a genetic marker for scleroderma in two population subtypes. This center is designed to bring together basic and clinical researchers in a way that helps to translate fundamental discoveries into new drugs, treatments, and diagnostics.

The NIH-funded National Family Registry for Scleroderma is collecting biological samples from patients and, when possible, their parents, so that genetic differences between patients and healthy individuals can be detected and potentially traced to a parent. Further research based on this registry may reveal genes that contribute to the development of scleroderma, which may identify new targets for treatment.

PARTICIPATION OF MINORITIES IN ACCESSING ARRA FUNDS

Ms. Lee: Thank you for your testimony Dr. Kington, and thank you and all the NIH directors and the staff for all the work that you do to advance research in this country.

I appreciate the urgency and diligence that the NIH is putting into using the funds we provided in the economic recovery package.

I'm particularly concerned however that as we dole out these funds that we are especially mindful about the need to ensure that they can benefit all segments of our diverse population.

As you know its often been difficult for minorities to break into the research professions and compete for NIH grants.

Can you describe how you plan to ensure diversity among the new investigators that will benefit from funding provided in the recovery package?

Dr. Kington: NIH is committed to ensuring diversity among New and Early Stage investigators. We have established new policies and award mechanisms designed to increase new investigator participation in NIH research. http://grants.nih.gov/grants/new_investigators/. NIH Institutes and Centers (ICs) have broad flexibility in their allocation or distribution of ARRA funds. For example, ICs may use ARRA funds to invest in new research applications and use targeted supplements to recruit new faculty, or to submit competitive revision applications. ICs may provide ARRA funds for administrative supplements under the Research Supplements to Promote Diversity in Health-Related Research, or to support new types of activities (such as the NIH Challenge Grant program). We have dedicated at least $20 million over two years for summer research experiences in NIH-supported laboratories for students and science educators. Efforts like these are expected to increase diversity among the New Investigators funded by the recovery package.

The new funding opportunities announced by NIH for using ARRA funds each encourage individuals from underrepresented racial and ethnic groups as well as individuals with disabilities to apply for NIH support. Also, these funding opportunities include among the list of eligible institutions, those institutions that serve diverse populations, including but not limited to: Hispanic-serving institutions, Historically Black Colleges and Universities, Tribally Controlled Colleges and Universities, and Alaska Native and Native Hawaiian Serving Institutions.

Ms. Lee: Can you provide the committee with your specific outreach plans to ensure that African American, Latino, Asian Pacific Islander, Native American and other racial groups are represented among these investigators?

Dr. Kington: In addition to encouragement of underrepresented racial and ethnic groups as applicants and the inclusion of institutions that serve primarily underrepresented groups in the NIH funding opportunities announcements, specific outreach also is underway. Of note is the outreach being done for the Administrative Supplements Providing Summer Research Experiences for Students and Science Educators. For this program, desk-to-desk communications are being sent to all grantee institutions and a wide array of professional organizations, encouraging involvement in identifying summer research opportunities, as well as students and educators to engage in the opportunities. Included in this outreach, are communications with institutions and organizations that primarily serve underrepresented racial and ethnic groups.

In addition, NIH Institutes and Centers have methods tailored to their respective research domains for outreach to African American, Latino, Asian Pacific Islander, Native American investigators, and investigators from other racial groups. These efforts may include outreach to current grantees, or targeted outreach to professional associations and scientific societies dedicated to increasing the presence of racial and ethnic minorities in the scientific workforce.

Ms. Lee: How are you coordinating these efforts across each Institute and Center?

Dr. Kington: The NIH ARRA website (http://grants.nih.gov/recovery/) is the locus of all news, resources, policies and funding opportunities. NIH ARRA initiatives are coordinated by the Office of Extramural Research (OER), within the Office of the Director. In addition, OER manages an internal web site for NIH staff that provides guidance, frequently asked questions, and presentation materials to better coordinate access to information. A central email also has been created for staff and the public to submit questions, which in turn leads to further refinement of the public and internal communication.

Ms. Lee: As far as the funding to support extramural research facilities, what are you doing to ensure that minority serving medical institutions (like Meharry Medical College) know about these funding opportunities and are able to compete for these funds?

Dr. Kington: The NIH Guide for Grants and Contracts is the official publication for NIH medical and behavioral research Grant Policies, Guidelines, and Funding Opportunities, including those related to ARRA. All institutions are encouraged to join the NIH LISTSERV, which will ensure awareness of all grant activities on a weekly basis. In addition, program directors in the Institutes and Centers have been encouraged to use their existing contacts in order to encourage participation in recovery opportunities. As mentioned previously, for the Administrative Supplements Providing Summer Research Experiences for Students and Science Educators, attention is being given to providing outreach to organizations and institutions that primarily serve underrepresented racial and ethnic groups.

TRANSLATING NIH RESEARCH TO RACIAL AND ETHNIC GROUPS

Ms. Lee: Dr. Kington, as you know we have a severe problem with racial and ethnic health disparities in our country. Part of the problem is that our nation has a severe shortage of primary care doctors, and a severe shortage of diverse, minority primary care doctors who have the cultural competency to care and treat minority communities that are often leery of visiting a doctor.

In my view, the NIH plays a critical role in supporting research into diseases, and in translating those research results into actual clinical practice in order to benefit everyone.

While we have made dramatic progress over the years in reducing mortality from a number of diseases, like heart disease, cancer, and diabetes, the gap in racial and ethnic health disparities has continued to widen.

How do we ensure that the gains provided by NIH research are translated across all racial and ethnic groups so that we aren't still facing growing health disparities ten years from now?

Dr. Kington: NIH, guided by the *NIH Health Disparities Strategic Plan, Fiscal Years 2004-2008*, is making progress in translating NIH's research findings to address racial and ethnic health disparities. Through a range of NIH institutes and centers (IC) efforts and novel partnerships, the NIH is expanding the nation's infrastructure and capacity within academic institutions and within health disparity communities to reduce and ultimately eliminate health disparities.

The National Center on Minority Health and Health Disparities (NCMHD) Community-Based Participatory Research (CBPR) and the NCMHD Center of Excellence (COE) programs, are two of several ongoing NIH extramural research efforts to ensure that NIH funded research findings are translated and disseminated to health disparity populations. Both programs conduct research promoting minority health and the elimination of health disparities. The CBPR initiative is a multiple-phase program requiring that health disparity communities and researchers work as equal partners in designing and implementing an intervention addressing a significant public health issue within the community of the health disparity partner. Using the community participatory approach, translation and dissemination of the research are ensured when the interventions are conceived, designed and pilot tested by both community and scientific partners. The partners can collaboratively identify and adopt an existing intervention, tailoring the intervention to the culture, values, practices, and language of the health disparity community. Most of the NCMHD Center of Excellence programs contain a community engagement and outreach core. This core supports the establishment of partnerships between the academic institution and health disparity communities, for translating and disseminating health information to health disparity communities, and providing research training to community members. The partnerships established by the NCMHD COE to date are helping to ensure that findings generated

by researchers funded by NCMHD and other NIH ICs are being incorporated into ongoing health promotion and prevention efforts.

In addition, the NCMHD COE are actively preparing and training the next generation of the minority and health disparity researchers and clinician scientists.

Other NIH Institutes are also contributing to translation efforts. The National Heart, Lung and Blood Institute's (NHLBI) Comprehensive Sickle Cell Centers emphasize the translation of fundamental investigations into clinical studies, as well as community translational research to promote evidence-based clinical practice. The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) Centers of Research Translation program translates basic research discoveries into clinical trials for diagnostic approaches and treatments. Health literacy, a significant barrier to health care for health disparity populations, is being addressed through efforts of the National Library of Medicine (NLM) and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and NCMHD programs. The National Cancer Institute (NCI) addresses translation through its Patient Navigator Research and the Community Research Networks programs.

## NIH RESEARCH CONTRIBUTING TO THE ELIMINATION OF HEALTH DISPARITIES

Ms. Lee: Can you specifically describe what research at NIH and within your institutes is contributing to the elimination of racial and ethnic health disparities?

Dr. Kington: The NIH strategy for eliminating health disparities is guided by the comprehensive *NIH Health Disparities Strategic Plan, Fiscal Years 2004-2008* All NIH Institutes/Centers (IC) are engaged in research addressing the complex societal, biological, biobehavioral, biomedical and environmental factors and their interactions contributing to this Nation's foremost health challenge, health disparities. The National Center on Minority Health and Health Disparities (NCMHD) is the focal point for planning and coordination of NIH IC-specific minority health and disparities research.

NCMHD is helping lead in the support of research to reduce and eliminate health disparities. The NCMHD Community-Based Participatory Research (CBPR) Initiative and the NCMHD Center of Excellence (COE) programs conduct research promoting minority health and the elimination of health disparities. The CBPR Initiative contributes to this effort through its forty different interventions covering a range of diseases and conditions facing these communities. The NCMHD COE supports biomedical, behavioral and educational interventions, basic and clinical biomedical, biobehavioral, and policy research for reducing and eliminating health disparities. Examples of activities are provided below.

1) A NCMHD CBPR project being conducted in the lower Mississippi Delta has identified some of the barriers to successful interventions. They have identified co-

learning between researchers and community members and mutual capacity building efforts to be important in eliminating health disparities.

2) NCMHD COE researchers have explored the relationship between the quality of primary care experiences of Mexican, Puerto Ricans, and Cubans and limited English proficiency and are using this knowledge to develop cultural competent health care.

3) NCMHD supports researchers at the Center for Native and Pacific Health Disparities Research at the University of Hawaii conduct research, training and community engagement aimed at cardiometabolic health and health disparities among Native Hawaiians (NH), Alaska Natives (AN) and other Pacific Islanders (PI) including Filipinos, Samoans, and Tongans. The Partnerships for Improving Lifestyle Interventions (PILI), has been formed among five community groups, the medical school and department of health to reduce and eliminate obesity health disparities.

4) NCMHD COE researchers at Drew University have examined the association between serum levels of 25-hydroxyvitamin D and select cardiovascular disease factors in U.S. adults. Findings showed lower levels of 25-hydroxyvitamin D in women, elderly persons, racial/ethnic minorities, and participants with obesity, hypertension and diabetes mellitus.

5) NCMHD and the NHBLI support the Jackson Heart Study, the largest single-site, prospective, epidemiologic investigation of cardiovascular disease among African Americans ever undertaken. The Jackson Heart Study exemplifies a unique collaborative model among Jackson State University, Tougaloo College and University of Mississippi Medical Center, the Jackson community and the NIH to discover and test best practices for eliminating health disparities.

6) The NCMHD supported University of Oklahoma Center for American Indian Diabetes Health Disparities (OCAIDHD) aims to reduce and eventually eliminate the excess mortality, morbidity, and quality of due to diabetes. In recognition of the complexity of the factors of diabetes, the OCAIDHD employs a multi-disciplinary and college team of diabetes researchers on specific biological, physiological, behavioral, and cultural stressors of the disease. Research studies underway include: 1) Early Markers of Pre-eclampsia in American Indians with Type 2 Diabetes; 2) Insulin Resistance and Glucocorticoid Treatment of Inflammatory Diseases of High Prevalence among American Indians; and 3) American Indian Diabetes Beliefs and Practices: Maternal Care, Infant Mortality, and Adherence.

7) NCMHD COE researchers at the University of Miami are conducting a 3-year experimental study evaluating the effectiveness of a randomized HIV risk reduction intervention led by Hispanic women and culturally tailored to the specific needs of Hispanic women who are disproportionally impacted by HIV/AIDS. This research evaluates the effectiveness of a refined and culturally-tailored specific intervention to increase HIV prevention behaviors for inner city Hispanic women and explores the role

of acculturation, family, stress, and family functioning as risk and/or protective factors in the prevention of HIV/AIDS among Hispanic women.

8) The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) supports research on Systemic Lupus Erythematosus (Lupus): Incidence of lupus is three times higher in African American women than in White women, and more common in Hispanic, Asian, and Native American women. NIH researchers have reported that most women with moderate lupus that is inactive or stable, taking estrogen appears to have no detrimental effect on disease activity. Researchers with mice have shown that blocking the effects of two proteins, which normally recognize viruses and bacteria and activate immune cell responses, produced different and unexpected effects on disease severity, suggesting these proteins might be new targets for lupus treatment.

9) The National Institute of Aging (NIA) is supporting a study investigating how social factors work through biological mechanisms to impact health and contribute to racial health disparities. A unique study of Detroit residents will explore how personal and neighborhood stressors affect the health by an interdisciplinary research team with expertise in social and behavioral science, cell biology, psychology and biochemistry.

## ELEVATION OF NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES TO INSTITUTE

Ms. Lee: In that regard don't you think it makes sense to make the National Center on Minority Health and Health Disparities a formal NIH Institute?

Dr. Kington: Ms. Lee, your leadership on the issue of health disparities has always been valued by NIH and remains an asset in the national discussion of this important issue. Health disparities continue to affect major segments of the U.S. population and the subject is a priority area of research at our Agency. Your question has enormous implications for the overall direction of science and NIH. The mechanisms for organizational change were addressed in the NIH Reform Act, which provides for a reasonable process for examining the Agency's research structure which might lead to organizational changes.

The NIH Reform Act of 2006, landmark legislation affirming the importance of NIH's vital role in improving the Nation's health, added new tools to maximize NIH's effectiveness, including new authorities to enable the Director of NIH and the Director of the Institutes and Centers to make organizational changes following a public process and certain approvals. In addition, this law established the Scientific Management Review Board to conduct periodic organizational reviews and make recommendations regarding the use of such authorities. The intent of these provisions is that before organizational changes are made to the structure of NIH, an examination takes place in a deliberative manner that explores the need and anticipated value of such changes. For example, the scientific potential of the field should be reviewed and a determination made if a center has sufficiently demonstrated that, as an institute, it can support a thriving intramural and extramural research program. Therefore, it is NIH's position

that before changes to the structure of the NIH organization take place, these processes be allowed to take place and not pre-empted by Congress. These processes allow the scientific community, the public, and others to provide input to determine whether the state of the science merits a change taking place.

## TRANS-NIH PRIMARY CARE RESEARCH

Ms. Lee: The other critical role that I believe the NIH can play in reducing health disparities is by directing more funding towards primary care research.

By funding this type of research we can determine what set of interventions work best for different populations, and then we can further determine the best methods for delivering those interventions, recognizing that minority communities often interact with the health system in vastly different ways.

For example even something as basic as health literacy is dramatically different among different racial and ethnic groups. Do we know how different levels of health literacy among different groups impact the quality of patient care? How do varying levels of literacy affect patient choice in interacting with the health care system and the type of public health interventions that we fund? And how does that impact the outcome of the health intervention?

It's these kinds of applied research questions that I believe the NIH could really help with to not only improve health outcomes and reduce disparities, but also dramatically reduce costs.

Can you tell me what the NIH is doing to support primary care research from a cross cutting trans-NIH perspective?

Dr. Kington: NIH has at least nine institutes and centers that support projects with a major focus on primary care research to reduce and eliminate health disparities. The National Center on Minority Health and Health Disparities (NCMHD) has the Community-Based Participatory Research (CBPR) and the NCMHD Centers of Excellence programs which develop interventions and conduct research on a variety of diseases (diabetes, cancer, AIDS, etc.) to reduce and eliminate health disparities. The National Cancer Institute (NCI) is supporting primary care research to reduce health disparities through its nationwide Cancer Research Networks, minority cancer screening, tobacco biomarkers studies and various cancer survivorship outreach programs. The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) supports primary care research on diseases that disproportionately affect minority communities including diabetes, liver disease and obesity. The National Institute of Mental Health (NIMH) funds primary care research on the prevention of suicide and depression, and adolescent bio-behavioral HIV research training. The National Institute on Aging (NIA) supports research on medication and health literacy in elderly populations. The National Center for Complementary and Alternative Medicine (NCCAM) supports research on acupuncture to decrease disparities in

outcomes of pain management. The National Center for Child Health and Health Development (NICHD) supports projects on literacy and maternal health, and defining obstacles to care.

## HIV/AIDS RESEARCH

Ms. Lee: Dr. Fauci, can you provide an update on the current state of HIV/AIDS research for the committee? Vaccines, microbicides?

I'm also curious about a new experimental HIV prevention strategy called Pre-Exposure Prophylaxis or (PrEP). Essentially if I understand it, PrEP involves giving HIV negative individuals in high risk groups, or high prevalence areas antiretroviral drugs as a prophylactic measure to prevent the transmission of HIV.

It's my understanding that there are currently seven clinical trials testing the safety and effectiveness of PrEP, and that its being considered among the most promising of potential HIV prevention interventions now being studied. These clinical trials are expected to start reporting results starting next year.

What is the NIH doing to work with the Centers for Disease Control and Prevention (CDC) and the United States Agency for International Development (USAID) to prepare for the potential utilization of this new intervention? Are you all working on developing a strategy to help deliver PrEP given its potential?

Dr. Fauci: For more than 25 years, the National Institutes of Health (NIH) -- supported by Congress and encouraged by this Committee's leadership—has devoted substantial financial and intellectual resources to the fight against HIV/AIDS. This comprehensive effort is coordinated by the Office of AIDS Research (OAR) in the Office of the Director, and the National Institute of Allergy and Infectious Diseases is the leading institute in this area. Nearly every other Institute and Center conducts or supports AIDS research within its mission. As a result, NIH has made great strides in treating people with HIV/AIDS as well as in HIV prevention. Researchers have, for example, demonstrated that antiretroviral drug regimens can substantially extend survival of HIV-infected adults, adolescents, and children and greatly reduce mother-to-child transmission of HIV and promote child survival; elucidated the potential benefits of male circumcision; and shown that a microbicide to prevent sexual HIV transmission may be possible. Priorities for NIH AIDS research are established through the Trans-NIH Strategic Plan for HIV-Related Research developed by the OAR in consultation with the ICs and outside experts. The plan establishes that efforts to develop new biomedical and behavioral prevention modalities, including safe and effective HIV vaccines and microbicides, as well as to improve antiretroviral regimens for individuals who are already HIV-infected remain priorities for NIH.

## HIV/AIDS VACCINE RESEARCH

Ms. Lee: Dr. Fauci, can you provide an update on the current state of HIV/AIDS research for the committee? Vaccines, microbicides?

Dr. Fauci: NIH remains firmly committed to develop a safe and effective vaccine against HIV. Currently, 21 vaccine candidates are being evaluated, individually and in combination, in 20 different vaccine trials (15 Phase I, Ib, I/II; 2 Phase II, IIA; 2 Phase IIb; and 1 Phase III).

Current vaccine research plans have been shaped to a large extent by the disappointing early termination of two trials known as STEP and Phambili in September 2007. Both trials involved the Merck recombinant adenovirus (rAd5) vector HIV vaccine candidate. The vaccine candidate was found to be ineffective in protecting against HIV infection or lowering the viral load of subjects who became infected during the trial. Although the HIV vaccine candidate in the STEP study could not directly cause HIV infection, researchers found a greater number of HIV infections among a subset of participants who received the vaccine, particularly uncircumcised men who have sex with men (MSM), who had pre-existing immunity to adenovirus 5 (Ad5) from a prior natural infection. NIAID had planned to conduct a study known as PAVE 100 to evaluate an NIAID Vaccine Research Center (VRC) candidate vaccine based on a rAd5 prime-boost strategy. However, after internal and external advisory review, NIAID determined that PAVE 100 would not go forward. Instead, the Institute is planning a smaller, more focused exploratory study to evaluate the effects of the VRC candidate vaccine product on viral load in vaccinated people who subsequently become HIV-1-infected.

In light of the outcome of the STEP trial, NIAID has renewed its emphasis on basic vaccine discovery research. This is being accomplished, in part, by three new initiatives. The *Basic HIV Vaccine Discovery* program will support a new generation of knowledge to inform new conceptual approaches to HIV vaccinology. The *Highly Innovative Technologies to Interrupt Transmission of HIV* (HIT-IT) program will stimulate "out-of-the-box," novel, unconventional approaches that might provide long-term, safe protection from HIV acquisition. Lastly, the *B-Cell Immunology Partnership* will foster collaboration between B-cell immunologists and vaccinologists to help inform vaccine discovery, specifically addressing the problem of how to elicit broadly neutralizing antibodies against HIV.

## HIV/AIDS MICROBICIDE RESEARCH

Ms. Lee: Dr. Fauci, can you provide an update on the current state of HIV/AIDS research for the committee? Vaccines, microbicides?

Dr. Fauci: NIH remains deeply committed to supporting basic, clinical and translational research on safe, effective and acceptable microbicides to prevent HIV infection. The NIH Office of AIDS Research coordinates microbicide research and

development across the various institutes and centers at the NIH. In keeping with our commitment to microbicide research, the NIAID Division of AIDS recently established the Microbicide Research Branch (MRB) within the Prevention Sciences Program. MRB coordinates a comprehensive program within NIAID in support of HIV microbicide research, oversees preclinical and clinical research programs to evaluate the safety and efficacy of microbicide candidates, and provides oversight for the Microbicide Trials Network (MTN), a global clinical trials network dedicated to evaluating and testing HIV microbicides for safety, acceptability and effectiveness. The MTN currently has five trials underway or in development.

Of note, a recent study indicates real promise for the development of potential microbicides. A clinical trial known as HPTN 035 evaluated the safety and effectiveness of the vaginal microbicides BufferGel and 0.5% PRO2000/5 Gel (P) for the prevention of HIV infection in women. The study enrolled 3,100 women in the United States, Malawi, Zimbabwe, Zambia, and South Africa. PRO2000 was found to be safe and reduced the risk of HIV infection by approximately 30 percent. While this finding is not statistically significant, it is encouraging. HPTN 035 is the first major human microbicide study to suggest that a vaginal gel may prevent heterosexual HIV transmission in women. Additional clinical data are needed to conclusively determine whether PRO2000 protects women from HIV infection. Another clinical trial currently being conducted by the United Kingdom's Medical Research Council could provide further insight into PRO2000's effectiveness. This study is expected to conclude in late 2009.

The NIH topical microbicide program also supports programs and initiatives to help develop candidate microbicides and advance the most promising ones into human clinical trials. Through programs such as the Integrated Preclinical/Clinical Program for HIV Topical Microbicides (IPCP-HTM), the Microbicide Innovation Program (MIP), and the Microbicide Design and Development Teams (MDDT), more than 100 proposed candidates have entered the microbicide product development "pipeline". Nine of these candidates representing new classes and mechanisms of microbicide action are in ongoing or planned Phase I clinical trials.

The OAR promotes both trans-NIH and trans-U.S. government collaboration on microbicides research. The OAR regularly convenes the Trans-NIH Microbicide Research Coordinating Committee, comprised of the NIH Institutes and Centers that support microbicide research (NIAID, NICHD, NIMH, NIDA, NINR, NCI, FIC, NHLBI, NCRR, and ORWH). CDC, FDA, VA, USAID, and the Department of Defense also participate in this process, along with a group of non-government experts from academia, industry, and community representatives.

NIH and NIAID collaborate with other organizations such as the Centers for Disease Control and Prevention (CDC) , the U.K. Medical Research Council/Microbicides Development Programme, the Bill & Melinda Gates Foundation, Alliance for Microbicide Development, the International Partnership for Microbicides, Population Council, the United States Agency for International Development (USAID),

and CONRAD (Contraceptive Research and Development Program) to share information and ensure coordination of microbicide design, development, and testing activities.

## PRE-EXPOSURE PROPHYLAXIS

Ms. Lee: Dr. Fauci, can you provide an update on the current state of HIV/AIDS research for the committee? Vaccines, microbicides?

Dr. Fauci: Pre-exposure prophylaxis (PrEP) refers to antiretroviral therapy administered to uninfected people who are at high risk of HIV to prevent infection if they are exposed to the virus. Recent NIAID-supported mathematical modeling of PrEP use in U.S. populations at high risk for HIV infection suggests that PrEP could dramatically decrease the likelihood of becoming infected with HIV and could be as cost-effective as other widely recommended public health and medical prevention interventions in the United States.

Seven PrEP studies are underway in various populations, sponsored by a variety of government agencies and nongovernmental organizations. For example, the phase III NIAID iPREX study was launched in July 2007 to test the preventive effect of Truvada (tenofovir + emtricitabine) among HIV-negative men who have sex with men (MSM), in conjunction with safe-sex counseling and condom use. The study is being conducted in collaboration with the Bill and Melinda Gates Foundation at sites in Peru, Ecuador, the United States, Brazil, South Africa and Thailand.

NIAID has taken the lead in organizing the U.S. Government's PrEP Sponsors Working Group (PSWG), which includes participation of USAID and the CDC. NIAID serves as the Secretariat for this group and convenes regular meetings to share information about ongoing federally funded HIV PrEP trials. Additionally, the PSWG will consider how decisions regarding study termination and/or modifications are made and discuss possible communication strategies that would enable other study teams to rapidly assess the impact on their studies.

While it is too early to predict the feasibility of this approach, the PSWG members, led by CDC, are taking preliminary steps to develop a strategy to implement PrEP in anticipation of its potential general utility. NIAID will continue to provide input in this planning process.

## UPDATE ON DIABETES & SICKLE CELL

Ms. Lee: About a year and a half ago I worked with Dr. Griffin Rodgers and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to help address a problem that many of my constituents with sickle cell had experienced.

People with sickle cell who were diagnosed with diabetes and who were measuring their blood sugar levels with the common A1-C test, were getting faulty test results.

This lead to mismanagement of their disease and frequently created additional medical complications.

Working with NIDDK we helped identify the source of these errors. Labs were using A1-C blood sugar tests that reacted differently for individuals with a variant form of hemoglobin like sickle cell. And it wasn't just for African Americans. Individuals of Mediterranean and South Asian heritage were also susceptible to getting an unreliable reading.

Thanks to the NIDDK we helped roll out a public awareness campaign during Diabetes month, and new A1-C test protocols and standards have since been developed to factor in sickle cell and variant hemoglobin.

Can you provide an update on these efforts to educate the public about the potential problems with the A1-C test and to ensure that laboratories and doctors are using the new A1-C tests?

Dr. Rodgers: This is an important question and I thank the Congresswoman again for her leadership on this issue. NIH research has established the value of the hemoglobin A1c test (HbA1c) as a tool to help people with diabetes and their healthcare providers better monitor the course of diabetes treatment. The test also is also an enormous asset in research. In addition, the American Diabetes Association is expected soon to recommend its adaptation as a method for diagnosis of diabetes, in addition to its current use for assessing management of the disease. Such a recommendation would elevate even further the importance of the issue of the test's accuracy.

The problem is that some methods for assaying HbA1c have been shown to deliver inaccurate results in people with certain variants of hemoglobin, such as in people with sickle cell trait. The NIDDK has therefore published information about this issue through a press release (http://www.nih.gov/news/pr/nov2007/niddk-28.htm), development of a brochure for patients (http://diabetes.niddk.nih.gov/dm/pubs/traita1c/SickleCell-Booklet.pdf) and another for physicians (http://diabetes.niddk.nih.gov/dm/pubs/hemovari-A1C/SickleCell-Fact.pdf). We have continued to work to disseminate knowledge of the issue in the Winter 2008 edition of NIH Diabetes Dateline (http://diabetes.niddk.nih.gov/about/dateline/wint08/Diabetes_Newsltr_Winter08.pdf).

To try to promote the use of HbA1c test methods that provide accurate readings regardless of a patient's hemoglobin variant, the NIDDK and the Centers for Disease Control and Prevention have been supporting the National Glycohemoglobin Standardization Program (NGSP). Information on the NGSP website (http://www.ngsp.org/prog/index.html) highlights the test methods that give accurate results regardless of hemoglobin variant, so that patients and their doctors can inquire to make sure their diagnostic lab is performing the appropriate test.

To gauge progress in transitioning methods for assaying HbA1c in use by routine clinical laboratories it is helpful to look at proficiency survey data generated by the College of American Pathologists (CAP). These data tell us how many participating labs (~2700 in total participate in the CAP survey) are using each method. Not every lab in the US participates in this survey but it is the best and largest survey available in the US.

Based on the CAP survey we know that at the end of 2007, 12 percent of labs used methods that can yield inaccurate results when patients have the HbS and HbC variants, two of the more common ones. By the end of 2008, the number of labs using these methods had fallen to 9.4 percent. In interpreting this information, it is important to remember that some labs perform far more HbA1c assays than others, however, as more labs adopt the use of the better testing methods, it is hoped that more patients and their healthcare providers will have access to accurate tests.

Three of the five HbA1c assay methods that exhibit the hemoglobin variant problem are being improved by the companies that manufacture them so that they yield accurate results even with HbS and HbC. Because of this, we hope to see the fraction of labs using the problematic methods fall even further. The NIDDK will continue efforts to promote the importance of accurate HbA1c testing methods, to improve the health of all patients, including those with hemoglobinopathies.

## SUPPORT FOR NURSE SCIENTISTS AND FACULTY

Ms. Lee: According to the American Association of Colleges of Nursing, U.S. nursing schools turned away 49,948 qualified applicants from baccalaureate and graduate nursing programs in 2008.

Nursing schools responding to the survey pointed to faculty shortages as the top reason for not accepting all qualified applicants into nursing programs.

Recent data show a national nurse faculty vacancy rate of 7.6%. Most of the vacancies, 88.1%, were faculty positions requiring or preferring a doctoral degree.

Knowing that many of the nurse researchers in our country also serve as nurse faculty in our schools of nursing, what type of initiatives are being under taken to support our nation's aspiring nurse researchers and faculty?

Dr. Kington: National Institute of Nursing Research (NINR) training strategies seek to enhance the pipeline of a diversified nursing faculty, which will have a direct impact on improving the ability of schools of nursing to educate aspiring nurse scientists. These strategies focus on the training and early entry of these investigators into research careers. Ultimately, NINR trainees can go on to become nursing faculty and improve the ability of nursing schools to enroll and educate more nurses.

NINR supports innovative training programs such as the NINR Career Transition Award, in which awardees receive postdoctoral research training in

NINR intramural laboratories in Bethesda, Maryland, followed by two years of extramural support as they begin tenure-track faculty positions. NINR also participates in the NIH Pathway to Independence Award program, designed to shorten the amount of time trainees spend as post-doctoral fellows and to facilitate their transition to independent research careers. Awardees receive one to two years of mentored research training, followed by three years of independent support once the awardee has secured an independent research position.

In addition, NINR participates in the NIH Graduate Partnership Program (GPP), in which the Institute partners with individuals and schools of nursing to support the research training of doctoral students at the NIH intramural laboratories. NINR also supports the Summer Genetics Institute (SGI), an intensive research training program for nurse scientists at any stage of their career in order to expand scientific training in the field of genetics. Over 150 students have successfully completed this challenging program with a significant number of participants actively contributing to new scientific studies and research publications. NINR continues to devote substantial funding toward individual and institutional predoctoral and postdoctoral National Research Service Awards, about twice the percentage of most other Institutes and Centers at NIH. NINR, in conjunction with the Bravewell Collaborative and the NIH Clinical Center, will support postdoctoral fellows who will receive training in addressing key issues in integrative medicine research and multi-disciplinary collaboration. In addition, using funds provided by the American Recovery and Reinvestment Act of 2009, NINR will support summer research opportunities to encourage students at early stages of their education to pursue careers in the health related sciences. NINR will also continue to support career development opportunities for underserved and disadvantaged investigators. Such opportunities provide these new investigators an intensive, supervised career development experience in the nursing sciences leading to research independence.

Finally, every research grant supported by NINR presents an opportunity for nurses at the undergraduate, graduate, and post-doctoral level to be involved in research that directly impacts patient care and health outcomes. This clinical and basic research builds the scientific foundation for clinical practice, prevents disease and disability, manages and eliminates symptoms caused by illness, and enhances end-of-life and palliative care.

## INTERACTING AND ENGAGING MINORITY COMMUNITIES IN RESEARCH

Mr. Honda: My staff has heard from several community groups that NIH-funded researchers frequently do not engage communities in such a way that residents feel engaged in the decision making process about the kinds of research conducted. Also, the researchers frequently do not go back to the communities with the results of their work, leaving the communities frustrated and confused about the outcomes of the studies.

I would like to know if NIH gives any guidance to researchers on how to interact with and engage the communities in which they work and I would encourage you to reach out to the Office of Minority Health to discuss these complaints and find a solution.

Dr. Kington: The NIH is committed to addressing the multiple barriers limiting the full participation of minorities and other health disparity populations in NIH funded research, including their recruitment and retention in clinical trials. Your concerns are being addressed most directly through the National Center on Minority Health and Health Disparities (NCMHD) Community-Based Participatory Research (CBPR) Initiative. The CBPR initiative is a multiple-phase program requiring that health disparity communities and researchers work as equal partners in designing and implementing an intervention addressing a significant health issue within the community of the health disparity partner. Using the community participatory approach, the continued engagement of the community throughout all stages of the research process, including translation and dissemination of research findings are ensured, especially when the interventions are conceived, designed and pilot tested by both community and scientific partners. The partners can collaboratively identify and adopt an existing intervention, tailoring the intervention to the culture, values, practices, and language of the health disparity community.

Another program addressing this concern is the NCMHD Center of Excellence (COE) program. Most of the NCMHD COE contain a community engagement and outreach core. This core supports the establishment of partnerships between the academic institution and health disparity communities, for translating and disseminating health information to health disparity communities, and providing research training to community members. The partnerships established by the NCMHD COE to date are helping to ensure that findings generated by researchers funded by NCMHD and other NIH ICs are being incorporated into ongoing health promotion and prevention efforts.

## TUBERCULOSIS DISPARITIES RESEARCH

Mr. Honda: Tuberculosis continues to be a significant problem in the United States. Tuberculosis has a particularly significant impact on the Asian community which, according to the Centers for Disease Control and Prevention the tuberculosis rate

in 2006 was 25.6 per 100,000 and actually increased to 25.8 per 100,000, an increase of 3,295 cases in 2006 to 3,423 cases in 2007. This is the highest rate of any ethnic group in the United States and is nearly two-and-a-half times higher than the next highest ethnic group by rate. Given the increasing rates of multiple and extremely drug resistant TB, what initiatives is NIH currently undertaking to study the treatment of and disparities in rates of infection of tuberculosis?

Dr. Kington: The National Institute of Allergy and Infectious Diseases (NIAID) is the lead institute of the National Institutes of Health (NIH) for the conduct and support of research on TB. NIAID supports an extensive and robust TB research portfolio, including fundamental studies of TB and its causative agent, *M. tuberculosis*; translational studies that apply basic science findings to the identification and development of candidate drugs, vaccines and diagnostics; and clinical studies to evaluate new interventions and improved regimens of existing drugs. The Institute's broad efforts to develop new drugs, vaccines, and diagnostics for TB are aimed at reducing the overall global TB burden; however, NIAID does support studies to evaluate the effectiveness and utility of TB treatment in special populations such as incarcerated individuals, persons with HIV/AIDS, and children.

The Institute long has recognized that racial and ethnic differences affect susceptibility to infection and disease. Risk factors for acquiring TB include, among others, being born outside the United States in TB-endemic countries, being infected with HIV, having low socioeconomic status, and living in crowded conditions. NIAID investigators are learning that a number of barriers may contribute to lack of treatment success among ethnic minorities, including Asian/Pacific Islanders. One such barrier can be the considerable length of treatment and follow up required for effective clearance of the bacteria that cause TB. Typically, six to twelve months of antibiotic treatment therapy is required. Further, behavioral restrictions and considerable side effects of treatment may present additional barriers to compliance.

Strong correlations have been shown between TB infection among Asians and Pacific Islanders in the United States and the prevalence of TB in their foreign birthplace. NIAID researchers are directly addressing TB infection among Asians and Pacific Islanders by studying the disease in their countries of origin. For example, NIAID initiated a research protocol at the Masan National Tuberculosis Hospital in South Korea to study the natural history of MDR-TB. The Masan Hospital has the largest population of inpatient MDR-TB patients in the world. In addition, this cohort has provided the opportunity to study the occurrence of XDR-TB in patients who have completely failed chemotherapy.

"VALLEY OF DEATH" COMMERCIALIZING NIH RESEARCH RESULTS

Mr. Tiahrt: The American people have made a substantial and significant investment in NIH since 1998, when the agency's budget was just over $13 billion. Today, just over a decade later, NIH has total resources in excess of $40 billion. That sum of money clearly funds a great deal of research. However, I am concerned with what known as the "Valley of Death," where NIH-supported research reaches a point where it, for lack of a better term, withers on the vine.

What is NIH doing to help close the gap in this respect?

Dr. Kington: The Valley of Death refers to the period between target identification and early lead development and the delivery of a drug compound to the clinical trial phases leading to FDA approval. While drug development represents one means of translating NIH research to benefits in public health, this is not the only pathway to benefit our understanding of biology and disease. With respect to the Valley of Death, NIH has a number of approaches that will directly and indirectly improve the ability to move therapeutics into the marketplace:

1) Basic and applied research programs sponsored by the National Institute of General Medical Sciences (NIGMS) and others are working toward a better understanding of how compounds bind and cause effects, thereby providing tools that will increase the efficiency of drug design;

2) Research in pharmacogenomics and NIGMS' Pharmacogenomics Research Network (PGRN) will shed light on who will benefit from and who will experience adverse events as a result of treatment, again improving the ability to design trials showing safety and efficacy of medications and allowing more personalized treatments to be made available;

3) The Molecular Libraries Roadmap offers public sector biomedical researchers access to the large-scale screening capacity necessary to identify small molecules that can be optimized as chemical probes to study the functions of genes, cells, and biochemical pathways. This will lead to new ways to explore the functions of genes and signaling pathways in health and disease. NIH anticipates that these projects will also facilitate the development of new drugs, by providing early stage chemical compounds that will enable researchers in the public and private sectors to validate new drug targets, which could then move into the drug-development pipeline. This is particularly true for rare diseases, which may not be attractive for development by the private sector.

4) The NIH RAID (Rapid Access to Interventional Development) program makes available, on a competitive basis, certain critical resources needed for the development of new therapeutic agents. This program uses resources of NCI's Developmental Therapeutics Program and the National Heart Lung and Blood Institute's (NHLBI) Gene Therapy Resource Program. Services available include: production, bulk supply, GMP manufacturing, formulation, development of an assay suitable for

pharmacokinetic testing, and animal toxicology. Assistance also will be provided in the regulatory process, through access to independent product development planning expertise.

5) The RNDI (Rare and Neglected Disease Initiative) is a newly authorized effort coordinated through the Office of Rare Diseases at NIH, and will have as a focus the leveraging of the National Center for Chemical Genomics (part of the Molecular Libraries Activity described above) to enhance the ability to develop therapeutic interventions that may not be of interest to the pharmaceutical industry. Furthermore, there is an effort underway to explore the potential for partnership opportunities with outside entities such as patient advocacy groups, industry, and others to fill the need to advance new paradigms and processes for the development of therapeutics for rare and neglected diseases and their "safe passage" through the drug approval system. The benefits of this effort will include not only the development of beneficial interventions for patients with rare and neglected diseases, but also to develop new tools that may decrease the high attrition rate of new compounds going into the drug development process.

Mr. Tiahrt: For example, I am aware of an interesting concept at the Department of Energy called the "Entrepreneur in Residence" program. It is a commercialization initiative that aims to move viable technologies to the market by placing venture capital firms in a position to work directly with the national laboratories. I think it might be worthwhile for NIH to take a look at this concept to determine if perhaps this is something that will help bring biomedical research across the "Valley of Death" so that we can more effectively use the vast resources at NIH to cure diseases. I would be interested in NIH's thoughts on this concept.

Dr. Kington: With regard to the commercialization of NIH technologies, the Office of Technology Transfer is highly efficient and effective at identifying and disseminating access to NIH inventions. Their facilitation of roughly 400 new inventions reports per year, 300-400 new patent applications per year, about 250 new licenses of NIH technologies per year, and receipt of royalties of about $90M per year demonstrates the effectiveness of an approach which seeks to emphasize non-exclusive licensing to entities capable of making NIH inventions viable to improve the public health.

The Valley of Death is not due to insufficient exposure of research generated inventions, rather to the intrinsic difficulties in identifying molecular entities which will have the desired effects without inducing unacceptable adverse events. The need is for new tools to improve medicinal chemistry, new efficient and highly predictive high throughput screening methods, and novel clinical trial designs that can diminish the attrition rates from the current 90% and diminish drug development costs from a cost of nearly $1 over 12-15 years. Having an Entrepreneur in residence is unlikely to provide needed traction in these critical areas. Furthermore, the EIR programs have one or a small number of individuals placed in the agency and provide a right of first refusal for inventions and IP generated within government. This narrow access may impede the

ability of NIH to make biomedical discovery and inventions broadly available to the most likely parties able to bring them to the public.

## SMALL BUSINESS PARTICIPATION IN NIH'S FUNDING FROM THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

Mr. Tiahrt: The NIH recently announced that applications for $1.5 billion in Recovery Act Funds are now available, including at least $200 million for the new Challenge Grant Program. The Challenge Grant Program will support research on topic areas that address specific scientific and health research challenges in biomedical and behavioral research that would benefit from significant 2-year jump-start funds.

I noticed that small businesses are eligible to compete for this program. Given the current economic climate and the impact it is having on small biotechnology companies ability to continue to develop innovative treatments and therapies, let alone fund early-stage research projects, shouldn't the NIH have additional plans to allow small biotechnology companies to compete for NIH grants funded by the Recovery Act?

Dr. Kington: Yes. Small businesses are eligible to apply for the newly established Research and Research Infrastructure "Grand Opportunities," or "GO" grants in addition to Challenge Grant awards. Grand Opportunities are for applicants proposing to develop and implement critical research innovations to advance the research enterprise, stimulate future growth and investments, and advance public health and health care delivery.

The NIH also has announced administrative supplements and competitive revision (formerly known as "competitive supplements") funding opportunities for which small businesses with currently active SBIR or STTR grants are eligible. The supplement and revision programs are intended to provide continuity to ongoing science through targeted funding to current grants.

The NIH Institutes and Centers also will support recently peer-reviewed, meritorious SBIR and STTR applications from FYs 2008 and 2009 that were approved but not funded, if those applications meet the programmatic needs and scientific priorities of the individual Institute or Center.

For these reasons, we expect more NIH funds to be awarded to small biotechnology companies in FY 2009 than in prior years.

## THE RECOVERY ACT AND HIV/AIDS RESEARCH

Ms. Pelosi: The NIMH has long been a leader in research on behavioral approaches to HIV prevention. Given new CDC estimates of HIV infections in the US and the need to move to cost-effective, evidence-based approaches to the domestic challenges of HIV, this is an area of research where Recovery Act funding to accelerate the "pace and achievement of scientific research" could be highly productive. The AIDS portion of the NIMH budget for FY08 was about 17%. Does NIMH intend to expend Recovery Act funds proportionate to the FY08 allocation for the AIDS program? What specific plans does NIMH have to use Recovery Act funds to respond to this need? To what extent is the goal of developing, evaluating and disseminating social and behavioral interventions to prevent HIV acquisition and transmission part of the overall NIMH Strategic Plan?

Dr. Kington: HIV prevention has long been a priority research area for the National Institute of Mental Health, especially in light of the changing nature of the AIDS epidemic both domestically and internationally. As the disease has moved from an acute to a chronic condition due to the advent of effective treatments, there is greater need for cost-effective, evidence-based interventions to prevent adverse mental health consequences that can result from living with a chronic condition, and greater need for interventions designed to prevent transmission through high risk behaviors from those that are infected to those that are not. Funds from the American Recovery and Reinvestment Act (the Recovery Act) will be used by the Institute to create or retain jobs and accelerate scientific progress in a few priority areas, especially areas that have not been funded previously where two years of support can create an important resource or technology for future research. Estimated Recovery Act dollars to be invested in AIDS research is currently unknown. An estimate will be determined once applicants successfully compete in the peer review process and awards are made.

Nevertheless, HIV/AIDS research, especially the testing of cost-effective, evidence-based approaches towards prevention of HIV transmission and mental health consequences of HIV infection, is a priority area for the Institute. As such, investigators working in this area will have the opportunity to apply for funding through several of the Recovery Act initiatives. For example, in the NIH-wide Challenge Grants in Health and Science Program, the Institute has specified its interest in funding studies on: social networks and negative health behaviors related to HIV/AIDS; developing evidence–based practice guidelines for HIV prevention strategies; and, technologies to improve treatment adherence for mental disorders and HIV/AIDS. While the Institute invests significantly in research on the intersections between mental health and HIV/AIDS, it is important to note that the NIMH investment in HIV research is guided by an NIH-wide Strategic Plan coordinated through the NIH Office of AIDS Research.

WEDNESDAY, APRIL 1, 2009.

# PATHWAY TO HEALTH REFORM: IMPLEMENTING THE NATIONAL STRATEGY TO REDUCE HEALTHCARE-ASSOCIATED INFECTIONS

**WITNESSES**

**PANEL 1: DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**DR. DON WRIGHT, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**DR. RICHARD BESSER, ACTING DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION**

**DR. CAROLYN CLANCY, DIRECTOR, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY**

Mr. OBEY. Good morning, everybody.

Let me welcome our panelists for the hearing today.

We have a problem in this Country. When people go to the hospital, we hope that they are going to be made well. Instead, to put it bluntly, there are a hell of a lot of people who wind up being made sick and some of them dying.

CDC estimates that there are 1.7 million healthcare associated infections in American hospitals each year, with 99,000 associated deaths affecting 5 to 10 percent of hospitalized patients.

To me, that is absolutely shocking, when you read the literature and you see what simple steps could be taken in many cases to reduce this threat. We are spending billions of dollars and focusing an incredible amount of energy to prevent this Country from being hit by al Qaeda again. The average American has one hell of a lot better chance to be killed by a hospital infection than being impacted by al Qaeda.

When I look at the simple steps that could be undertaken in order to reduce this calamity, I am reminded of the old movie about Dr. Pasteur, who was simply trying to teach the medical profession to wash their hands. I know it is not that simple, but I do not believe that there has been a sufficient sense of urgency on this issue, either on the part of Congress or on the part of administrators throughout the government, and certainly on the part of health providers.

I remember Paul O'Neill, the first Secretary of the Treasury under President Bush, started to get interested in this issue in Pittsburgh and expressed frustration at how hard it was to move the needle.

So we are here today to talk about this problem. I have got a much longer, windier open statement than I care to deliver today, so let me simply say we are here to try to hear from these two panels about what we can do to solve a huge medical problem in this Country.

Before I call on the first panel, let me simply ask Mr. Tiahrt for whatever comments he might have.

Mr. TIAHRT. Thank you, Mr. Chairman. I want to welcome all the witnesses today. I would also like to point out that our Chairman has now served in the United States House of Representatives for 40 years, and I find that an incredibly great record, something to admire and——

Mr. OBEY. Some people might think it is horrifying. [Laughter.]

Mr. TIAHRT. Well, it is comforting to me to know that the national parks, which you love so dearly, have trees who have not been here as long as you have.

Mr. OBEY. Thanks a lot. [Laughter.]

Mr. TIAHRT. Mr. Chairman, this is a particularly interesting topic to me. There is a thought, when we go to the hospital, that we are going there to get well. Unfortunately, for 1.7 million people, they acquire an infection while they are in the hospital attempting to get better.

I know that the hospitals are very concerned about that and work to try to turn that around. Our job in this Committee, I think, is to determine how the Federal Government can assist, and not hinder, implementing safety protocols. Sometimes we make it more difficult, more complicated, more inefficient, and less responsive, and I think we do not have to do that. I think we can be assisting in this process, and hopefully that is what we will do.

I know that there is need for guidance and incentives from the experts at AHRQ, and the public needs the information from the CDC. But we need to find a balance that allows the providers to be innovative and flexible in their response, while keeping patients healthy.

I look forward to the testimony. I think this is a very important hearing.

I yield back.

Mr. OBEY. Thank you.

The first panel is made up of Department of Health and Human Services officials who are taking the lead in administering programs at the Federal level focused on understanding the problem: Dr. Don Wright, Principal Deputy Assistant Secretary for Health, U.S. Department of Health and Human Services; Dr. Richard Besser, Acting Director, Centers for Disease Control and Prevention; and Dr. Carolyn Clancy, Director, Agency for Healthcare Research and Quality.

Additionally, Dr. Thomas Valuck, Medical Officer and Senior Advisor to the Center for Medicare Management; and Mr. Thomas Hamilton, Director of the Surveys and Certification Group from the Centers for Medicare and Medicaid Services are available, I am told, in the first row immediately behind the witnesses, to answer questions if any of our panelists decides they want to duck a question or simply turn it over to somebody who can buttress their answer.

With that, why do we not proceed with Mr. Wright first?

## DR. WRIGHT'S OPENING STATEMENT

Dr. WRIGHT. Good morning, Chairman Obey, Ranking Member Tiahrt, and other distinguished members of the Committee. I am

Dr. Don Wright, the Principal Deputy Assistant Secretary for Health in the Office of Public Health and Science at the U.S. Department of Health and Human Services. Let me say I am pleased to be here today to describe HHS's efforts to reduce the rates of healthcare-associated infections and also the development of the HHS Action Plan to Prevent Healthcare-Associated Infections which was released in January 2009.

There are several agencies in HHS that have played a significant role in addressing this important public health challenge, including the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the Centers for Medicare and Medicaid Services.

Healthcare-associated infections are infections that patients acquire while receiving treatment for medical or surgical conditions. They occur in all settings, including hospitals and ambulatory surgical centers.

These infections are associated with a wide variety of causes, including the use of medical devices such as catheters and ventilators, from complications following surgical procedures, and from transmission between patients and healthcare workers. They exact a significant toll on human life and are among the top 10 leading causes of death in the United States.

In addition to the substantial human suffering caused by healthcare-associated infections, the financial burden attributable to these infections is staggering. Healthcare-associated infections result in an estimated $28,000,000,000 to $33,000,000,000 in excess healthcare dollars each year.

Despite these sobering facts, healthcare-associated infections are largely preventable. Broad implementation of prevention guidelines can result in reductions in healthcare-associated infections, which not only save lives and reduce suffering, but can result in healthcare cost savings as well.

## DEVELOPMENT OF THE HHS ACTION PLAN

Successful infection prevention and elimination efforts have been underway for years at the various agencies of HHS. However, in 2008, HHS began a Department-wide effort to approach this issue. HHS established a senior-level Steering Committee for the Prevention of Healthcare-Associated Infections last year in order to improve and expand HAI prevention efforts. The Steering Committee is chaired by me as the Principal Deputy Assistant Secretary for Health within the Office of Public Health and Science in the Office of the Secretary.

Last year, we were charged with developing the HHS Action Plan to Prevent Healthcare-Associated Infections in hospitals. The Plan establishes national goals and outlines key actions for enhancing and coordinating HHS-supported efforts, and also outlines opportunities for collaboration with external partners.

A critical step in the Action Plan development process was the identification of priority measures and five-year national prevention targets for assessing progress in HAI prevention. The targets serve to enable us to evaluate progress and focus prevention efforts in order to achieve the goals outlined in the Action Plan.

While there has been considerable activity across HHS related to the prevention of healthcare-associated infections, clearly, more work needs to be done. The Steering Committee will next focus its second tier efforts on the ambulatory surgical setting. Ambulatory surgical centers have been the fastest growing provider type participating in Medicare.

FY 2009 FUNDED ACTIVITIES OUTLINED IN THE ACTION PLAN

With the $5,000,000 in funding provided to the HHS Office of the Secretary in the fiscal year 2009 Omnibus Bill, OPHS plans to continue the valuable work of the HHS Steering Committee for the Prevention of Healthcare-Associated Infections. The Steering Committee will have the continued responsibility for coordinating implementation of the current Action Plan, monitoring progress in achieving the national goals of this plan, as well as leading tier two efforts. In addition, the Steering Committee is coordinating the use of HAI-related American Recovery and Reinvestment Act 2009 funds.

OPHS also plans to use the Omnibus funds to develop and implement a nationwide campaign to raise awareness of the importance of addressing healthcare-associated infections. The campaign will focus on empowering consumers to be active participants in preventing healthcare-associated infections and encouraging them to be more involved in their own healthcare. We acknowledge that some of the information on preventing HAIs may be too technical or not accessible for healthcare consumers, and we have identified health literacy as an important component of health communication to the consumer.

Remaining OPHS funds will be provided to a variety of interagency projects, all directly linked to the Action Plan. One such example is an information systems project designed to support a standards-based solution for integrating data collection across specific HHS data systems. The intent of this project is to use interoperability standards to reduce siloed departmental data systems and reduce data collection and reporting burdens for healthcare facilities.

Fifty million for HAI prevention was included in the ARRA funds. In a moment you will hear from Dr. Besser, my colleague, who will discuss how $40,000,000 of these ARRA funds will be spent to fund activities that support the Action Plan and benefit the States.

The remaining $10,000,000 will be used by CMS to improve the process and frequency of inspections of ambulatory surgical centers. The ARRA funds allocated by CMS will allow States to hire additional surveyors, which will increase the States' capacity to maintain expected levels of ambulatory surgical center inspections, while building a greater capacity to use an improved survey tool nationwide.

HEALTHCARE-ASSOCIATED INFECTION PREVENTION IN A REFORMED HEALTH SYSTEM

The investment of ARRA funds in the fiscal year 2009 appropriations represents critical investments that we believe show the value of how small investments can yield a large health impact.

The President has articulated that in order to reform healthcare, prevention, healthcare quality, and patient safety must also be priorities. Monitoring and preventing healthcare-associated infections is fundamental to protecting patients and improving healthcare quality. We at HHS are committed to strong partnerships between Federal, State, and local governments and communities to help prevent these infections.

Thank you for the opportunity to testify today and, at the appropriate time, I would be happy to answer any questions.

[The information follows:]

**Testimony**
**Before the House Committee on Appropriations**
**Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies**
**United States House of Representatives**

**Pathway to Health Reform:**
**HHS Action Plan to Prevent Healthcare-Associated Infections**

*Statement of*
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***Principal Deputy Assistant Secretary for Health***
***Office of Public Health and Science***
***Office of the Secretary***
***U.S. Department of Health and Human Services***

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**Introduction**

Good morning Chairman Obey, Ranking Member Tiahrt and other distinguished Members of the Committee. I am Dr. Don Wright, Principal Deputy Assistant Secretary for Health in the Office of Public Health and Science (OPHS) at the U.S. Department of Health and Human Services (HHS).

I am pleased to be here to describe HHS' efforts to reduce the rates of healthcare-associated infections (HAI) and the development of the HHS Action Plan to Prevent Healthcare-Associated Infections. There are several agencies within the Department that have played significant roles in addressing this important public health challenge, including the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Medicare and Medicaid Services (CMS). My colleagues from CDC and AHRQ are here today to talk about the considerable work occurring in their agencies with respect to the prevention of healthcare-associated infections. My CMS colleagues are also here to address any questions you may have about the healthcare-acquired infection prevention initiatives that CMS is implementing.

Today, I will focus my remarks in four specific areas: (1) the development of the HHS Action Plan to Prevent Healthcare-Associated Infections; (2) the future direction of the coordinated HHS effort; (3) how the American Recovery and Reinvestment Act of 2009 (ARRA) and the Fiscal Year (FY) 2009 Omnibus Bill funds will support prevention activities outlined in the Action Plan; and (4) how prevention activities improve healthcare quality in a reformed health system.

**Background**

Healthcare-associated infections (HAI) are infections that patients acquire while receiving treatment for medical or surgical conditions. Healthcare-associated infections occur in all settings of care including hospitals, same-day surgical centers, ambulatory outpatient care clinics, and long-term care facilities, such as nursing homes and rehabilitation centers. The infections are associated with a variety of causes including the use of medical devices, such as catheters and ventilators, complications following surgical procedures, and transmission between patients and healthcare workers.

Healthcare-associated infections exact a significant toll on human life. They are among the top ten leading causes of death in the United States, accounting for an estimated 1.7 million infections and 99,000 associated deaths in 2002.[1] In hospitals, they are a significant cause of morbidity and mortality.

In addition to the substantial human suffering exacted by healthcare-associated infections, the financial burden attributable to these infections is staggering. It is estimated that healthcare-associated infections incur an estimated $28 to $33 billion in

[1] Klevens RM, Edwards J, Richards C, Horan T, Gaynes R, Pollock D, Cardo D. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports* 2007; 122:160-166.

excess healthcare costs each year.[2] Despite the sobering facts, healthcare-associated infections are largely preventable and can be drastically reduced in order to save lives and avoid excess costs. Recent research efforts in Pennsylvania supported by AHRQ and CDC have shown that implementation of HAI prevention recommendations can reduce healthcare-associated bloodstream infections by as much as 70 percent for bloodstream infections through targeted approaches.[3,4] Broad implementation of prevention guidelines can result in reductions in healthcare-associated infections, which will save lives and reduce suffering. The growing demands on the healthcare system, coupled with concerns of antimicrobial-resistant pathogens and rising healthcare costs, reinforce the imperative to address this issue.

**Development of the HHS Action Plan to Prevent Healthcare-Associated Infections**

In recognition of this important public health and patient safety problem, HHS has developed a comprehensive plan to prevent healthcare-associated infections over the next several years. Successful infection prevention and elimination efforts have been underway for years across the various agencies within HHS. However, in 2008, HHS began a concerted, Departmental-wide effort to approach this issue. The goal of the effort was to marshal the extensive and diverse resources of HHS and cooperate effectively with public and private sector partners to accomplish the large-scale prevention of healthcare-associated infections.

In March 2008, the Government Accountability Office (GAO) completed a review of healthcare-associated infections in hospitals.[5] The GAO acknowledged HHS-supported efforts, but noted a lack of centralized coordination of activities in order to appropriately leverage resources across the Department. The report encouraged HHS to further its leadership of preventing healthcare-associated infections through enhanced coordination of all intervention activities. In particular, the report directed the Department to (1) prioritize existing recommended infection control practices to facilitate their implementation in healthcare facilities and (2) reduce "silos" across its Operating Divisions with regards to the various information technology systems used to measure healthcare-associated infections. While there are numerous systems and databases collecting HAI-related data across HHS, the GAO noted a need for greater consistency and compatibility of the data to enhance the information provided, including data used to obtain reliable national estimates of the major types of healthcare-associated infections.

In order to improve and expand HAI prevention efforts, the Department established the Steering Committee for the Prevention of Healthcare-Associated Infections in the summer of 2008. The Steering Committee included senior-level representatives from the

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[2] Scott Rd. The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, 2009. Division of Healthcare Quality Promotion, National Center for Preparedness, Detection, and Control of Infectious Diseases, Coordinating Center for Infectious Diseases, Centers for Disease Control and Prevention, February 2009.

[3] MMWR. Reduction in Central Line--Associated Bloodstream Infections Among Patients in Intensive Care Units --- Pennsylvania, April 2001--March 2005. October 14, 2005 / 54(40); 1013-1016.

[4] Pronovost P, Needham D, Berenholtz S, et al. An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU. N Engl J Med 2006; 355:2725-2732.

[5] United States Government Accountability Office. Health-Care-Associated Infections in Hospitals. GAO-08-283, Washington, DC, April 2008.

Offices and Operating Divisions of HHS, including AHRQ, the Office of the Assistant Secretary for Public Affairs, the Office of the Assistant Secretary for Planning and Evaluation, CDC, CMS, the Food and Drug Administration (FDA), the National Institutes of Health (NIH), and the Office of the National Coordinator for Health Information Technology (ONC). The Steering Committee was chaired by me as the Principal Deputy Assistant Secretary for Health within OPHS which is within the Office of the Secretary (OS). The HHS Deputy Secretary charged the Steering Committee with developing the Action Plan to Prevent Healthcare-Associated Infections. This plan established national goals and outlined key actions for enhancing and coordinating HHS-supported efforts. In addition, the plan outlined opportunities for collaboration with external partners.

The Steering Committee utilized a working group structure to accomplish its charge. The working groups were each led by one or two agencies and comprised of subject matter experts across the Department. Each of the five working groups enumerated strategies for accomplishing a portion of the Action Plan:

- The *Prevention and Implementation* group, in partnership with HHS' Healthcare Infection Control Practices Advisory Committee (HICPAC), prioritized existing recommended clinical practices to facilitate implementation in healthcare organizations;
- The *Research* group identified gaps in the existing knowledge base of current infection control practices and developed a coordinated research agenda to strengthen the science for infection control and prevention in hospitals;
- The *Information Systems and Technology* group established a plan to progress towards the standardized measures and definitional data alignment needed to measure healthcare-associated infections across agencies and provided opportunities to make the varied HHS data systems interoperable to enhance understanding of healthcare-associated infections;
- The *Incentive and Oversight* group explored opportunities for evaluating compliance with infection control practices in hospitals through certification processes required for Medicare participation and identified additional options for the use of payment policies and financial incentives to motivate organizations to provide better, more efficient care; and
- The *Outreach and Messaging* group developed a plan for national messaging regarding HAI prevention to raise awareness among various stakeholder groups across the United States with particular emphasis on empowering healthcare consumers to be active participants in preventing healthcare-associated infections.

Given the substantial breadth and depth of healthcare-associated infections, the Steering Committee decided to concentrate its activities on a first tier of six high priority HAI-related areas within the acute care hospital setting. Surgical site infections, central line-associated bloodstream infections, ventilator-associated pneumonia, and catheter-associated urinary tract infections account for approximately three quarters of healthcare-

associated infections in the acute care hospital setting.[6] Thus, these four infection categories were included in the initiative's first tier.

In addition, the Steering Committee believed it was important to address emerging HAI issues, and therefore decided to include two organism specific priorities: *Clostridium difficile,* as well as methicillin-resistant *Staphylococcus aureus* (MRSA) in its first tier efforts. A recent publication demonstrated that *Clostridium difficile* is occurring almost as frequently in the hospital setting as MRSA, impacting resource use and inpatient mortality.[7] Methicillin-resistant *Staphylococcus aureus* was addressed as a causative organism, given its contribution to the four HAI priority procedures. While remaining aware of the larger issues regarding HAI prevention, including settings outside of the hospital, the initial development phase of the Action Plan focused on the hospital setting, four site-specific infections, and two emerging organisms defined in the first tier.

A critical step in the Action Plan development process was the identification of priority measures and five-year national prevention targets for assessing progress in HAI prevention. The targets serve to enable the Department to evaluate progress and focus prevention efforts, including priority setting and task assignment, in order to efficiently achieve the goals outlined in the Action Plan. Recognizing the importance of working synergistically with partners, the primary measures selected by the Steering Committee complement and support existing national measures and targets identified and/or adopted by key national stakeholder organizations. Shared measures promote the efficiency of all organizations working to prevent healthcare-associated infections and discourage unnecessary duplication of efforts. In addition, the Steering Committee sought to coordinate measure identification and target setting with existing Departmental initiatives, including Healthy People 2020, a science-based, 10-year list of national objectives for promoting health and preventing disease.

The Action Plan was issued in January 2009. Concurrently, comments were invited from the public in order to further engage stakeholders and solicit input on how to enhance the Action Plan and establish priorities for HAI prevention. Notices were placed on the Department's website, posted in the Federal Register, and sent to key partners in order to obtain valuable input. The initial comment period closed in early February 2009 with receipt of comments from professional organizations, businesses, and individual healthcare consumers. Substantial comments were received from all major stakeholder organizations. The feedback received was positive with many organizations applauding the government for its work in coordinating activities and establishing prevention priorities across the Department, as well as for developing the Action Plan in such a short period of time. Also, several organizations and individuals noted they were pleased that the issue had risen to the level of national importance it had.

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[6] Klevens RM, Edwards J, Richards C, Horan T, Gaynes R, Pollock D, Cardo D. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports* 2007; 122:160-166.

[7] Elixhauser A and Jhung M. Clostridium Difficile-Associated Disease in U.S. Hospitals, 1993–2005. *AHRQ Healthcare Cost and Utilization Project Statistical Brief* 2008; 50:1-11.

**Future Direction of the HHS Healthcare-Associated Infections Prevention Effort**

While there has been considerable activity across HHS related to the prevention of healthcare-associated infections, more work needs to be done. The Department is in the process of synthesizing the comments received from the public and revising the Action Plan in the spring of 2009. In addition, we are planning three public engagement meetings for the spring and summer of 2009 to connect with healthcare consumers and receive additional input on the Action Plan. The first meeting will be held in Washington, DC in the spring with the others to follow in locations across the country.

The Steering Committee resumed meetings in March 2009 with the purpose of implementing the steps outlined in the Action Plan and commencing discussions on the next tier of the effort. Recognizing the dramatic expansion of healthcare provision in outpatient settings, the Steering Committee will focus its second tier efforts on the ambulatory care setting. Ambulatory Surgical Centers (ASCs) have been the fastest growing provider type participating in Medicare, increasing in number by more than 61 percent between 2000 and the start of 2009.[8] It is estimated that Ambulatory Surgical Centers performed 14.9 million procedures in 2006 or 43 percent of all same-day surgeries.

**FY 2009 Funded Activities Outlined in the Action Plan**

OPHS, consistent with its leadership role in developing the HHS Action Plan to Prevent Healthcare-Associated Infections, will continue to provide coordination and oversight of the overall Departmental healthcare-associated infections prevention effort. With the $5 million in funding provided to the OS in the FY 2009 Omnibus Bill, OPHS plans to continue the valuable work of the HHS Steering Committee for the Prevention of Healthcare-Associated Infections and provide the necessary leadership, coordination, and infrastructure for supporting the Steering Committee's activities. The Steering Committee will have the continued responsibility for coordinating implementation of the Action Plan across the Department and monitoring and tracking progress in achieving the national goals outlined in the Action Plan, as well as for commencing second tier efforts. In addition, the Steering Committee will continue to coordinate the use of HAI-related ARRA funds.

As outlined in the Action Plan, OPHS also plans to use the FY 2009 funds provided in the Omnibus to develop and implement a national campaign to raise awareness of the importance of addressing healthcare-associated infections. Outreach efforts will include gathering healthcare providers from various healthcare institutions for regional stakeholder meetings to get their input on how to best address HAI prevention. The campaign will also focus on empowering consumers to be active participants in preventing healthcare-associated infections and encouraging them to be more involved in their own healthcare. The campaign could include creative uses of new media, television, radio, and print announcements, as well as the development and dissemination of an HAI prevention toolkit.

[8] CMS Survey & Certification (S&C) Providing Data Quickly (PDQ) Database.

Funds will also be provided to inter-agency projects designed to support the development and deployment of a standards-based solution for integrating data collection across specific HHS data systems. The intent of these projects is to use interoperability standards to reduce "siloed" Departmental data systems, reduce data collection and reporting burdens for healthcare facilities, and progress towards the achievement of broader goals, including the wide-scale adoption of electronic health records. In addition to positioning the Department to be better able to leverage information technology resources to prevent healthcare-associated infections, these projects directly address the concerns raised in the GAO report.

In addition, funds will be provided to CDC to collaborate with AHRQ and CMS as described in the Action Plan and develop systematic processes, based on health services research findings and cost benefit analyses for ongoing prioritization of CDC prevention recommendations, identifying those recommendations in which investments will yield the greatest potential benefits to patient safety. Additional FY 2009 funds provided in the Omnibus will be provided to CMS to perform an inter-agency (AHRQ/CDC/CMS) evaluation of the Medicare Hospital-Acquired Conditions (HAC) payment policy, which was also discussed in the Action Plan.

The ARRA included $50 million for HAI prevention. The Steering Committee deliberated over the best use of these monies, which were strictly defined to be distributed to the states, and jointly decided on the most appropriate projects to fund. In a moment, you will hear from Dr. Besser who will describe how $40 million of these ARRA funds will be spent to support activities outlined in the Action Plan to benefit the states. The remaining $10 million will be used by CMS to rollout a new infection control survey instrument for inspections of Ambulatory Surgical Centers. Inspections have proven to be potent deterrents to relaxed infection control practices and thus have much potential for preventing healthcare-associated infections.

To help prevent serious infections resulting from services performed in Ambulatory Surgical Centers, CMS will use the funds provided in the ARRA to implement the nationwide application of a new infection control survey tool developed in consultation with CDC and a case tracer methodology that tracks a patient's care from admission to discharge. In addition, CMS will use the ARRA funds to survey Ambulatory Surgical Centers using this survey application at the rate of approximately once every three years during this national pilot.

A CMS/CDC pilot program tested the enhanced survey process in Maryland, Oklahoma, and North Carolina in 2008 and demonstrated superior results in the ability to detect deficient infection control practices. The particular focus on Ambulatory Surgical Centers for this funding was chosen because the available infection control tool was developed for Ambulatory Surgical Centers and because of the likely continuing infection control deficiencies in this setting.

The primary use of these dollars will be to pay for the expansion of Ambulatory Surgical Center surveys (both in quality, time, and number) using the new infection control tool and case tracer methodology. The funds will allow states to hire additional surveyors (one to four per state dependent upon Ambulatory Surgical Center growth), which will increase a state's capacity to maintain expected levels of Ambulatory Surgical Center inspections while building greater capacity to use the improved survey tool nationwide. In recent years, funding for survey and certification activities supported recertification of Ambulatory Surgical Centers once every ten to fourteen years;[9] this new funding will enable CMS to perform targeted survey and certification activities much more frequently.

**Healthcare-Associated Infection Prevention in a Reformed Health System**

The administration has made the expansion of affordable healthcare a priority. Access to healthcare is essential for improving the health of the population and the competitiveness of American businesses. The President has articulated that in order to reform healthcare, prevention, healthcare quality, and patient safety must also be priorities.

Monitoring and preventing healthcare-associated infections is fundamental to protecting patients and improving healthcare quality. The investment of the ARRA and the FY 2009 appropriations represent critical investments that can yield quantifiable health impact. Moreover, improving the oversight of inspections in outpatient settings provides a baseline of protection where healthcare delivery has expanded dramatically over the previous decade. As care has exploded in outpatient settings, oversight of these facilities has not kept pace. If ambulatory surgical centers or any healthcare provider compromises on the fundamentals of safe practice -- such as the safe delivery of injections and medications – patients will suffer the consequences.

If we are to succeed in expanding access to healthcare, we must ensure that the healthcare delivered is safe and effective. Just as healthcare delivery and care are dynamic processes that evolve with the emergence of new treatments and technologies, so too must HAI prevention and patient safety evolve. The sources and routes of tomorrow's infections are unknown. Thus, we must remain vigilant in our monitoring of healthcare-associated infections and consistent in our application of evidence-based HAI prevention recommendations. The President has articulated that we must improve both access and quality in healthcare; HHS is dedicated to seeing that these goals are achieved.

Thank you for the opportunity to testify today; I am happy to take any questions you may have.

[9] CMS FY 2009 Congressional Justification, page 65.

## Principal Deputy Assistant Secretary for Health

### Biography of Don Wright, M.D., M.P.H.
### Principal Deputy Assistant Secretary for Health
### U.S. Department of Health and Human Services

Dr. Don Wright became the Principal Deputy Assistant Secretary for Health on December 10, 2007. Dr. Wright acts as an advisor to the Assistant Secretary for Health on matters involving the nation's public health and science. His responsibilities include planning and execution of public health policy as it relates to disease prevention, health promotion, women's and minority health, the reduction of health disparities, the fight against HIV/AIDS, blood safety, and pandemic influenza planning. Dr. Wright also has broad management and policy responsibility for the HHS Office of Public Health and Science.

Prior to becoming the Principal Deputy Assistant Secretary for Health, Dr. Wright served as the Director of the Office of Occupational Medicine for the Occupational Safety and Health Administration (OSHA). As a result of his leadership, OSHA now recognizes impairment with drug and alcohol as an avoidable workplace hazard and recommends the adoption of Drug Free Workplace Programs as part of a comprehensive occupational health and safety program.

In response to the 9/11 terrorist attack and Hurricane Katrina, Dr. Wright organized and moderated nationwide conferences focused on enhancing hospital emergency preparedness for natural disasters, acts of terrorism and pandemic influenza. While at OSHA, Dr. Wright developed strong collaborative working relationships with the Centers for Disease Control and Prevention, the American Red Cross, the Joint Commission on Accreditation of Healthcare Organizations, and the American Heart Association on issues related to health and safety.

As a clinician, Dr. Wright dedicated himself to the prevention of injuries and illnesses. During his 15 years in the private sector, Dr. Wright maintained an extensive clinical and consulting practice in Central Texas.

Dr. Wright received his undergraduate degree from Texas Tech University and his medical degree from the University of Texas. Dr. Wright completed his family medicine residency training at Baylor College of Medicine. In addition to his medical degree, Dr. Wright holds a Master of Public Health degree from the Medical College of Wisconsin. He is board certified in both Family Medicine and Preventive Medicine and is a fellow of the American College of Occupational and Environmental Medicine and the American Academy of Family Physicians.

DR. BESSER'S OPENING STATEMENT

Mr. OBEY. Dr. Besser.

Dr. BESSER. Thank you. Good morning, Chairman Obey, Ranking Member Tiahrt, and other distinguished members of the Subcommittee. I am Richard Besser, Acting Director of the Centers for Disease Control and Prevention, and it is my pleasure to be here today to share with you CDC's plans for utilizing the funds provided by Congress through the American Recovery and Reinvestment Act of 2009 and the fiscal year 2009 Omnibus Appropriations regarding the prevention of healthcare-associated infections.

I respectfully ask to have my written statement included for the record.

Healthcare-associated infections are a serious and pervasive public health concern. Mr. Chairman, as you noted, these infections occur in all types of healthcare settings, including hospitals, long-term care facilities, and ambulatory surgical care facilities.

There are approximately 1.7 million healthcare-associated infections, or HAIs, per year in U.S. hospitals alone, and they are associated with 99,000 deaths. They have a tremendous financial toll, resulting in an estimated $28 billion to $33 billion of excess healthcare costs per year.

Almost everyone knows someone who has been affected by healthcare-associated infections. We have all heard stories of a co-worker, a friend, or a loved one who has entered the healthcare system with one problem, only to acquire a life-threatening, potentially preventable infection. Such stories speak to the heart of the HAI problem.

The good news is that most of these infections are preventable, and CDC has made significant progress in developing effective prevention guidelines, tools, and strategies. CDC is fully committed to achieving the national goals and targets of the Department of Health and Human Services Healthcare-Associated Infections Action Plan and will continue to work collaboratively with our sister agencies to assure our collective success. The funds provided in the Recovery Act will supply much-needed investments to move toward the elimination of these infections.

CDC plans to distribute approximately $40 million of these funds dedicated to healthcare-associated infections, which will be available to States, the District of Columbia, and Puerto Rico. These investments will complement investments made by HHS and the Agency for Healthcare Research and Quality, and will ramp up State and local efforts to support prevention efforts by doing three things:

First, creating or expanding State-based healthcare-associated infection prevention collaboratives; they will implement HHS recommendations and use CDC's National Healthcare Safety Network system or standards to measure outcomes and prevent these infections. These collaboratives will include State hospital associations, Medicare quality improvement organizations, and other partners, and will link to complementary activities supported by AHRQ and CMS.

Second, enhancing State abilities to assess where these infections are occurring and evaluate the impact of hospital-based interventions in other healthcare settings.

And, third, building a public health workforce and health departments with the knowledge base and expertise who can lead Statewide initiatives to ensure progress towards the national prevention targets outlined in the HHS Action Plan.

CDC will also use the Recovery Act funds to expand the use of CDC's National Healthcare Safety Network and to enhance data validation in States. The Safety Network is a secure Internet-based surveillance system that provides a way to track, analyze, and interpret data on healthcare-associated infections. The Safety Network provides standard definitions and protocols for tracking and reporting these infections. It allows tracking of prevention practices and infections rates, and it provides tools for data analysis.

Partially due to State legislation, participation in the Safety Network has increased dramatically in the past few years, from less than 500 in 2007 to presently over 2,200 U.S. healthcare facilities in all 50 States. Demonstrating the Network's success as a prevention tool, from 1997 to 2007, participating hospitals have decreased bloodstream infections by up to 50 percent.

CDC will use the Recovery Act funds to support new activities in the State-based emerging infections program to support targeted efforts to monitor and investigate the changing epidemiology of these infections in populations as a result of prevention collaboratives. As these collaboratives move forward, the epidemiology of these infections will change.

Reporting through the Safety Network will provide a picture of these infections in hospitals, and increasingly in long-term care facilities and ambulatory surgical centers. Emerging infections program findings will provide us with additional insight into the impact of Recovery Act-funded prevention activities, especially outside of the hospital setting.

In summary, the Recovery Act funds will be invested in State efforts that support surveillance, improve healthcare quality, encourage collaboration, train the workforce in HAI prevention, and measure outcomes. Many of these funds will be used to support activities outlined in the HHS Action Plan which was released in January of 2009.

Based on the success that CDC and AHRQ have seen in local, regional, and national initiatives, we anticipate a 10 percent to 20 percent reduction in healthcare-associated infections within two years of the successful implementation of the State-based collaboratives.

CDC's 2009 Omnibus funds will complement Recovery Act funding by expanding and enhancing the capabilities of the Safety Network, as well as rapidly expanding efforts in States to validate these data. This will enable CDC to improve the Safety Network electronic reporting and thus reduce the burden of data collection while increasing interoperability across agency data systems.

In the future, electronic reporting will be a key component of ensuring data validity and assessing the impact of HAI prevention efforts in both hospital and outpatient settings. CDC will also pro-

vide technical support for the National Healthcare Safety Network implementation to all States.

In addition, CDC's injection safety funding will be used to ensure that infection control measures are adhered to through collaborations with the Centers for Medicare and Medicaid services in support of their Recovery Act-funded activities in outpatient settings that Dr. Wright just described.

The Recovery Act and Omnibus appropriations make investments in healthcare-associated infection and prevention and healthcare quality that form the foundation of a national effort to improve the U.S. healthcare system. Small investments made across States can yield a large impact by preventing thousands of new infections in deaths and billions in unnecessary costs for patients and the healthcare system.

We expect that with these investments, many more infections will be prevented, many lives will be saved, and we will not have as many sad stories to tell.

Thank you for holding this hearing on this important health issue. I would be happy to answer any questions at the appropriate time.

Mr. OBEY. Thank you.

[The information follows:]

Testimony before the
Committee on Appropriations,
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies,
United States House of Representatives

# CDC's Role in Preventing Healthcare Associated Infections

*Statement of*
**Richard E. Besser, M.D.**
*Acting Director*
*Centers for Disease Control and Prevention*
*U.S. Department of Health and Human Services*

CENTERS FOR DISEASE CONTROL AND PREVENTION

**For Release on Delivery**
**Expected at 10:00 am**
**April 1, 2009**

**Background:**

Good morning Chairman Obey, Ranking Member Tiahrt, and other distinguished Members of the Subcommittee. I am Dr. Richard E. Besser, Acting Director of the Centers for Disease Control and Prevention (CDC), and it is my pleasure to be here today. CDC appreciates the opportunity to address this timely issue.

In the area of healthcare associated infections (HAIs), CDC defines and monitors the size and scope of the HAI problem, determines who is at risk, develops strategies to prevent infections, and tests the impact of existing interventions. I look forward to discussing with you CDC's activities directed toward preventing healthcare-associated infections. These activities can be categorized as: 1) tracking and monitoring HAIs; 2) developing guidelines for prevention; 3) implementing prevention strategies; 4) developing new strategies for prevention; and 5) identifying and responding to new and emerging threats. CDC is committed to these activities in alignment with the Department of Health and Human Services (HHS) Action Plan to Prevent Healthcare Associated Infections and through collaborations with other agencies and partners. I will also share with you information surrounding the HAI spending plans under the American Recovery and Reinvestment Act and FY2009 Omnibus, as well as implications for the future of HAI in our health system.

Healthcare associated infections are infections that patients acquire while undergoing care in any healthcare setting, including hospitals, long-term care facilities and ambulatory surgical care facilities. CDC estimated in 2002 that approximately 1.7 million HAIs occurred annually in U.S. hospitals, affecting five to ten percent of patients, and are associated with 99,000 deaths. There has also been a rapid increase in complexity and number of healthcare procedures being performed in settings outside of hospitals that have led to life-threatening infections.

Based upon CDC data, the four most frequent infections that account for approximately three quarters of HAIs are: 1) urinary tract infections; 2) surgical site infections; 3) bloodstream infections; and 4) pneumonia. Infections are caused by well-recognized pathogens such as *Staphylococcus aureus*, including MRSA, and by evolving pathogens such as drug-resistant *Klebsiella pneumoniae*. HAIs also have a tremendous financial toll, resulting in an estimated $28 to $33 billion of excess healthcare costs each year. However, despite their pervasiveness, most HAIs are preventable. CDC and its public and private sector partners are working together to prevent these costly and deadly infections that threaten the public's health.

The HHS Action Plan sets specific targets for monitoring and preventing HAIs nationally and represents a blueprint for prevention. CDC has played an integral role in the HHS led effort to develop and implement the HHS Action Plan, including chairing the Prevention and Implementation working group and co-chairing the Information Systems and Technology working group. In September 2008, CDC hosted a meeting of experts to help define prevention targets and metrics for the Action Plan. CDC continues to work closely with HHS and the other agencies to implement the plan.

**Summary of CDC Activities in HAIs: Tracking and Monitoring HAIs**

Leading the nation's activities to track HAIs, CDC emphasizes the importance of these activities to understand the impact of HAIs across the population and in communities. CDC has developed and validated standardized definitions for tracking HAIs and mechanisms to compare facilities and regions that are now used by most hospitals in the United States, and by many hospitals around the world. The National Healthcare Safety Network (NHSN), formerly the National Nosocomial Infection Surveillance (NNIS) System, is a tracking and prevention tool for hospitals and state health departments to measure HAIs. Participation in NHSN has increased dramatically in the past few years from 300 to over 2,000 U.S. healthcare facilities in all 50 states. This represents roughly 1/3 of all U.S. hospitals. The network is expected to continue to expand in order to accommodate local, state, and federal HAI reporting initiatives and state legislative mandates.

NHSN has multiple modules and allows healthcare facilities, as well as states, to track both infection prevention safety practices and infection rates. NHSN also has a broad set of analytic tools to enable users to evaluate the effectiveness of interventions and thereby focus prevention strategies. Additional options include the system's ability to track MRSA and other multidrug resistant organisms like *Clostridium difficile* infections (CDI).

In recent years, many states have passed laws requiring reporting of facility-specific HAI data to state health departments with public disclosure of infection rates. Currently, 27 states mandate hospitals to report HAIs publicly, the majority of which use NHSN. CDC provides training, technical assistance and data analysis to the 19 states that are using NHSN to fulfill state reporting requirements and assists states that are considering legislation to mandate public disclosure of HAI data. CDC's support has been critical in improving state efforts to implement evidence based best practices regarding reporting.

In order to decrease time for data collection and to increase data accuracy, CDC is improving its ability to capture data from electronic sources in an automated fashion. As part of the HHS Action Plan, NHSN will be used for measurement of outcomes, standardization of data, and comparisons of individual healthcare facilities within states and collaborative groups, and within the national user data.

**Summary of CDC Activities in HAIs: Developing Guidelines for HAI prevention**

CDC in collaboration with the HHS Healthcare Infection Control Practices Advisory Committee (HICPAC) has developed evidence-based guidelines for HAI prevention. These guidelines are translated into practice in several ways, and are the basis for the 'checklists' developed and implemented by multiple groups in hospital settings for the prevention of HAIs. These include those activities funded by Agency for Healthcare Research and Quality (AHRQ) research funds. They have also served as the basis for national healthcare quality initiatives such as the Institute for Healthcare Improvement's 100,000 Lives Campaign and the Centers for Medicare and Medicaid Services (CMS) Surgical Care Improvement Project. Several of these evidence-based recommendations have also been incorporated into Joint Commission standards for accreditation

of U.S. hospitals and have been endorsed by the National Quality Forum. CDC helped to shape the development of national prevention targets and metrics for the HHS Action Plan, including identification of priority recommendations from CDC guidelines for implementation within the plan. In addition to developing guidelines, CDC also develops and disseminates educational materials and toolkits for healthcare providers and the public.

**Summary of CDC Activities in HAIs: Implementing Prevention Strategies**

Implementation of CDC guidelines has been shown to successfully prevent and reduce HAIs. For example, through CDC supported efforts in Southwestern Pennsylvania, local hospitals have reduced bloodstream infections by as much as 70 percent. Similar success was observed when Michigan fully implemented CDC guidelines in an AHRQ funded project in more than 100 ICUs.

CDC and its partners have translated successful pilot projects at the local level into regional and ultimately national implementation programs. CDC funded and collaborated with the Pittsburgh Veterans Affairs Medical Center to prevent MRSA infections using CDC recommendations. These efforts led to greater than 60 percent reductions in MRSA rates. Because of this success, healthcare facilities in southwestern Pennsylvania collaborated on the development of a regional MRSA initiative and subsequently, the Veterans Health Administration launched a national MRSA prevention initiative involving every Veterans Health Administration hospital in the country, modeled after Pennsylvania's success. In order to increase adherence to CDC recommendations, CDC is working with several groups to assess the effectiveness of many other successful implementation strategies, such as Positive Deviance strategies. These and other prevention implementation examples demonstrate the savings in lives and healthcare costs that can result from national implementation of evidence-based HAI prevention programs.

CDC and its partners are working together to prevent infections caused by *Clostridium difficile* (CDI) in Ohio hospitals and nursing homes. In concert with CDC, the Ohio Hospital Association, the Ohio Department of Health, and the Ohio Prevention Epicenter are implementing a set of tiered interventions to reduce CDI rates using by NHSN definitions for reporting. This is one of the first and largest CDI prevention collaboratives to date, and demonstrates the preventability of CDI among a large cohort of hospitals while helping to define the most effective strategies for prevention.

In addition to monitoring, NHSN also proves to be an effective prevention tool. Since 1990, facilities reporting to NHSN have seen significant reductions of up to 70 percent in rates of catheter associated urinary tract infections (CAUTI) in ICUs. From 1997 to 2007, hospitals participating in CDC's NHSN have decreased bloodstream infections by up to 50 percent. A total of 10,600 device-associated infections are estimated to have been prevented, and at least 1,300 lives are estimated to have been saved.

Several states have implemented initiatives based on CDC guidelines and included the use of NHSN to monitor HAI rates. For example, in New York, the Greater New York Hospital Association used CDC guidelines as the basis for their prevention initiatives, one of which

focused on incrementally building the infrastructure needed for prevention of bloodstream infections and other future prevention initiatives.

**Summary of CDC Activities in HAIs: Developing New Strategies for Prevention**

CDC supports the identification and evaluation of effective HAI prevention strategies and funds extramural research through a network of academic centers, called the Prevention Epicenter Program. The Epicenters work in a collaborative manner to identify new ways to improve infection control and healthcare quality, assess the effectiveness of existing prevention strategies, including the prevention of MRSA and other resistant organisms, and pilot new implementation tools to bring CDC guidelines to the bedside. Research activities include developing new methods for electronic data collection, assessing new strategies to decrease MRSA and bloodstream infections. Collaborations among the Epicenters resulted in improved detection of surgical site infections, decreased inappropriate use of antimicrobial agents, reduced bloodstream infection rates in ICUs, and decreased infections caused by MRSA and vancomycin-resistant enterococci. Other examples of additional CDC funded research projects include the development and testing of methods to assess compliance to prevention recommendations. These research activities complement the health research services of AHRQ.

**Summary of CDC Activities in HAIs: Identifying and Responding to New and Emerging Threats**

CDC serves as a national and global leader in the investigation and control of outbreaks of HAIs. Through outbreak investigations, CDC identifies problems, develops new prevention strategies, and works with the Food and Drug Administration (FDA) to implement policy changes. Since the1970s, CDC has responded to hundreds of requests for assistance from state and local health departments to identify sources of outbreaks of HAIs. These investigations have identified several preventable causes of infections including issues with the construction, use, and cleaning of medical devices; contamination of medical products; and unsafe clinical practices. Several potential infections were prevented because of interventions that were implemented in collaboration with FDA and other partners to stop the outbreaks. These strategies included the recall of contaminated or defective products, changes in device construction, revised recommendations for device use, and changes in healthcare practices to prevent additional infections.

CDC deploys experts including epidemiologists, physicians, and laboratory scientists to assess healthcare settings, evaluate practices, review data and perform microbiologic testing in response to a recognized outbreak or problem. Information from these investigations not only serves to control the immediate problem, but also has a direct impact on future HAI prevention nationwide. Experience from investigations also contributes to refinement of infection control guidelines and improvements in HAI tracking. Increasingly, CDC activities incorporate investigations of outbreaks in outpatient settings, including recent investigations related to lapses in injection safety in Nevada, and a recent outbreak of an emerging HAI pathogen, carbapenem resistant *Klebsiella pneumoniae* in a long term care facility.

CDC maintains critical core laboratory capacities to support public health activities and respond to environmental and diagnostic needs. As part of this laboratory capacity, CDC is able to investigate microorganisms at a molecular level in order to inform prevention efforts, identify threats to public health and guide interventions for outbreak control. CDC is providing insights that lead to new technologies for the prevention or mitigation of infections, examples include: the use of biofilm research investigating how microorganisms attach to surfaces such as implanted medical devices and intravascular catheters. Extensive activities are ongoing to identify causes and mechanisms of antimicrobial resistance and improve strategies for prevention, improve sampling methods to detect infectious agents in the environment, and develop and evaluate methods for detection of antimicrobial resistance in bacterial agents. CDC epidemiological and laboratory activities are crucial in the identification of emerging problems, such as newly virulent strains, and in the development of new strategies for prevention of these problems. For example, CDC identified a new virulent strain of CDI and is now working to evaluate the role of environmental cleaners, sanitizers, and new cleaning regimens for CDI prevention.

In addition to responding and preventing MRSA and CDI, CDC is responding newly emerging resistant bacteria such as Acinetobacter bacteria and Carbapenemase-producing Enterobacteriaceae (CRE, including carbapenemase-producing *Klebsiella pneumoniae Carbapenemase,* or KPC) that have caused nearly untreatable HAIs. These pathogens are readily transmitted in healthcare settings and new treatment options are non-existent. State public health laboratories and clinical laboratories will continue to rely on CDC to provide laboratory guidance to ensure that U.S. laboratories can correctly identify the dangerous strains so that prompt infection control interventions can be instituted. Ongoing monitoring is required to changing patterns of resistance and to track the spread of these pathogens. Well established state based programs for HAI prevention are crucial to the effective implementation of such strategies. New technologies and other advances in care provide great promise including life-saving treatments in healthcare settings. At the same time, new devices, materials, and medications can be accompanied by unintended risks and new problems. To give an example, in 1998 the Occupational Safety and Health Administration (OSHA) mandated the use of needle-less connectors between intravascular tubing and patients' intravenous catheters. These connectors reduced the risk of needle stick injuries to healthcare personnel. Upon investigating a subsequent outbreak of bloodstream infections, CDC determined that these newly required connectors were associated with the increase in infections. The investigations identified recommendations for the safe use of the new connectors with improved cleaning and maintenance. Numerous other examples reiterate the importance of maintaining vigilance in order to adapt to rapid and sometimes unexpected changes in healthcare delivery, and ensure that patients receive the safest care possible.

**Summary of CDC Activities in HAIs: Collaborations with HHS Agencies**

CDC and other HHS agencies have made concerted efforts to establish greater consistency and compatibility of HAI data collected across the Department. CDC's collaborations with AHRQ include programmatic input and technical assistance for AHRQ's Patient Safety Organization (PSO) program, including providing specifications for data collection and reporting of HAI data based upon those used in CDC's NHSN. CDC has provided technical support and additional

funds to define the best strategies in MRSA prevention activities funded by AHRQ, including projects that test implementation of novel MRSA-reducing practices. In addition, CDC and AHRQ partner on projects to develop and apply interventions related to CDI, reduce the overuse of antibiotics in ambulatory and long-term care settings, improve measurement of surgical site infection risk, and to reduce infections caused by highly resistant *Klebsiella pneumoniae*.

CDC has worked with CMS to provide technical support and collaboration in the implementation of the Hospital Acquired Conditions provision of the Value Based Purchasing Program of the Deficit Reduction Act. CDC has also worked with CMS to develop a quality initiative to reduce MRSA infections nationally through the Quality Improvement Organization (QIO) program's 9th Scope of Work, which will increase use of NHSN by hospitals participating in the QIO. CDC worked with CMS to support the Surgical Infection Prevention Program (SIPP) and subsequent Surgical Care Improvement Project (SCIP) and provided substantial technical assistance to CMS on infection control regulations and surveyor guidance in dialysis, hospitals and long term care facilities, including providing interpretative guidance to surveyors. CDC and CMS worked together to develop and pilot a new survey tool in multiple states that state inspectors can use to better ensure the quality of care in ambulatory surgical centers. Currently, CDC is working with CMS to coordinate collection of data on infections and infection control practices in dialysis units, and the use of these as quality measures.

**CDC's Support of HAI Tracking and Prevention through the American Recovery and Reinvestment Act (ARRA) and the FY 09 Omnibus:**

The American Recovery and Reinvestment Act (ARRA) provided $50 million under the Prevention and Wellness fund for states to carry out activities to implement HAI reduction strategies. The HHS Steering Committee for HAI Prevention has coordinated efforts for the $50M that are consistent with the goals, objectives, and recommendations in the HHS Action Plan. CDC is excited to utilize these historic resources in partnership with state partners and in cooperation with HHS and the other HHS operating divisions involved in the HHS Action Plan.

CDC believes that it is critical to support state efforts to monitor and reduce HAIs. By creating state health department capacity in HAI prevention, a capacity similar to that which exists in states for food borne illness prevention, immunization, chronic disease prevention, and HIV prevention, HAI prevention will grow from small efforts at a few hospitals to sustainable statewide efforts with large measureable impact. Savings in statewide healthcare costs will contribute directly to national healthcare cost control efforts.

Specifically, CDC will allocate approximately $40 million in spending that would be available to all 50 states, the District of Columbia and Puerto Rico. These investments will ramp up state and local efforts to monitor and reduce HAIs by:

- Creating or expanding state-based HAI prevention collaboratives that will implement HHS recommendations and use CDC's NHSN to measure outcomes and prevent HAIs. Those collaboratives will include state hospital associations, QIO's and other partners, and will link to complementary activities supported by AHRQ and CMS.

- Enhancing states abilities to assess where HAIs are occurring and evaluate the impact of hospital-based interventions in other healthcare settings.
- Building a public health workforce in health departments who can lead state-wide initiatives to ensure progress towards the national prevention targets outlined in the HHS action plan.

The HAI prevention collaboratives are modeled after CDC and AHRQ funded projects in Pennsylvania and Michigan. As previously described, concerted efforts by healthcare facilities in those states resulted in HAI rates reductions of approximately 70 percent. While prevention collaboratives have been successful in individual healthcare facilities or healthcare networks, a state or community focus with accountability for prevention results has been missing. Building on this model, the HAI prevention collaboratives would be state campaigns bringing together the state health departments, healthcare facilities and providers, state hospital associations, and Medicare QIOs to develop coordinated strategies, share lessons learned, and create a state-wide HAI prevention focus. Having the state health department as a central convener of state and community efforts to prevent HAIs is critical for creating a population focus on HAI prevention that complements the current hospital centric approach, and will complement the role for state health departments in mandated HAI reporting.

CDC will also use ARRA funds to support new activities in the state-based Emerging Infections Programs (EIPs), which are a critical part of our nation's infrastructure for public health work in infectious diseases. Established in 1995, the EIPs consist of 10 centers of excellence across the U.S. that are collaborations among state health agencies, academic institutions, CDC, and other federal agencies. Collectively, they form a specialized network of research centers for infectious disease work that goes beyond the routine functions of health departments. The EIP network's unique strength and contribution lies in its ability to quickly translate surveillance and research activities into informed policy and public health practice.

CDC will use ARRA resources to support targeted efforts to monitor and investigate the changing epidemiology of HAIs in populations as a result of prevention collaboratives. As HAI prevention collaboratives move forward, the epidemiology of HAIs will change. Reporting through NHSN will provide a picture of HAIs in hospitals, and increasingly, in long term care facilities and ambulatory surgical centers. The strength of the EIP program is that data collected by the participating states and their academic partners includes the entire population under surveillance thereby creating a guide to state health departments on where prevention efforts may have the most benefit. For example, EIP findings published in the New England Journal of Medicine in fall 2007 demonstrated that while most MRSA infections were healthcare-associated, many occurred after patients left hospitals or while receiving medical care in non-hospital settings. EIP findings will provide us with additional insight into the impact of ARRA funded prevention activities are having, especially outside of the hospital setting.

Based on the success that CDC and AHRQ have seen in local, regional and national initiatives, we anticipate 10-20 percent reductions in HAIs within two years of the successful implementation of the state-based collaboratives. These HAI reductions are contingent up the capacity of state and federal partners to quickly ramp up efforts to track infections and increase adherence to

prevention recommendations. In the long term, CDC will evaluate the lives saved and cost savings of these efforts.

Under the FY 09 Omnibus, Congress provided $10.1 million for NHSN and $2.5 million for responding to and the prevention of outbreaks caused by the re-use of syringes in outpatient settings. The FY 09 Omnibus also includes language compelling states to submit HAI reduction plans to HHS no later than January 2010. These plans must be consistent with the HHS national action plan for reducing HAIs and include measurable 5-year goals and interim milestones for reducing such infections. Under the funding solicitation to states for ARRA funds, there will be specific guidance instructing states that they can choose to use stimulus monies to develop their HAI reduction plans, detect and report Healthcare Associated Infection Data, or establishing a prevention collaborative. States may choose two of the three previously mentioned categories. Using monies from its FY 2009 appropriation, CDC will provide technical assistance to states to take action that is consistent with the HHS action plan. FY 2009 monies will be directed towards expanding NHSN to support the state collaboratives as they increase the number of hospitals and other healthcare facilities participating and the types of infections collected by each facility. CDC will also continue its investments in transitioning NHSN to an electronic HAI reporting standard that improves automation and reduces manual inputs for the facility, focusing on enabling electronic messaging and electronic document transition. CDC will also help states with data validation. These improvements will not only reduce the burden of data collection, but will also increase interoperability across agency data systems.

CDC will use its injection-safety resources to ensure that infection control measures are adhered to broadly. Specifically, CDC will provide technical support to CMS HAI prevention activities under the ARRA. CMS works with state surveyors to inspect ambulatory surgical centers (ASCs) to ensure that they are following infection control procedures and protecting the public from poor quality of care. Following the large exposure of patients last year to Hepatitis C in Las Vegas gastroenterology clinics, CDC and CMS worked together to develop a new survey tool that state inspectors can use to better ensure the quality of care in ASCs. As use of the tool expands, CDC will provide subject matter expertise to CMS and state inspectors to improve the quality of care in ASCS nationwide.

CDC also will increase its capacity to respond to outbreaks in healthcare setting related to injection safety and will work with partners to develop a pilot provider education and patient awareness campaign. Finally, CDC plans to convene a meeting with industry and university researchers to identify existing and new technologies that could reduce the possibility of disease transmission through injections in the healthcare setting.

**The Future of HAI Prevention**

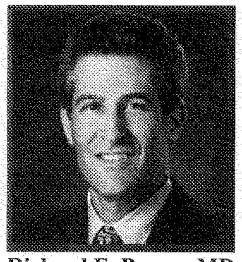
In addition to reducing the cost of healthcare delivery and improving quality of care for patients, this is an opportunity to build state health department capacity to coordinate prevention services with healthcare delivery, reinforce the healthcare oversight and regulatory roles played by the states, and ensure interoperability among federal agencies that assess healthcare quality and monitor performance. Small investments made across states can yield a large impact by

preventing thousands of new infections and saving unnecessary costs for patients and the healthcare system.

Timely and accurate monitoring remains necessary to gauge progress towards HAI elimination. Increased participation in NHSN combined with improvements to simplify and enhance data collection, improve dissemination of NHSN reporting results to healthcare providers and the public, enhance analysis and validation functions, and support the work of other agencies including AHRQ research networks, are essential building blocks for successful healthcare reform. Electronic reporting efforts are underway at CDC to foster greater use of electronic data stored in healthcare databases to detect HAIs and monitor antimicrobial use, resistance and quality care indicators. These efforts focus on automated healthcare data transmission and data quality validation, and are essential to reduce the reporting burdens placed on healthcare personnel and state health authorities. Through expansions in electronic data reporting systems and e-surveillance, enabling capabilities like electronically transmitted lab data and pharmacy messages, and algorithmic detection of infections, the impact of HAI prevention methods can be catalyzed in both hospital and outpatient settings.

To date, we have shown remarkable and measureable success in preventing HAIs, such as the prevention of bloodstream infections in ICUs. However, there remains much work to be done for other infections and in other healthcare settings; ongoing commitment will be needed to assure this work is completed. In moving forward, efforts must be expanded beyond ICUs and into other wards and non-hospital settings. As prevention and monitoring efforts move beyond hospital settings into outpatient settings the traditional reliance on hospital-based prevention strategies no longer suffice. State health departments will increasingly be required to address oversight and regulation of these expanding arenas of care. Targeted efforts to monitor and investigate the changing patterns of HAIs in those settings will be crucial to allow adoption of timely and effective prevention strategies.

Building the infrastructure for HAI prevention in state health departments is a key to sustainability for these efforts. The ARRA and FY2009 funds will lay the foundation for a systematic national approach to preventing HAIs. Assessing the impact and effectiveness of the investments is a priority for CDC. Future efforts of CDC, AHRQ, CMS and HHS will build upon that foundation to extend monitoring and quality improvement throughout hospital settings and into non-hospital healthcare settings, further enhance the accuracy and timeliness of reporting, and respond to new threats to patient and personnel health. Through ongoing monitoring, outbreak response, research, guideline development, and prevention implementation, CDC will continue to work with states, partners and other agencies to lead the prevention of healthcare-associated infections.



**Richard E. Besser, MD**
**Acting Director, Centers for Disease Control and Prevention**
**Acting Administrator, Agency for Toxic Substance and Disease Registry**

Richard Besser, MD, took the helm as Acting Director of the Centers for Disease Control and Prevention (CDC) and Acting Administrator of the Agency for Toxic Substance and Disease Registry (ATSDR) on January 22, 2009.

Before becoming the Acting Director of CDC and Acting Administrator, ATSDR, Dr. Besser served as the Director of the Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER), CDC at the main headquarters in Atlanta, Georgia. He was responsible for all of CDC's public health emergency preparedness and emergency response activities. COTPER is the primary CDC/ATSDR organization tasked with oversight of terrorism preparedness, response and protection for the nation from biological, chemical, radiological, and naturally occurring emergencies.

He began his career at CDC in the Epidemic Intelligence Service working on the epidemiology of food–borne diseases. He has served as the epidemiology section chief in the Respiratory Diseases Branch, acting chief of the Meningitis and Special Pathogens Branch in the National Center for Infectious Disease, and as the medical director of *Get Smart: Know When Antibiotics Work*, CDC's national campaign to promote appropriate antibiotic use in the community.
Doctor Besser received his Bachelor of Arts degree in economics from Williams College in Williamstown, Massachusetts, and his medical degree from the University of Pennsylvania. He completed a residency and a chief residency in pediatrics at Johns Hopkins University Hospital in Baltimore, Maryland. He has authored and co–authored more than 100 presentations, abstracts, chapters, editorials, and publications and has received many awards for his work in public health and his volunteer service.

## DR. CLANCY'S OPENING STATEMENT

Mr. OBEY. Dr. Clancy.

Dr. CLANCY. Mr. Chairman and members of the Committee, I want to thank you for inviting me to this important hearing on initiatives to improve and expand efforts to prevent altogether healthcare-associated infections and ask that my entire statement be made part of the record.

I would also like to building on Mr. Tiahrt's comments and also add our congratulations to you on this important anniversary and thank you for your service and leadership to the Country.

### AHRQ'S MISSION

AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of healthcare for all Americans, so we do this through research to improve the quality of healthcare, reduce its costs, improve patient safety, and address medical errors.

But a big, big focus for us is making sure that we can work with hospitals, clinicians, and others to translate the findings of research into practice and policy. So we are thrilled and quite delighted to be working very closely with our partners in HHS, particularly our partnership with CDC and the Office of Public Health and Science, focused on reducing and ultimately eliminating healthcare-associated infections.

Our mission at AHRQ is focusing on developing practical scientific evidence-based information that clinicians and healthcare organizations can use to improve care right now, and this complements CDC's focus on public health and epidemiology. Together, our investments will strengthen capacity in States and local communities.

AHRQ's role also includes helping patients and doctors to communicate better, so we have been working to encourage patients to ask questions when they are in healthcare settings, such as whether clinicians have washed their hands and have offered them suggestions on how they might do that; it is not such an easy thing to do. So I want to thank the Committee for your continued support of AHRQ's investments in helping to achieve this objective.

This is a very serious issue today. The infections do not know any boundaries. They can affect people regardless of race, gender, or socioeconomic status. So, therefore, the solutions to this epidemic also have to break traditional healthcare boundaries.

### MRSA

One of the most common infections is MRSA, and I know that this is well detailed in our written statements. Our data from hospitals show that these infections have increased dramatically in hospitals and that people with these infections have longer hospital stays. In addition, our data from the same hospitals is tracking the rapid emergence and rapid increase of a new dangerous infection called Clostridium difficile. This is alarming, to put it mildly. As you said, patients expect to go into hospitals and get better, not come out with a second problem.

PREVENTING INFECTIONS

The good news here is that these infections can be prevented and dramatically reduced. AHRQ funded a research team from Johns Hopkins University—and I know you will be hearing from Dr. Pronovost in the second panel—that developed a program designed to implement CDC recommendations to reduce serious bloodstream infections in intensive care units. Known as the Keystone Project, it reduced the rate of these infections by two-thirds within three months in ICUs throughout the State of Michigan. In addition, the average ICU reduced its infection rate from 4 percent to close to zero. Over 18 months, the program saved more than 1,500 lives and nearly $200,000,000.

So how did this happen? Using a simple five-step checklist designed to prevent certain hospital infections, and instilling a change in how hospitals and clinicians view infection prevention. Among other things, the checklist reminds doctors to wash their hands and put on a sterile gown and gloves before putting IV lines into their patients. One leader in critical care medicine that I met said that this was the most important development in his field in a generation. He said we knew about these infections, of course, but we kind of thought they were inevitable, that we could not do anything about them.

I am sure you are used to seeing doctors and nurses on TV medical shows scrubbing their hands before surgery. Because of this project, the practice is now routine in these intensive care units as well.

So we are now funding an expanded project building on this success and this project is being implemented across 10 States, with at least 10 hospitals in each State to help prevent infections related to the use of these central lines.

Thanks to your support and leadership, our fiscal year 2009 appropriation also gives us the opportunity to make this initiative truly nationwide. AHRQ will expand our work in reducing these central line bloodstream infections beyond the 10 States. We are going to expand the number of hospitals in each participating State and increase the number of participating States by an additional 20 States. And we will be making sure that as our colleagues implement the funds in the Recovery Act and we are working with State hospitals and hospital associations so that our efforts are directed in such a way as to build capacity in these States and local communities.

The goal here is to reduce the average rate of central line-associated blood infections in hospitals by at least 80 percent. But the ultimate goal, of course, is complete eradication of these infections. We are also supporting five of our ACTION partners to examine the barriers and challenges to reducing HAIs at 34 hospitals. From this study we will be developing a tool kit that healthcare organizations can use to learn about how these projects and initiatives were successfully implemented, the challenges that they faced, and how they addressed them. Early results indicate that these 34 hospitals showed a 60 percent decrease in infections, and we think that is only the beginning.

Mr. Chairman, we greatly appreciate the Committee's understanding of the grave problem of HAIs and your foresight in providing AHRQ with additional funds in fiscal year 2009, and we will use the funds to invest in evidence-based research to reduce the incidence of MRSA and other healthcare-associated infections.

I am very pleased that the interagency workgroup that you heard about from Dr. Wright has begun to develop potential projects that build on our efforts in fiscal year 2009 and address new high priority issues. These are also detailed in my written statement.

Our funding in fiscal year 2009 will also help us address infections, including urinary tract infections and surgical site infections, as well as research on these infections in other healthcare settings. Your chances of getting an infection in a healthcare setting are not just limited to hospitals. So we will be looking at units outside the ICU: dialysis centers, nursing homes, and ambulatory care settings.

So, Mr. Chairman, thank you again for inviting me to discuss AHRQ's efforts to improve and expand prevention of healthcare-associated infections nationwide. We are committed to continuing to work closely with our Department colleagues to improve the quality of healthcare in our Nation and to ensure that the public have access to the information they need to make educated and informed decisions about their healthcare.

I look forward to answering any questions.

[The information follows:]

*Statement Before the*

**House Appropriations Subcommittee on Labor, HHS, Education, and Related Agencies**

**Reducing Health-care Associated Infections**

*Statement of*

**Carolyn M. Clancy, M.D.**
*Director*
*Agency for Healthcare Research and Quality*
*U.S. Department of Health and Human Services*

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**INTRODUCTION**

Mr. Chairman and member of the Committee, I want to thank you for inviting me to this important hearing on initiatives to improve and expand healthcare-associated infection prevention efforts.

As you may know, AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. We do this by supporting research to improve the quality of health care, reduce its cost, improve patient safety, and address medical errors.

A major focus for us is to translate the findings of our research into practice and policy. We work closely with our partner agencies in the Department of Health and Human Services, such as Centers for Disease Control and Prevention (CDC) to achieve this objective.

AHRQ and CDC have been collaborating closely on the issue of healthcare-associated infections, taking advantage of the complementary strengths of the two agencies.

AHRQ's mission focuses on developing practical, evidence-based information that clinicians and health care organizations can use to improve care rapidly; this complements CDC's focus on public health and epidemiology. Together our investments will strengthen capacity in states and local communities.

Today, I would to like to discuss with the Committee our work to reduce health-care associated infections. Before I proceed, I want to thank the Committee for their continued support of AHRQ's investments in helping to achieve this objective.

## Healthcare-associated Infections

Healthcare-associated infections, or HAIs, are a very serious issue in healthcare today. They have become the most common complication of hospital care. According to the CDC, nearly 2 million patients suffer from an HAI in U.S. hospitals each year, resulting in 99,000 deaths and it is estimated that healthcare-associated infections incur an estimated $28 to $33 billion in excess healthcare costs each year.[1]

[1] Scott Rd. The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. 2009. Division of Healthcare Quality Promotion, National Center for Preparedness, Detection, and Control of Infectious Diseases, Coordinating Center for Infectious Diseases, Centers for Disease Control and Prevention, February 2009.

Unfortunately, the news is full of stories about patients throughout the country who have contracted an HAI. These infections do not have boundaries and can affect people regardless of race, gender, or socioeconomic status

One of the most common infections is methicillin-resistant *Staphylococcus aureus* (MRSA). It is highly resistant to antibiotics, which makes it much more challenging to combat. CDC's data show that people are more likely to contract MRSA when they go into health care settings than any other way.

About 85 percent of all invasive MRSA infections were contracted in health care settings. Of those, about two-thirds occurred in non-hospital settings, and about one third occurred during hospitalizations.

Data from AHRQ's Healthcare Utilization Project shows that the number of hospital stays to treat MRSA infections more than tripled after 2000, reaching 368,600 in 2005. Patients hospitalized for MRSA have longer hospital stays and are more likely to die than patients who don't have MRSA. These infections are especially common in intensive care units (ICUs). One of every 20 of the roughly 368,600 patients treated in U.S. hospitals in 2005 for MRSA died.

**AHRQ Research on the Prevention of Health-care Associated Infections**

Mr. Chairman, these statistics are alarming and quite concerning; however, the good news is that HAIs can be prevented and dramatically reduced.

AHRQ funded a research team at Johns Hopkins University that developed a program designed to implement CDC recommendations to reduce HAIs in the ICUs. This initiative, known as the "Keystone Project," reduced the rate of bloodstream infections from intravenous (IV) lines by two-thirds within 3 months in ICUs throughout Michigan. In addition, the average ICU decreased its infection rate from 4 percent to zero. Over 18 months, the program saved more than 1,500 lives and nearly $200 million.

Keystone did this by employing a simple five-step checklist designed to prevent certain hospital infections. Among other things, the checklist reminds doctors to wash their hands and put on a sterile gown and gloves before putting intravenous lines into patients. One leader in critical care medicine described these results as one of the most important developments in a generation.

We are now funding an expanded project that will try to build on the success of the Keystone Project. Using a comprehensive unit-based patient safety program, the project is being implemented across 10 states to help prevent infections related to the use of central line catheters. Each state is asked to enroll at least 10 hospitals in the program. The new project aims to reduce the average rate of central line-associated blood infections in hospitals by 80 percent, from the

national average of five infections per 1,000 days in which patients had a catheter placed to one infection for every 1,000 such days.

In other AHRQ efforts on HAIs, AHRQ is supporting five of our Accelerating Change and Transformation in Organizations and Networks (ACTION) partners to examine the barriers and challenges to reducing HAIs at 34 hospitals. Multidisciplinary teams at each hospital are in the process of collecting data on what barriers and challenges exist in fostering a culture of infection safety. From this study, the Agency plans to develop an HAI "toolkit," to help health care organizations learn about how the HAI project participants implemented infection safety training, the challenges they faced, and how they addressed them.

Another AHRQ-supported study on HAIs was conducted by the Stanford-University of California, San Francisco Evidence-based Practice Center. The researchers recommended several strategies as worthy of future study and possibly wider implementation if an appropriate plan is in place to monitor their effectiveness and potential adverse effects. These include:

- Printed or electronic reminders with use of automatic stop orders to reduce unnecessary urethral catheterization.

- Printed or electronic reminders for improving adherence to recommendations for timing and duration of surgical antibiotic prophylaxis.

- Staff education, including use of video and Web-based interactive tutorials and checklists, to improve adherence to insertion practices for placement of central venous catheters.

From our limited studies on HAIs to date, we know that through proper training and an evolution to an infection safety culture, we can make great strides in reducing HAIs. This, of course, is just the tip of the iceberg given the vastness and complexity of our health care system. There is much more to be done.

**AHRQ's Planned Investments for HAIs**

Mr. Chairman, we greatly appreciate the Committee's understanding of the grave problem of HAIs and your foresight in providing AHRQ with additional funds in FY 2009. We will use the funds to invest in evidence-based research to reduce the incidence of MRSA and other HAIs.

I am pleased to report that an interagency work group comprised of AHRQ, CDC, and Centers for Medicare and Medicaid Services has begun to develop potential projects that build on our efforts in FY2008 and address new, high priority issues. These include:

- Reducing *Clostridium Difficile* infections in a regional collaborative of in-patient settings.
- Reducing the overuse of antibiotics by primary care clinicians treating patients in ambulatory and long-term care settings.
- Establishing a MRSA chlorhexidine study in a multi-hospital quality improvement environment.
- Improving measurement of surgical site infection risk stratification and outcome detection.
- Producing rapid national, regional, and state-level estimates of HAIs to evaluate the impact of interagency HAI initiatives.
- Reducing infections caused by carbapenem-resistant enterobacteriaceae (KPC-producing organisms) through application of recently-developed CDC/ HICPAC recommendations.

In addition, AHRQ plans to expand our work in reducing central-line bloodstream infections beyond the 10 states we recently funded. We will expand the number of hospitals in each participating state and increase the number of participating states by approximately 20 states. The FY 2009 appropriation offers the opportunity to make this initiative truly nationwide.

With this funding, we also will address other HAIs, including urinary tract infections and surgical site infections. AHRQ also will support research on ways to reduce HAIs in other health care settings, including hospital locations outside the ICU, dialysis centers, nursing homes, and ambulatory care settings.

**Conclusion**

Mr. Chairman, thank you again for inviting me to discuss AHRQ's effort to improve and expand HAI prevention efforts nationwide. We are committed to continuing to work closely with our Departmental colleagues to improve the quality of health care in our nation, and to insure that the public and patients have access to the information that they need to make educated and informed decisions about their health care. I appreciate this opportunity and look forward to answering any questions.

**Carolyn M. Clancy, M.D.**
**Director, Agency for Healthcare Research and Quality**
**U.S. Department of Health and Human Services**

Carolyn M. Clancy, M.D., was appointed Director of the Agency for Healthcare Research and Quality (AHRQ) on February 5, 2003. Prior to her appointment, Dr. Clancy served as the Agency's Acting Director and previously was Director of AHRQ's Center for Outcomes and Effectiveness Research.

Dr. Clancy, who is a general internist and health services researcher, is a graduate of Boston College and the University of Massachusetts Medical School. Following clinical training in internal medicine, Dr. Clancy was a Henry J. Kaiser Family Foundation Fellow at the University of Pennsylvania. She was also an assistant professor in the Department of Internal Medicine at the Medical College of Virginia before joining AHRQ in 1990.

Dr. Clancy holds an academic appointment at George Washington University School of Medicine (Clinical Associate Professor, Department of Medicine) and serves as Senior Associate Editor, *Health Services Research*. Dr. Clancy has served on multiple editorial boards and is currently on the board of the *Annals of Family Medicine*, *American Journal of Medical Quality*, and *Medical Care Research and Review*. She has published widely in peer reviewed journals and has edited or contributed to seven books. She is a member of the Institute of Medicine and was elected a Master of the American College of Physicians in 2004.

Her major research interests include improving health care quality and patient safety, and reducing disparities in care associated with patients' race, ethnicity, gender, income, and education. As Director, she launched the first annual report to the Congress on health care disparities and health care quality.

Dr. Clancy lives in the Maryland suburbs of Washington, D.C, with her husband, Bill. She enjoys jogging, movies, and spending time with her extended family, especially four nieces in Virginia.

Mr. OBEY. Thank you very much.
Mr. Tiahrt.

PREVENTION CHECKLIST

Mr. TIAHRT. Thank you, Mr. Chairman.

Based on the testimony today, it sounds like it is very simple. A five step plan? Can it be that simple? You know, 1.7 million people, 99,000 deaths, and it just boils down to not washing your hands and a few other steps? This five-step process, when you got the 60 percent reduction in these hospitals, was that the inspiration of it or the methodology used to achieve that?

Dr. CLANCY. Five steps worked very, very well in intensive care units. Like many things in life, the what to do is not so hard; the how to do it is actually harder than rocket science. The difficulty is getting everyone on the same page and committed to consistently washing hands, sterile technique, and also collecting data so that people can see the connection between how they have changed their activities and the rate of infections. They can see this. In the Keystone Project, people got feedback quarterly. So this is not the quality department's problem or the infection control department's problem, this is our problem, and we have a role in fixing it.

In the other activities that we are funding that look in a broader way across hospitals, one of the issues that they have found is that there are overlooked aspects of breakdowns in sterile technique. For example, in one institution, the transportation folks were able to let the doctors and nurses know that, once the patients go down to physical therapy, off came the gloves, gowns, and so forth. So people upstairs were working very, very hard at sterile technique and trying to prevent spread of infection; they got downstairs for something else, and all bets were off. So it is that kind of getting everyone on the same page, because everyone has to be part of the solution.

Mr. TIAHRT. I think the feedback is very good.

Dr. Besser, you mention in your written testimony that 27 States require hospitals to report HAIs publicly. How many States require reporting but do not make it public?

Dr. BESSER. Mr. Tiahrt, I do not have an answer to that question. It is a moving target. Currently, of those States that require reporting, 19 of them are using the National Healthcare Safety Network, and we have more information on those.

Mr. TIAHRT. Can you use a trend where they do report publicly that they are more attentive to these common sense practices to avoid infections?

Dr. BESSER. I think what we see in general is that what you measure drives change, and the goal of these programs is quality improvement at the hospital level, at the patient level, at the individual level. So the primary work that a hospital is doing by being able to look at their data and seeing where they have problems will drive implementation of improved application of hospital infection control.

It is not rocket science. The principles that Dr. Clancy was talking about, about sterile technique and hand washing, are very simple. I served for five years as a pediatric residency director. Getting students and residents to apply these principles and do them in

practice is the hard thing. So simple things like checklists, which just seem so rudimentary, can have dramatic impact.

Mr. TIAHRT. In your testimony you talked about how everybody has had some kind of contact with someone. I have experienced it myself, going into a hospital for a knee operation and coming out with an infection. I had to stay a lot longer. I know of other instances just recently. But is there a risk? By requiring hospitals and other clinics and the whole list that you have talked about, by requiring them to publicly report this, does it put them in jeopardy of litigation, where they become part of a lawsuit because somebody has a bad experience like I did? Should we be concerned about that, public reporting ending up in a court system where the hospital or the physician or somebody gets sued over this reporting?

Dr. BESSER. I think whenever a preventable bad outcome occurs in a healthcare setting, there is risk of litigation. But I think without awareness of the problem, it does not give the institution or an individual the choice over where they want to acquire their healthcare, and having that choice I think is a major driver for change. I know that, personally, I would want to go to a facility that had a lower rate of infection than another.

Mr. TIAHRT. And so would I. I just think there is a conflict here. We want the reporting. The reporting is successful, it helps do the things we want to do to prevent these from happening. Yet, it places an additional risk on these facilities and physicians.

Thank you, Mr. Chairman.

Mr. OBEY. Thank you.

Ms. LEE.

MRSA

Ms. LEE. Thank you very much, Mr. Chairman, and thank you very much for this hearing, and welcome to all of you.

I guess as we age and as our family members age, we become more acutely aware of what is taking place, and I, again, personally, with a disabled sister and aging mother, have had many, many experiences with this; and I would want to litigate, let me tell you. And for those of you—and I probably know just enough to not know enough, but let me just mention one incident which confirms what you are saying as being, I think, a good strategy.

A family member went into the hospital with a white cell count of 10,000, normal; came out with a white cell count of 33,000, way up. Had to go right back into the hospital. Never once did the hospital admit, or the physician admit, what had taken place in terms of this infection having been developed in the hospital. Everyone else knew it, but we could never get—I knew it just by my elementary knowledge of what white cell count, what is normal, what is abnormal, what transpired during that 24-hour period. But you could never ever get the hospital officials, the physicians, anyone to even raise that as a possibility; and, as a result, we were trying to figure out what, legitimately, we could do and what took place and never got the correct answers, when we really knew what had happened.

So I do not mind the litigation round, really, if that has to happen, but hopefully, with requiring the data to be published, the scoring and what have you, that would help hospitals step up to

the plate and do what they need to do to prevent these infections from happening.

I am concerned about the outreach efforts that are going to take place in terms of them being culturally appropriate, linguistically appropriate, because oftentimes African-Americans, Latinos, Asian-Pacific-Americans, Native Americans, we have to handle our outreach in an appropriate way so that people understand what they are dealing with and what the information really means based on their cultural background.

So I am asking you how do you plan to move forward on this front and how, also, are you going to review the information that you are proposing in your strategies with the minority medical schools so that they too can incorporate this now into some of their curriculum, if they have not already?

Thank you very much.

Dr. BESSER. Thanks very much for the question. I will address part of that and let my colleagues join in.

CDC is undertaking a campaign around MRSA, methicillin-resistant Staphylococcus aureus infections. These have been in the press a lot. These occur both in healthcare facilities and in the community. So we have developed a lot of communication materials, education materials, and in the development of those, part of that is putting together focus groups from different ethnic and minority group populations to make sure that the messages that are in those will resonate.

One of the areas I think that we need to do more work in, and we are thanks to the Committee and the resources in the Recovery Act, is looking at healthcare-associated infections in populations, so that we can get a better sense of what are the different rates in various populations, where are there disparities, and what is driving those disparities.

We know that African-Americans have higher rates of kidney failure and diabetes, and that some of these infections are associated with those conditions; and that the efforts that we take to address the disparities that underlie those conditions will help with the infections. But I think there is more to it than that, and we need to understand are there particular infections that we are seeing at disparate rates, and we need to address that.

MALPRACTICE

Ms. LEE. And why will the hospitals not admit that this infection occurred under their watch?

Dr. BESSER. I do not know if you want to go for that one. [Laughter.]

Dr. CLANCY. Well, I think that is fear of liability. When we have done work with doctors and patients, most patients say that if they are harmed by healthcare—and this would be a prime example—they want three things: they want an apology, they want to know——

Ms. LEE. You are right, that is what we would like.

Dr. CLANCY [continuing]. They want to know what happens to me now——

Ms. LEE. Yes.

Dr. CLANCY [continuing]. And, very importantly, they want to know that the hospital or organization is going to learn something and not do it again.

Ms. LEE. Yes.

Dr. CLANCY. And doctors sure agree with them. They are terrified of step one because of the potential for litigation.

Ms. LEE. Well, I will tell you one thing, they should be. But we have to make sure that somehow, short of litigation, that they know they have to clean their act up.

Dr. WRIGHT. Congresswoman, let me say I share your concerns about the outreach campaign and making sure that it is targeted to the appropriate audiences. The outreach campaign will actually occur within the Office of Public Health and Science, and we intend to make every effort to make sure that we address the appropriate communities. These messages will be tested for effectiveness moving forward to address the concern you just expressed.

Mr. OBEY. Mr. Alexander.

Mr. ALEXANDER. No questions.

Mr. OBEY. Mr. Bonner.

HAI REDUCTION STRATEGIES

Mr. BONNER. Thank you, Mr. Chairman.

As we all know, Congress provided $50,000,000 in the stimulus bill explicitly for States to implement healthcare-associated infection reduction strategies. So I have got a few questions I would love to get your knowledge to try to help me understand.

It is our understanding, my understanding, that $40,000,000 of the $50,000,000 would be used by CDC to help States reduce infections. In your written testimony, Dr. Besser, you mentioned that the funds are being used for three purposes: first, creating or expanding collaboratives that will implement HHS recommendations; second, what appears to be enhanced surveillance capability; and, third, what looks to be a subsidy for State health departments to hire additional employees.

So my first question is how much of that $40,000,000 do you expect would be spent in each of these three areas?

Dr. BESSER. We are still working through the finalization of the spend plan for this, but each of those components is a critical part of the equation. The collaboratives are absolutely essential because they pull all the players together who have a stake in this, both a stake in improving, but also have the ability to work with their members and with the medical community to address those issues.

Healthcare-associated infections is one of those areas that State health departments have not had many resources to support for a long time, so being able to support this at the State level will allow them to look at data within their State and identify where the problems are, and have individuals who are focused on that and focused on working on solutions. So both of those components are very important.

The other piece of looking at these infections in communities is important because there will be changes in how these infections are occurring by the very efforts we do to prevent them in healthcare settings. One example is the issue around methicillin-resistant Staphylococcus aureus, where this was a problem that we initially

saw almost exclusively as a problem in healthcare facilities. Then, over time, we saw this in the community. And it was the work done in these surveillance systems that let us really understand that these were related problems, but had very different epidemiology and very different control strategies.

So the vast bulk of the money is going to the States and the coalitions for the implementation of what we know are evidence-based strategies that work.

Mr. BONNER. Well, how much does it cost a hospital or a State to report infection data to the National Healthcare Safety Network, and what percentage of hospitals currently participate in HSN?

Dr. BESSER. NHSN, we have been very pleased by the dramatic increase in its use over the past couple of years, from a few hundred to over 2,000. A third of all hospitals are now participating in that system. And what we are seeing is that the standards that are in NHSN are used by additional hospitals.

Our goal is the reporting, not the system. We are really pleased that many hospitals find this to be a very useful system for reporting. We do not charge hospitals anything to use this system, and, thanks to the Committee and the 2009 appropriations, we are going to be able to provide additional technical support to States so that there can be training, we can make improvements to the system, because we do hear from some hospitals about difficulty in data entry and problems with our servers. We are going to be upgrading those systems.

So the resources that are coming from the Recovery Act and the resources that are coming through the Omnibus appropriation will synergistically help build a system that is really focusing on these preventable infections.

Mr. BONNER. And that leads to my last question. If I am correct on the workforce issue, has any thought been put into how the States will sustain these new employees if and when Federal funding for HAIs ends?

Dr. BESSER. Well, one of the requirements is that all States submit a plan on healthcare-associated infections by January of 2010, and one of the components of that is looking at sustainability. What I expect States will see, States who take this seriously and implement this, is that they are going to see cost savings in terms of the added burden to their healthcare system and their healthcare dollars from treating infections that were preventable. And hopefully that will lead to States seeing the benefit in providing support for these personnel.

Mr. BONNER. Thank you, Chairman.

Mr. OBEY. Thank you.

Ms. Roybal-Allard.

## OUTREACH CAMPAIGN

Ms. Roybal-Allard. Thank you, Mr. Chairman, and thank you for having a hearing on this truly critical issue.

When we are talking about this issue, sometimes I cannot believe what I hear. You know, when you talk to parents sometimes, they say, well, I try and get my children to wash their hands, but I cannot always get them to do that. I am trying to get them to eat their vegetables, but we cannot. But we are talking about children.

In this case we are talking about health professionals who supposedly their primary goal is the care of patients. Just in the last few months, I have had, in hospitals and a friend, a newborn baby die of respiratory infection in the neonatal unit because of an infection, an adult died of cardiac arrest because they forget to put his heart monitor on, and the best friend of my daughter just died here, he was a U.S. marshal, because they released him from the hospital with staph infection and went into a coma at his home.

And what I am hearing is, gee, this is a good thing to do, but we cannot get the students to do it and we cannot get the doctors to do it. To me, it is absolutely incomprehensible and there has to be some penalty. It is not good enough just to say, gee, we would like to get them and we hope that this happens.

Which leads me to my question. While I do think it is important to empower families and individuals, the reality is—and I spent months in the hospital with my mother and my father—the reality is that not every family can do what my family did and stay 24 hours and alternate every night. And we were not other to keep either my mother or my father company; we were there to protect them from my mother being wheeled out to have some procedure, operation done for which it was the wrong patient, and I could just go through a whole list of things.

So I agree that it is important to help to empower the public, but also I believe the primary responsibility to ensure an infection-free environment starts with the healthcare providers themselves.

So given the high costs associated with the national campaign, would not the money be better spent in educating and ensuring that physicians and healthcare providers are following the infection control guidelines, and put the focus on that, while at the same time there are other less expensive ways—and I am sure that members of Congress would be more than happy to assist in getting that information out to our constituents—and use those resources that you have to do whatever is necessary to get the health profession to do what they are supposed to do and make the care of their patients and their well-being the priority?

Dr. WRIGHT. Congresswoman, I agree and I share your concern. I will say that, as part of the outreach and messaging program, I mentioned that we were going to try to educate consumers, and we are. But that is not our only audience. Clearly, healthcare institutions have a big role in solving this problem, as well as health providers, and we will have an outreach strategy targeting those two groups as well.

A particular focus group that we think will also be a focus group of this outreach campaign are paraprofessional schools—medical schools, nursing schools and ancillary health schools. It must be in the curriculum of these schools—good infection control practices—so that we can create a culture of safety that will follow healthcare providers as they go through the next 20 or 30 years of their careers.

We do want to address both healthcare institutions and healthcare providers going forward.

Ms. ROYBAL-ALLARD. Well, I guess my point is that I do not think that it should be optional and we should not be hoping that they do this. There has to be a way that it is required and that

there is a penalty to pay if they do not. And if it means that, as Congresswoman Lee said, litigation, then so be it.

Dr. CLANCY. The only thing I would add is I definitely agree with everything that you had to say. I think most of us, for ourselves and our family members, parents, whatever, would want to know ahead of time what hospital—particularly for elective admissions, where you are going to have a procedure or surgery or something—which hospitals are doing a better job. I do not think that is too much to ask, until we get to a place where they are all doing a superb job.

Ms. ROYBAL-ALLARD. I agree, and that is why I am concerned, if I understand it correctly, that it is voluntary to report. So, therefore, how do you get an accurate picture of the various hospitals when everything is voluntary. And given the concerns that were raised about litigation and other things, you really are not going to have a clear picture, and it could be very misleading to the public to think, by looking at that list, they are getting the right information.

Mr. OBEY. Mr. Tiahrt.

INFECTION TOOL KIT

Mr. TIAHRT. Dr. Clancy, you mentioned a tool kit that had some success or great success in, was it hospital ICUs?

Dr. CLANCY. No, this was hospitals more broadly.

Mr. TIAHRT. More broadly?

Dr. CLANCY. Looking at methicillin-resistant Staphylococcus aureus.

Mr. TIAHRT. Could you just give me a brief idea what is in the tool kit, because I picture a metal box.

Dr. CLANCY. No, and we may need a better word than that. Some of it is actually just decision support so that they can remind folks about what they need to do for those hospitals that already have electronic health records. Some of this work is coming out of Indianapolis, where they are well ahead of the rest of the Country in terms of not just having electronic health records, but actually being able to share information across hospitals.

Some of the tool kit that they use in Indianapolis, which is probably only suitable for them, is that if you have been in one hospital, go home and are then readmitted, when you go to the second hospital, you are automatically identified if you have had one of these infections before. Whereas, today, that would depend on the patient or a piece of paper following the patient.

Some of the other elements of the tool kit are protocols for getting all the members of the healthcare team and making it very clear who is the healthcare team, including people transporting patients and so forth, as well as a very succinct summary of what has worked for them and how they had to customize from national guidelines.

Mr. TIAHRT. Thank you. I have a much better idea now.

Mr. OBEY. Ms. McCollum.

INFECTIONS

Ms. MCCOLLUM. Thank you, Mr. Chair. I had the privilege of having an appointment by the Speaker to be on Government Re-

form last year, so we had several hearings on this, and I am pleased that we are moving forward, because we have identified that there is a problem. Sometimes everybody has to admit there is a problem. And the funding in the recovery package—and I would like for you to elaborate on this a little more—can be one-time funding to help do the computer patches so that your system and another system can talk to each other so we can collect data.

And coming together and collecting data to provide best practices is really important. I guess I am entitled to a few boasting rights with Hubert Humphrey's quote on the wall here, but Minnesota, when I was in the State House on health and human services, we started talking long and hard in getting everybody on board to see this as not threatening, not as litigation. It took a while to get everybody there, but we worked on developing what is in the best interest of the patient, the doctor, the hospital, everyone.

So, in 2003, Minnesota was the first State in the Nation to pass a mandatory adverse health event reporting law, and it took us a while, in my opinion it took too long to get there, but we did get there, and people were gearing up and getting ready for it. So we do have some best practices out there. There are 23 other States that have some best practices models out there.

What we found now is that Minnesota now, according to our hospital association, ranks first in the Nation of overall healthcare quality performance indicators, and what we are talking about today in preventing infections from happening, is one of those performance indicators.

So what you are kind of looking at doing—to go back to the toolbox analogy—you have got some tools in the toolbox and now you are ready to take them out and show them to other States. And when you do this right, it does not necessarily mean litigation, but what it does mean, is that if you have the information in front of you, if you have had the check sheet and if you have not followed it, people in perhaps an operating room, are now bound to report that it was not followed. It is going to make it much easier for someone to litigate a case because everybody has been aware of what is supposed to happen, and it better not be happening; and if it does, people will be held accountable.

And it goes as far as—if we had a different outcome. A dear friend had a baby on Christmas Day, and when I went in, it was at a hospital where my kids had been born too, and when I walked in, I knew I needed to wash my hands and everything, but posted up above it was, as you are washing your hands, please sing to the baby Twinkle Twinkle Little Star, so that you are washing your hands and rinsing them long enough. And it also had it available in Mong and Spanish, multi-language.

So there are best practices out there. So could you maybe elaborate on how you are going to take these tools that you have in your toolbox and take them out there?

Dr. BESSER. I think that the story you tell there about a promising practice in Minnesota is just a great example of what we expect to come out of this recovery funding. The idea that all States are now going to be working on this, many States that had not been addressing issues of healthcare-associated infections before. We are going to see innovation. We are going to see creative ideas.

We are going to see promising practices come out of that. And in our roles within the Department, we are going to be able to capture those and share those ideas.

The point you made about measurement driving accountability is just right on target. Without measuring what is going on in a hospital, without bringing it to light, there is no way to hold individual clinicians accountable for what is taking place; there is no way that citizens are able to have choice between where they are seeking healthcare, and that will drive change.

I ran CDC's program on Legionnaires' disease for a number of years and we faced this same issue around Legionnaires' disease, that if you detect a case, it is going to drive a lawsuit. Well, if you are not addressing this issue and looking at prevention as a medical institution, yes, you are going to get a lawsuit. But if you are taking this on and you are doing what has been known to be done as evidence-based practice, and there is still an infection that takes place, you are in much better shape than if you had not been addressing this problem in the first place.

Dr. WRIGHT. Congresswoman, I wanted to also point out that we do believe that the inspection process provides a potent deterrent on these lapses in infection control practices. The $10 million in ARRA funds is directed to that effort, to increase the survey process of these ambulatory surgical centers that have had high rates of infections to make sure that we can drive those rates down through the survey process moving forward.

INFECTION CONTROL TRAINING IN CURRICULUMS

Mr. OBEY. Let me just make an observation. I do not want to take a lot of time because we have another panel, but, as I understand the numbers, 99 thousand people died from these infections last year, in comparison to, I believe, 14 thousand who died from AIDS last year in this Country. If those numbers are correct, that, to me, is astounding, because we have tremendous public attention paid to diseases like AIDS or cancer. Yet, we have six times as many people dying from something that ought to be much more easily correctable because at least we know, in most instances, what causes the problem and how to correct it.

We do not know the answer to dealing with diabetes or Parkinson's. We are spending a hell of a lot of money on that. It seems to me, for a very little bit of money we could have a tremendous increase in the quality of public health.

We have got a lot of talk about markets and how we should let the markets work. It seems to me the best way to make the market work in this situation is to make doggone sure that every single patient who walks into a hospital knows what the relative infection rates are in the hospital that he or she is considering entering. If they know that, it means that the good old market is going to work, because they are not going to go to the hospital that has a lousy infection rate if they know about it.

Second thing is that, to me, in addition to having the patient know this information, the press is going to know it if you get it out there enough, and the press will raise enough cane. That creates additional pressure to fix the problem. That is part of the market too.

I guess, in the end, the one place where I think we are on very weak ground is in relying on patients to ask the professionals to do what they ought to be doing. When you are a patient, you are intimidated by the people who are taking care of you; you do not want to antagonize the physician who is taking care of you because you want him to like you and care about you. So I think it is awfully tough to expect that the patient is going to blow the whistle and say, hey, did you change your gown.

I mean, what is the process by which an average doctor or another provider in any hospital gets the information today about how to do to avoid this avoidable problem?

Dr. WRIGHT. Well, certainly, I think good infection control practices are part of their curriculum, whether they are in medical school or nursing school, and we are going to target that area to make sure that those curriculums are enhanced.

CHECKLIST

But like other human behaviors, there needs to be reminders, and as one of the congressmen mentioned, there needs to be reminders to doctors, such as checklists, on an ongoing basis about the importance of hand washing. The checklist was basically a reminder of what the CDC had said for years was how you correctly insert a catheter to prevent infection, and yet it was this checklist that made sure that that occurred each and every time, and we can see what the dramatic result of a checklist of that nature actually did.

So I think it has to be a multi-pronged approach to ensuring that healthcare providers use good infection control practices.

Dr. BESSER. To add to that, I think that informing consumers is part, in terms of choice, but I think that your comments about the power relationship between a healthcare provider and a patient is on target. I started a program at CDC on appropriate antibiotic use, and promoting the use of antibiotics only where indicated; and was in on a focus group and people were asked, well, do antibiotics work for colds or they work for ear infections, or both, and half the people said both. Then they were told, well, they only work for bacterial infections, and one of the people in the focus group said, I cannot believe that, last week my doctor gave me an antibiotic for a cold, I am furious. We said, well, are you going to say anything to him? And it was like, oh no, I am not going to question my doctor.

So informing patients is part of it, but I think you are right on target that we need to work with the medical community. We have to ensure that the system is built to get these out of it. And making this information available, making an impact on the hospitals' bottom line, because they are going to see an impact on the bottom line if they are the worst hospital in their community in terms of infection rates; that is going to drive change. Each of these pieces is important, but there is not one that is the magic bullet.

Dr. CLANCY. So I guess I would just add to that. You know, I was in Ireland a couple years ago for a conference, and I was——

AWARENESS ABOUT INFECTIONS

Mr. OBEY. What is somebody named Clancy doing in Ireland? [Laughter.]

Dr. CLANCY. That is right. Amazing.

I was amazed that infection rates for all hospitals in the country, Ireland, are tracking infections that we are not keeping as close an eye on. They were all over the newspapers every single day. I want to say a little over 90 percent of the hospitals reported, and those that declined the opportunity were dutifully noted by the press.

I am not sure we can count on that as a full-time strategy here, but I think it helps.

And, I agree with everything you said about patients.

In terms of what students and residents learn, everybody learns about epidemiology and washing hands. What we have not valued in healthcare until recently is the notion that we are going to get it right every single time. So we learn about hand washing and infections so we can pass a test. What we do not get is the part that says if you do not own this and wash your hands every single time, then you will actually be creating infections. It is the not owning up to it that Representative Lee talked about.

So we are getting better on that in healthcare now. We are starting to focus more on reliability or doing the right thing every single time, but we still have a long way to go.

FINANCIAL INCENTIVES

Mr. OBEY. One last question. Financial incentives often are incentives. Beyond the positive incentive of a bonus payment for voluntary reporting, should we be considering moving to a value-based performance measuring system where a portion of a hospital's payment would depend on actual performance, including infection rates?

Dr. CLANCY. CMS is doing a little bit of this now by not paying for the extra expense incurred by some types of infections that are largely preventable. In the aggregate it will not save that much money. What it does do is it sends a very powerful signal to the green eyeshade guys, the chief financial officers and so forth at hospitals, that this matters.

So when your colleague asked how much does it cost hospitals to participate in NHSN, that depends how you look at it. They do not have to pay CDC, but they actually have to hire people and make sure that they are trained and have the time to do it.

So I think it is a powerful signal. It is not going to be transformative until we build more capacity and know-how within hospitals. I think the good news is hospitals want to go there too, but right now, if you set the bar too high, a lot of hospitals would not be able to do it; they simply do not have the infrastructure.

Mr. OBEY. All right, thank you.

Any other questions for this panel before we move to the next one?

Ms. LEE. Mr. Chairman, one more, please.

Mr. OBEY. One question, sure.

Ms. LEE. Okay, one more questions. Assuming that what you are proposing is enacted, what if there is no option? Public hospital, for

example. What if the rating on infections is so low the people do not have an option, they have to go to the hospital, first of all? Secondly, an ambulance is going to take you to the closest hospital where there is an emergency room whether the rating is high or low. So how do you factor these concerns in to an overall rating system where the public knows? Because oftentimes you cannot say where the ambulance is going to take you, and if you are a victim of a gunshot wound, you are going to go to the closest trauma unit, whether the infection rates are high or low.

Finally, just with regard to the infrastructure, the nurse shortage, physician shortage, how does that play into this, if it plays into this at all?

Dr. CLANCY. Right. The last thing I think anyone wants—and I am very worried about this—is to simply give more rewards to those hospitals that are already doing a good job and actually make it worse for those who actually do need more of a boost.

There are a variety of technical strategies to deal with that, that is to say, rewarding based on achieving a certain level of performance, as well as rewarding improvement. I would be happy to follow up with you on that.

[The information follows:]

TECHNICAL STRATEGIES

Dr. Clancy: Strategies to assist institutions with fewer resources might include: (1) "pay for improvement," where institutions are provided with financial rewards for improvement from a base level—even if low—as opposed to getting rewarded only for reaching a threshold level of performance; (2) "pay for participation," where institutions that may have trouble affording needed changes are given partial support as an incentive to participate; and (3) direct technical assistance on how to implement best practices. This could be achieved through AHRQ support for learning networks or partnerships, or targeted assistance from a quality improvement organization.

Dr. BESSER. I wanted to add to that. Recently, I have been asked by a number of people if there is universal access to care, why do we need public health. What is the value of public health if people can get to see their doctor? And I think that your question points specifically to an important role for public health.

Public health is there to assure that that a public hospital is not allowed to have standards that are worse than anything else. Public health is there to be able to go in and look at what is driving those issues of increased rates of infections or worse quality. And the resources that you have provided will allow States to fulfill that function, and it is a critically important function so that we do not end up with a two-tiered system of healthcare.

TRANSPARENCY

Dr. WRIGHT. Congresswoman, I want to make just one point and you are right on target. We do believe in transparency in healthcare, and that healthcare consumers need to be provided as much information as possible to make an informed decision of where they get care. This is very applicable in a large city such as Washington, DC, where there are multiple choices.

For rural America, there may only be one hospital in that area and the choice is much more limited, and that is the reason I agree with Dr. Besser that, for us to move forward, it is going to have

to be a multi-pronged approach. There is no single bullet. All of these will contribute in a positive way, but there is no single answer to this problem.

Ms. LEE. Well, thank you very much, Mr. Chairman. I still say litigation still has to be on the table.

Mr. OBEY. Ms. Roybal-Allard, you had a question?

Ms. ROYBAL-ALLARD. Yes.

Dr. Besser, my question has to do more with the ability to treat the infections after they occur. Some of the most deadly healthcare-associated infections are resistant to multi antibiotics. In fact, the Steering Committee has recommended research to prevent unnecessary antibiotic use.

I would like to point out that 70 percent of antibiotics used in the United States are used by farmers, and many scientists believe that the farming practice of buying antibiotics and feeding them to healthy cows and pigs contributes to this antibiotic resistance.

How does this overuse of antibiotics in agriculture contribute to drug-resistant infections in humans, and what should be done to address this overuse?

Dr. BESSER. Congresswoman, thank you for that question. The issue of antibiotic or antimicrobial resistance is a major public health problem, and it occurs for many different factors. It occurs because of overuse of antibiotics in people. We know that the use of antibiotics on the agricultural side drives resistance in strains that we see in animals, and that some of those strains then cause infections in humans.

But this is a big problem. It is a big problem not only because we are seeing a rise in resistance, but we are not seeing the development of new drugs that can be used to treat these infections. In the healthcare setting there are a number of strains of bacteria where we are reaching the end of the line; we are absolutely running out of drugs that will be able to treat them.

So I think you raise a very important issue. We need to look at the use of antibiotics in agriculture. And countries differ greatly in terms of their standards of what is allowed to be used on the farm, and we need to look at how antibiotics are used in this Country, both in the healthcare setting and in the outpatient setting, because they are all factors driving resistance.

Ms. ROYBAL-ALLARD. And whose responsibility is that to actually do that kind of study and research?

Dr. BESSER. I think that there are pieces of this that fall to different parts of government. At CDC, we have a campaign called Get Smart: Know When Antibiotics Work, which I founded about eight years ago, and that is directed at reducing the overuse of antibiotics in the outpatient setting. Our Division of Healthcare Quality Promotion does a lot of work on appropriate antibiotic use in healthcare settings, and we have a group at CDC on the food side that does studies to look at the development of resistance in animals and the transmission of those strains to humans.

A number of years ago there was a transfederal task force that was put together to address antimicrobial resistance that brought people in from across government to address these issues and develop an action plan. There was a lot of progress made on that ac-

tion plan, but there is so much more work that needs to be done to address those issues.

Ms. ROYBAL-ALLARD. Okay, but there is no directed effort to reduce this right now. Sort of what you are trying to do with hospitals.

Dr. BESSER. Well, there is work being done at FDA and USDA on the animal side, and I need to refer you to those groups to get details on those activities.

Ms. ROYBAL-ALLARD. Thank you. I appreciate that.

Mr. OBEY. All right. Let me thank the panel. I appreciate your time.

Next, we will ask our second panel to come forward: Dr. Peter Pronovost, Professor, Department of Anesthesiology and Critical Care Medicine and Director, Quality and Safety Research Group at Johns Hopkins; Ms. Rachel Stricof, Director of the Hospital-Acquired Infection Reporting Program, New York State Department of Health; and Dr. Robert Hyzy, Associate Professor of Internal Medicine, Division of Pulmonary & Critical Care Medicine, University of Michigan Health System.

Thank you all for coming. Dr. Pronovost, why do you not begin?

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## PATHWAY TO HEALTH REFORM: IMPLEMENTING THE NATIONAL STRATEGY TO REDUCE HEALTHCARE-ASSOCIATED INFECTIONS

### WITNESSES

**PANEL 2: OUTSIDE EXPERTS**

**DR. PETER PRONOVOST, PROFESSOR, DEPARTMENT OF ANESTHESIOLOGY AND CRITICAL CARE MEDICINE AND DIRECTOR, QUALITY AND SAFETY RESEARCH GROUP, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE**

**RACHEL STRICOF, DIRECTOR OF THE HOSPITAL-ACQUIRED INFECTION REPORTING PROGRAM, NEW YORK STATE DEPARTMENT OF HEALTH**

**DR. ROBERT HYZY, ASSOCIATE PROFESSOR OF INTERNAL MEDICINE, DIVISION OF PULMONARY & CRITICAL CARE MEDICINE, UNIVERSITY OF MICHIGAN HEALTH SYSTEM**

### DR. PRONOVOST'S OPENING STATEMENT

Dr. PRONOVOST. Thank you, Mr. Chairman. Given my family spent this summer visiting some of our national parks, I am indebted to your service.

Congressman Tiahrt, Congresswoman Lee, and Congresswoman Roybal-Allard, the healthcare systems ought to provide you better care than you receive. It ought to provide many of us better care, and, as a provider, I apologize for the care that you received at our U.S. healthcare system.

The outrage that you express, or the incredularity about addressing these problems are well deserved. What I would like to do is think through the science of how we might get a better solution, and I would like you to imagine that there is a new deadly disease in this Country, a disease that kills 100,000 people a year, and some researchers at Johns Hopkins tinkered around and found a cure. They then worked with funding from the Agency for

Healthcare Research and Quality and implemented that therapy in the entire State of Michigan and virtually eliminated the deaths from this disease, this once thought to be incurable disease.

If that word spread nationally, that would save more lives than virtually any other therapy in the last quarter century. Indeed, this 100,000 lives makes it about the fourth leading cause of death in this Country.

And if that therapy were a drug or device, it would be in every one of the hospitals in your States within months, probably. The market would respond. People would produce it, the cost would come down, lives would be saved, jobs would be created, and it would work.

And, yet, this disease is real. The disease is deadly and it is costly. And I can assure you the inventor of this therapy did not get wealthy; the market did not respond. And I think because the therapy is not some drug or device, it is a safety program. It is a safety program that has three key components to it: a summarizing evidence into a simple checklist, a valid measurement system based on CDC definitions to know whether we are making progress, and tools and strategies to improve teamwork, frankly, to get doctors and nurses to work collaboratively towards a common goal.

And to develop that, we approached it with the same scientific rigor that you would drug develop. In the first phase, Johns Hopkins was our learning lab and we sought how to summarize the evidence using much of what CDC put together on how to measure these. We then tried to, in phase two, apply it in a whole State; and you heard the results were almost breathtaking, somewhere around 2,000 lives saved a year, $200,000,000 saved, virtually eliminated two of the main types of this infection, cath-related infections and pneumonias, all with a $900,000 investment from the Federal Government.

In the third phase, now, we are finally, several years later, working to scale this nationally. We are fortunately coordinated under HHS to have funding from ARC to put this in 10 more States, working with the CDC to measure and summarize the evidence, and I believe what we have in this is truly a national model; because there are many woes that befall our healthcare system. It just, frankly, is not performing up to par.

But the reality is we do not have the equivalent of a polio campaign. We have not licked one of the problems, and we need to learn how to do it, and I think this provides a model, because what we saw is that debate about whether you should take a regulatory or a free market approach is a false choice, I think. It is neither efficient nor effective for every hospital to summarize the evidence or to develop their own measures; they ought to be centralized under our experts in the Federal Government.

Yet, at the same time, we need to have creativity and innovation of how to improve and implement that evidence. So there needs to be all the stakeholders involved in. Yes, we need the courage to set national goals. Yes, we need clarity about what the strategy is. And, yes, we need commitment to deliver that strategy. But it has to pull as many levers. Payment policy is part of the levers, science coordinated centrally is part of the levers, but so is coordinating hospitals with the States.

What I think is most informative is to think for us why has not this lifesaving therapy—literally, that would be the innovation of the last quarter century spread. And I think there are two reasons why it has not spread that can inform us. One is because these deaths are invisible. They are opaque and the public does not know about them. You do not know about them, for the most part. After a GAO hearing, Congressman Waxman surveyed States, and 11 States monitored these infections right at the time. As you heard from Dr. Besser, it is many more now.

But all the States said they are using the checklist, and yet none of those States where infections were anywhere near as close to as low as what Michigan was, and that is, I think, unacceptable. If these rates were transparent, people would respond; hospitals would compete, and we would see things down.

The second lesson why I think the market did not respond or why we did not spread this is this is really hard work, and it is naive to think that handing docs a piece of paper will do it. There is science to this, science of behavior change, science of measurement; and we have been woefully inadequate in our investment of those sciences.

Yes, Mr. Obey, there are about six times more people who die of these infections a year than do AIDS. And, yet, we spend $2,600,000,000 on AIDS research. The entire budget for AHRQ is $300,000,000. We spend 14–fold more on one disease than we do for all of these learning how to improve quality, and healthcare infections are but one of the many preventable causes. We do not know what the true estimates are, but if we looked at all preventable harm, it would undoubtedly be about the third leading cause of death in this Country, and the investment has not been commensurate, because, yes, we can get outraged and say why is this not happening, and that is needed and we need malpractice reform, we need payment reform.

All of those have to be part of the levers. But they are all incomplete. We have to invest in the science of this. That is what we did in Michigan. But there is no pipeline to say, well, who is funding the next program to do catheter infections or to prevent blood clots, because there has not been that commensurate investment.

So where I think we could go is I believe, and it is exciting to see, that we may use some funds to say this bloodstream program ought to be a national program, and not just save the 30,000 to 62,000 lives that die from these infections, but learn how to work together and build capacity to tackle the next ill that befalls us.

I think we need much more clarity in regulation about what quality data is reported. If you look at what hospitals put on their websites, it is far more marketing than science. You can click now and hospitals will say we have no infections, without saying which ones or for how long. You have private agencies rating hospitals that you can look in any State and you would find a hospital who makes it on somebody's top 10 list; and none of the three big—U.S. News & World Report, which we happen to be on, J.D. Power's or Health Grades—none of the same hospitals are on their top 20 list. How could that be if they are actually measuring quality? The reason is because there is no standards.

So I would encourage you to do what Franklin Delano Roosevelt did in 1934, when he created the Securities & Exchange Commission, is ensure that the data that is reported about healthcare quality is accurate in this Country.

I think it would be unwise to regulate "the use of this checklist," because just this list, in a major medical journal, a new technology came out that I will be speaking to Dr. Clancy and Dr. Besser about maybe adding to our checklist. And regulation, I think, is too slow to allow that innovation to occur.

But we ought to have confidence that you can select a hospital based on what these rates of infections are, and I think we need to invest substantially more in the science of healthcare delivery. If you look at what we did with the human genome, with your graciousness, we now sequenced, through a public-private partnership, all 3.2 billion letters in the human genome with 99.9 percent accuracy. It took us 15 years, but we now are using that to discover new drugs and therapy.

We have not had the same kind of investment in the delivery of healthcare, and we need the human genome project in healthcare to create an institute that coordinates these efforts, that advances the science and learns how to do it, and that trains clinicians, public health professionals, and researchers to learn how to do this.

I thank you.

Mr. OBEY. Thank you.

[The information follows:]

# JOHNS HOPKINS
## INSTITUTIONS

**Invited Testimony of**

**Peter J. Pronovost, MD, PhD, F.C.C.M., Professor**
**Departments of Anesthesiology and Critical Care, Surgery, and Health Policy and Management The Johns Hopkins University**
**Medical Director Center for Innovations in Quality Patient Care**
**Director, Quality and Safety Research Group**

**Before the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies**
**Hearing on Healthcare-Associated Infections**
**April 1, 2009**

Imagine that the U.S. is confronted with a deadly disease that claims nearly 100,000 victims a year; 2.5 million lives over the last quarter century. Researchers developed a new therapy that nearly eliminated the disease. The researchers received $900,000 in funding from the Agency for Healthcare Research and Quality, implemented the therapy in Michigan Hospitals and nearly eliminated disease, or at least two subtypes of the disease that account for most of the deaths, throughout the state saving about 2000 lives and $200 million each year. If provided on a national level, this therapy would have the potential to save more lives than virtually any other medical discovery in the last quarter century. To put this scenario in context, **583,298** died from AIDS in the U.S.in the past 25 years and 14,561 patients died in 2007.

If this therapy was a drug or device, the market would respond and very quickly spread the therapy throughout the U.S. Private companies would produce it, sell it and compete with each other. As a result, its costs would come down and quality would go up, lives would be saved, jobs would be created and the inventor would be wealthy and perhaps get a Nobel prize.

The disease is real, the disease is deadly and the disease is costly. It is healthcare acquired infections (HAI). And the equally real therapy was not a drug or device. It was a safety program. A program that summarized evidence into checklists, measured infection rates and used tools to improve teamwork and safety culture. Yet, the therapy did not spread to all 49 states. Patients are dying needlessly. We are fortunate now that after a GAO report, AHRQ provided support to implement the therapy in 10 states and private philanthropy provided us support to implement it in 18 more.

Yet we need to reflect why the market failed, why this therapy did not spread throughout the U.S, why patients continue to die needlessly. I believe there are two primary reasons. The first reason is because these deaths are largely invisible to patients, to payers, and to legislators. We lack valid and transparent reporting of these infections and as a result the infections and resulting deaths are viewed as inevitable rather than preventable. As part of the GAO report on healthcare infections, states were surveyed about their use of the MI program. All 50 states said they are using the "Pronovost checklist" yet only 11 states monitor rates of infections and none are a low as MI. We need to make these needless infections visible, we need to make the rates of infections transparent and valid and we need to do what the SEC did in 1934 for the reporting of financial data; ensure their accuracy.

There is tension regarding the extent to which we should take a regulatory or free market approach to financial markets, to public education and to healthcare. I think this is a false choice; we need wise regulation to make valid information transparent, we need regulation that makes knowledge markets efficient so that companies compete on performance not on misinformation and partial truths. Unfortunately, partial truths or flat out lies are the norm rather than the exception in monitoring healthcare quality. The reporting of healthcare quality data is comparable to the reporting of financial data prior to 1934 when accounting lapses seen with Enron are the norm rather than the exception.

The second reason the MI intervention was not spread to other states was that our public investments in the science of healthcare delivery are woe fully inadequate. Healthcare acquired infections (HAI) killed about 7 times more people than AIDs in 2007. Yet that year the Federal Government spent $23 billion on domestic and global HIV activities with $2.6 billion for HIV/AIDS research. Though welcome and overdue, the stimulus package included 50 million for HAI. The entire budget for AHRQ was $300 million. The investments to improve quality of care in general and HAI in specific are glaringly inadequate for the magnitude of the problem.

Indeed, we generally invest a penny on health services research for every dollar we spend finding new genes or new drugs. The public is paying for this lack of investment with their lives. This is not to say that we should reduce our investments in basic and clinical research; we need to increase them to keep the U.S the world's leader in biomedical science, to reduce death and suffering of our citizens and to create jobs and stimulate the economy. Yet, we need to substantially increase our investments into the science of healthcare delivery to ensure patients actually receive the life saving discoveries, to learn how to reduce costs and suffering. These investments will have the largest impact on saving lives reducing suffering and reducing costs of care. We need to substantially increase investments to AHRQ to enhance the science of healthcare delivery, we need to invest in the CDC to help monitor and reduce these infections and we need to support states to implement these life saving interventions.

We believe the effort to replicate the MI project across the U.S can be the model for large scale improvements in quality and reductions in cost of care. Indeed, it is by far the most successful quality improvement intervention to date. If spread across the U.S, it could have more lives than virtually any other intervention in the last quarter century. Progress in reducing HAI over the last decade has been slow or for most infections unknown. Pay for performance alone has proven an anemic mechanism to improve quality. Coordinated under the Secretary of HHS, congress could invest in CDC to measure these infections and summarize the evidence how to prevent them, invest in AHRQ to learn how to efficiently and effectively implement the evidence and reduce preventable deaths and dollars, and support states to help implement this program.

We need a investments to ensure that the MI program can be spread throughout the U.S and to ensure a pipeline of new programs; programs in which agencies within HHS, consumers, providers, states, payors and insurers collaborate toward a common goal of eliminating these infections. No one group alone is likely to make progress. We know have to do this; we have done it in MI, we are doing it in 10 states. Yet we need financial support to put it across the U.S.

We also need to correct the root causes regarding why the markets failed and why the simple, inexpensive and life saving MI therapy did not spread across the U.S. We need to ensure that valid information about quality of care and HAI are accurate, transparent and public. Just like in the financial markets, this will not happen voluntarily. We need you to create the equivalent of the SEC to ensure the reporting of healthcare quality data especially HAI are accurate.

Finally, we need investments in AHRQ to support training of people who can do this work and to create a pipeline of new programs, that when coupled with payment reform, will save lives and dollars.

A few years ago, 18-month-old Josie King died from preventable mistakes including a HAI at one of the world's best hospitals: my hospital, Johns Hopkins. On the four-year anniversary of her daughter's death, her mother, Sorrel, looked me in the eye and asked: If Josie was admitted to Johns Hopkins today, would she be less likely to die today than she was four years ago?"

I started telling her about our commitment to safety, listing all the quality and patient safety projects we were doing, and explaining the challenges with measuring quality. She abruptly and appropriately cut me off. She did not care what we were doing. She wanted to know if care was safer. She wanted robust evidence. Unfortunately, I could not give her an answer; we cannot give the U.S public an answer. I believe Sorrel and the public deserve one. With your help, we can answer her with a resounding yes.

**Healthcare acquired infections (HAI) are common, costly and lethal.**

HAI do not discriminate. Their victims are people of all races and ethnicities, young and old, rich and poor, in every state in the country. Yet these infections and the ensuring deaths and costs are largely preventable.

As shared in previous congressional hearings, I am concerned that we are not making more rapid and widespread progress toward reducing deaths from healthcare acquired infections. Four years after our success in Michigan, AHRQ provided financial support to the American Hospital Association and our research team at Johns Hopkins to replicate what we did in MI in a subset of hospitals in 10 more states. Philanthropists provided support directly to my research team to replicate the intervention in additional states. Using CDC estimates, we can assume that nearly 500,000 people died from HAI during the interval between our remarkable success in reducing these infections at Hopkins and in Michigan, and any additional support to share what we had learned.

Much as the debate regarding the financial crisis explores the virtues of a regulatory versus free market approach, so too does the debate to improve patient safety and prevent healthcare acquired infections. I believe this is not an either or choice. We need to regulate and centralize components of the work that provide accountability, monitor progress toward national quality and patient safety goals, and summarize knowledge. It is inefficient and ineffective for individual hospitals to do this. Yet we should encourage free market /local innovation regarding how to realize the goals.

My research team used these principles to reduce catheter associated bloodstream infections in intensive care units at Hopkins and across Michigan. We accessed central resources at the CDC as we summarized clinical evidence and standardized outcome measures. We accessed AHRQ resources as we studied the evidence around knowledge transfer and developed a method to translate clinical evidence into common practice, and we collaborated with state hospital associations to implement the program within their states. We are now collaborating with Consumers Union to mobilize consumers to help spread this program across all 50 states, to make infections rates visible and to prevent these needless deaths. It is a model that could substantially reduce many types of infections within the next decade.

Programs to improve safety, like our interventions to reduce infections, are often "faceless" and invisible in the ebb and flow of hospital activities. The victims of infections or any healthcare error, however, are never without faces, or stories, or compelling challenges. Josie King is but one of 100,000 deaths.

We know precious little about healthcare quality and patient safety. We *do know* healthcare is increasingly expensive; we can give you detailed cost reports, because we have standardized measures and regulated practices for reporting financial performance. We cannot tell Sorrel that Josie is less likely to die. The national report on healthcare quality is less than informative. In the ten years since the IOM report *To Err is Human* raised healthcare quality and patient safety to the level of national priority, we have made only minimal progress, and for most clinical diagnoses, we do not even measure performance.

Yet during those same ten years, advances in biomedical sciences have been astounding. Thanks to recent discoveries, AIDS is now a chronic disease and we have cured many childhood cancers. In just 13 years, an international collaboration between governments, scientists and private industries sequenced the entire human genome, all 3.2 billion letters with 99.99% accuracy. The results are publically available so that scientists around the world can use the information to develop new therapies.

**How do we explain this dichotomy between the success of biomedical science and the failure of patient care? It is because we have failed to view the delivery of healthcare as a science.**

For every dollar of federal health care research funding that goes towards learning how to better treat and understand disease, only one penny goes towards learning how to better care for patients. While it is essential that we continue to enhance funding for basic and clinical research, we need a more balanced research portfolio -- a portfolio in which we view quality and safety research as *essential to,* rather than separate from, basic and clinical research. We need to eliminate the gap that exists between what we learn in a lab and what actually reaches the patient. We must have a method to create standards and to measure and track our progress with measures that are meaningful and valid to those providing care, to those receiving care and to those paying for care, for resources are too scarce and patient safety is too precious to ignore.

Five years ago, wrong-site surgery – one of the most visible and troubling errors -- was incorporated into the National Quality Forum "Never Events" list. Reducing these errors became a national patient safety goal and hospital accreditation standards were established to guide local hospital efforts. Yet these standards were developed based on common sense, not science, without evidence of their benefit or costs, and without a valid method to monitor their effectiveness. Since the standards were introduced, reports of wrong site surgery have increased yearly. We do not know if this is due to better reporting, if the interventions do not work, or if they are not used correctly. However the results are not encouraging, and the public, the payers of healthcare and the providers of care deserve better.

We need to approach patient safety the same way we approach curing a disease, through rigorous scientific research that produces hard data with clear measurable results. We need to set explicit goals, summarize evidence into clear standards, develop measures and monitor performance with

valid, reliable data, and work to improve teamwork and communication so evidence can be implemented. Across the U.S, consumers do not now the rates of HAI at their local hospitals, consumers cannot select hospitals based on better outcomes because the information is either not collected, not transparent or inaccurate. Insurers and payors are limited in their ability to implement pay for performance and value based purchasing because that lack valid measures of quality. There is wide bipartisan support that paying less for lower quality care and more for higher quality of care is essential health reform. Yet payment reform will not work without valid data on the quality of care and without support for programs like the one in MI to support improvements in quality. Without these investments, improvements in quality and cost will remain elusive.

Our successful work in Michigan applied the model to reduce on type of HAI - central line associated blood stream infections (CLABSI) -- a type of infection that kills between 30,000 and 62,000 people a year and results in nearly 3 billion in excess costs. Prior to our study, little was known regarding how many of these infections were preventable.

We approached the problem scientifically. In phase 1, we reviewed empiric data and selected five key procedures that would most likely prevent these infections. We compiled these procedures into an easy to follow checklist. We identified potential barriers to using the checklist and developed tactics to overcome those barriers so we could optimize compliance. We then pilot tested the intervention at Johns Hopkins and measured performance. We nearly eliminated these infections.

In phase 2, AHRQ provided a matching grant to help us pilot test the program in the state of Michigan. Within three months of implementing the interventions, the median rate of infection in the 103 participating ICUs plummeted to 0, and has stayed at 0 for 4 years. These infections were reduced by 66%. The work was not easy; it required hospital leaders, doctors and nurses to implement interventions, improve teamwork, and monitor performance. But the results were well worth the investment. In just one year, the reduction in infections was estimated to have saved the hospital system millions of dollars and thousands of lives. All of this happened with a $900,000 investment from AHRQ.

In phase 3, we are trying to implement this program across the U.S., state by state, hospital by hospital. Thanks to funding from AHRQ we are working ` with the American Hospital Association to implement this life saving program in 10 hospital systems in 10 states. Additional philanthropic support donated to my research team at Hopkins will permit us to reach another group of states. Most states are trying to reduce these infections, but they need support in order to be efficient, and to rigorously measure and improve performance. Through this effort, researchers, AHRQ, CDC, state hospital associations and individual hospitals are collaborating rather than competing, recognizing their interdependence rather than independence, and ensuring integration rather than fragmentation. Indeed, this approach can be a model not just to eliminate CLABSI, but also to address other healthcare acquired infections and other types of preventable harm.

Similarly, the National Association of Children's Hospitals and Related Institutions (NACHRI) is developing efforts to bring this same program to pediatric centers in the United States. Indeed, my wife, Marlene Miller, is leading these efforts. They used our model, developed pediatric

specific standards and have impressive results in reducing infections in pediatric ICU's. Just as with our adult program, they struggle to fund, organize, implement and measure improvement.

There are many ills that befall the U.S. healthcare system; healthcare associated infections are but one. The fragmented approach to reducing these infections and the invisible or inaccurate monitoring of their rates points to a deep problem with our healthcare system; vague or non-existent performance standards, poor or absent and often invisible measures of performance, misaligned financial incentives, fragmented and under resourced labors all cripple efforts to improve quality, reduce costs and implement health information technology.

**Our ability to produce measured and sustained reductions in infections and costs in MI point to a possible way forward.**

Reducing these infections could be a polio campaign for the 21st century ~ and we need one. These infections are common, costly, and often lethal. We know how to reduce them, yet support for this improvement has been left to a haphazard patchwork of local, regional and national efforts involving clinical, operational and policy levers. No one could argue that whatever the clinical effectiveness of such efforts, the inefficiency is glaring. A coordinated national effort to eradicate these infections should be an immediate priority. The CDC has the ability to measure infections in all states; the intervention knows no state bounds, and patients in all 50 states are dying needlessly from these infections.

I believe our model offers tremendous potential for use on a broad scale. In the model, we centralize development of evidence-based clinical standards, measures and data collection standards for a nationally relevant set of patient safety goals. The CDC has a mechanism to measure infections and summarize evidence regarding how to prevent infections and AHRQ summarizes evidence and program regarding how to ensure patients actually receive the best evidence; how to ensure an efficient knowledge market. These Federal agencies can couple with states to innovate regarding how to prevent these infections. In this model with standardized national measurement, we can hold healthcare organizations accountable for improving quality, we can align payment to incentivize quality care, and we can advance the science needed to improve healthcare delivery, so that learning does not need to take place one patient, one physician, and one hospital at a time. In this model, payers, consumers, insurers, administrators, clinicians and regulators, work together to solve the problem. Now that we have a proven system that can measure and prevent harm, we should align payment policies to support safe care.

Yet there is no support to create, develop and implement programs to realize this model. From the original AHRQ investment in Michigan, in addition to nearly eliminating CLABSI, we also nearly eliminated ventilator associated pneumonia (VAP). The rate in the state was reduced by 70%, remains low three years after the intervention, and saved thousands of lives and millions of dollars. Why is there no mechanism to spread this life and cost saving intervention across the country; largely because we lack regulatory requirements to make the rates of these infections accurate, transparent and broadly available and because we have not invested in eliminating them. From the CLABSI effort we learned how. CDC can develop a national measurement system and summarize clinical evidence, AHRQ can summarize how we ensure patients actually receive the evidence and coordinate efforts with states, states can recruit hospitals to implement, innovate and evaluate the intervention, CMS can align patient policy, and consumers can drive healthcare organizations to improve quality.

We need support for research to ensure that patients actually receive life saving therapies, to ensure that children and the elderly receive these therapies and to ensure that your skin color or your gender does not determine whether you receive a life saving therapy. If we want to make progress, we have to view these as primarily scientific rather than political issues. With wise investments, we can help ensure that the citizens of your states do not die from preventable healthcare acquired infections, we can support the CDC to summarize evidence for how to prevent infections and develop a national measurement system, we can support AHRQ to summarize evidence regarding how to implement the evidence and coordinate state by state efforts, we can support states to monitor infections and partner with hospitals to eliminate them, we can provide Sorrel King a clear answer that Josie is less likely to die.

While the investment in comparative effectiveness research is wise and overdue, it is insufficient. Knowing what to do is insufficient. We must also ensure that patients actually receive evidence-based therapies, we must ensure an efficient healthcare knowledge market, and we must eliminate preventable harm. This will require a similar investment in knowledge translation.

The intervention to reduce CLABSI in MI saved more lives than virtually any other medical intervention in the last 3 decades, saved hundreds of millions of dollars per year and cost about $1 million for 2 years. The return on investment is between 200 and 400 fold. Why are we not making these life saving investments? We can translate evidence into practice, we can prevent healthcare acquired infections and we can prevent needless deaths and cost of care; we have done it. We need you to provide support to ensure these programs can be spread across the country and to ensure that we can develop new programs.

**Our national failure to view the delivery of healthcare as a science is also a significant factor in our limited success in learning from mistakes that do occur.**

Though it took over nine years, we are now close to having a voluntary mechanism for reporting healthcare errors at a national level. Yet we do not know how to learn from the errors that will be reported. There is no national infrastructure to learn from common, costly and lethal mistakes that are beyond the capacity of any single health system to fix. For example, in all of the 6,000 U.S. hospitals, patients sometimes get epidural pain medicine connected to an intravenous catheter, a potentially lethal error. The intervention to prevent this error is to encourage doctors and nurses to be more careful, to reeducate staff. Assume this education takes one hour: imagine the costs of reeducating all the doctors and nurses in the country and now imagine the probability that the education will work. Current methods for learning from this type of mistake are form over substance. They waste time, money, energy and the good will of caregivers who know they are human and will likely make the mistake again.

There is a better way. We learned it from aviation. In aviation, they recognized that is foolish to have individual airlines investigate and learn from mistakes in isolation. They formed a public private partnership called The CAST (The Commercial Aviation Safety Team). The industry works together to prioritize the greatest risks, investigate them thoroughly and implement interventions that work. Most of the interventions are product redesign. We need cast in healthcare. We need to get the manufacturers to design the catheters so that the epidural and intravenous catheters do not fit together. We need to eliminate the possibility of making this mistake rather than hoping that re-education will work. Yet there is no mechanism to bring

administrators, clinicians, regulators, and device makers together in healthcare to accomplish this. We have a small planning grant from the Robert Woods Johnson Foundation (RWJF) to pilot this concept. All parties are eager to participate. Yet we need federal leadership. We need your wisdom, your expertise and your support.

**We also need to ensure that the information provided to the public regarding the quality of care is accurate. Truth in data matters. Our current system for reporting quality of care data is neither sufficiently standardized nor accurate. We need the equivalent of the SEC for reporting healthcare quality data.**

Anyone who has fallen for a false ad or sales pitch surely knows that information about a product is only valuable when it's truthful and credible. Much if not most of the current financial crisis can be traced back not to a lack of information so much as a flood of complex but literally *in*credible information gushing through the markets. As a result, most ordinary people – even some experts -- are unable to figure out what's going on, or to identify enough credible, complete and accurate information to guide good choices in making financial decisions. They are rightly clamoring for stricter enforcement of good accounting principles and standards of operation that everyone can find and easily understand.

Yet, the financial crisis highlights the need for wise regulations to ensure truthful information. For the most part, financial markets provide accurate data. They do not do so voluntarily but rather they are regulated to. In 1934, Franklyn Delano Roosevelt established the Securities and Exchange Commission (SEC) to ensure accurate reporting of financial data. Form this, emerged trained professionals who report financial data, explicit rules for what and how to report, audits to ensure accuracy, and accountability with penalties when organizations or individuals deviate from the rules. As a result, our capital markets are much more efficient than they would be without the SEC and the public has trust that the information provided by companies is truthful.

Shockingly, perhaps, we're seeing the same challenges rising in healthcare: globs and gluts of information and claims about "quality of care," but few standards for gathering such information and even fewer guides for helping ordinary people understand what the information means. Healthcare generally lacks trained professionals to report quality of care data, rules regarding what to report, audits to ensure the reports are accurate or penalties for those who digress. The reporting of healthcare quality care is reminiscent of the pre SEC era.

Catalyzed by evidence of poor hospital safety and remarkable variations in patient outcomes and what treatments work best, hospitals and health care businesses are falling all over themselves to report "quality measures" on their websites. State and federal government agencies are issuing "performance" scorecards on individual physicians and hospitals. And hospitals and other health care providers are using those scorecards to market their services on websites, in glossy brochures, on billboards, and on TV.

Yet research shows that there is no assurance of the accuracy of their claims, because the measurement of quality in health care is neither standardized nor consistently reliable. Indeed, hospital reports about quality of care are held to no higher standard than the advertising of toothpaste or washing machines.

Examples of the health care information problem are easy to find. One hospital Web site reported that the institution saved 242 lives during 18 months. But how they made this estimate (what kind of patients were counted, how many and did they count people who were really sick or not very sick) were not reported. Another hospital Web site claimed that 90% of patients with pneumonia were screened and given pneumococcal vaccination, whereas a government web site (CMS's Hospital Compare) on the same day reported that only 64% of patients at that hospital were vaccinated. It's possible the hospital percentage is right, because CMS sometimes has delays getting data, but because the Web site failed to disclose its statistical and fact-gathering standards (such as dates of data collection, sample size, or the confidence interval), it's impossible to know. Another hospital reported the ratio of central line–associated bloodstream infections and ventilator-associated pneumonia compared with "CDC national averages." Yet the hospital did not provide the benchmark rates used, which vary by intensive care unit type, the number of patients evaluated, and the time period. Not surprisingly, this hospital's performance was great, with both a ventilator-associated pneumonia ratio and a central line–associated bloodstream infection ratio of 0. But how long have the rates been zero? A day? A week? A year? Does this mean that patients will never get these infections at this hospital? Without more information, who knows?

Profit-oriented private enterprises that report on the quality of care are completely unregulated and because their rating methods are proprietary, opaque and more promotional than scientific, they frequently misinform or confuse the public. For example, not one hospitals was listed on all three high profile ranking systems; the U.S News and World Report's list of top 20 hospitals, Health Grades list of the top 50 hospitals, and JD Powers list of the top 20 hospitals. If they are accurately measuring hospital quality, how can that be? Other companies create lists of "best hospitals" and "best doctors" and sell services to those they help gain public recognition as top performers. As such, most U.S Hospitals now boast they are part of at least one "top" list, evoking echoes of Garrison Keilor's Lake Woebegone where all the children are "above average."

Information collected by the Federal government is generally thought to be more robust than other sources. For example, data collected by the Center for Medicare and Medicaid Services (CMS) related to often lethal blood stream infections and the costs of treating this medical complication show that between 30,000 to 62,000 people die of these entirely preventable infections yearly in the U.S at a cost of $2-3 billion. Yet CMS, and many states, measure these infections using notoriously inaccurate hospital billing data even though another federal agency, the Centers for Disease Control collects much more accurate clinical data.

Such incomplete or misleading reports about quality-of-care measures pose significant risks to patients, clinicians, and insurance companies. Patients might choose care according to misinformation and make poor decisions. Health care organizations may become overconfident about the quality of care provided, reduce or eliminate improvement efforts and increase the risks of preventable harm. Payers may mistakenly provide financial rewards, channel patients to low-quality clinicians, or make inaccurate inferences about the value of the care they purchase.

Clearly, the public deserves better. Public reporting of quality measures should have at least the same reporting standards as the reporting of financial data, along with enforcement of those standards, to reduce bias, assure professional oversight of data collection, and assure regular auditing. Organizations that gather, report and publicize health care quality measures must be held accountable for e accuracy.

At the very least, the Federal government can and should do for heath care what it began to do in 1934 for financial data: ensure its accuracy and transparency. When healthcare has valid measures, healthcare markets can compete on quality. The U.S public should have confidence that the information they have about hospital quality is accurate, timely, understandable and continuously improving. Just like in the financial markets, this is not likely to happen without wise regulation. Without accurate and transparent data, the healthcare market will not improve quality.

One of the greatest interventions to facilitate healthcare reform would be to create a Healthcare version of the SEC; an independent, self funding, authoritative entity that could ensure accurate healthcare data. Whether reviewing a financial report, analyzing a mortgage contract, or reading a scientific report about global warming or a medical discovery, we assume the information is accurate. When it is not, disaster strikes. The fall of Enron, the Madoff ponzi scheme, and much of the financial crisis occurred from inaccurate data. Indeed, much of the financial crisis resulted from inaccurate data leading to an inefficient knowledge market. Because truthful information is fundamental to the functioning of markets, society has created safeguards to ensure their accuracy. Perhaps the greatest example is the reporting financial data.

Investors generally have confidence that the figures in financial reports are correct. The Securities and Exchange Commission designated and authorized the Financial Accounting Standards Board (FASB), an independent body, to establish and improve standards for financial accounting and reporting. The FASB recognizes that "standards are essential to efficient functioning of the economy because decisions about the allocation of resources rely on credible, concise, transparent and understandable financial information." Such standards provide investors, creditors, auditors, with credible, transparent, and comparable financial information. These standards force organizations to comply with generally accepted accounting principles (GAAP) in reporting data.

Through our work, we have learned that we can improve quality and reduce costs. Current efforts are too isolated, too weak on science, and too limited in focus. This will not get us where we need to go. There is something we can do to change this: to we can save lives and dollars, we can provide Sorrel an answer: is Josie less likely to die?

**Specific suggestions for Improving Healthcare Quality and Patient Safety:**

1. **Support AHRQ and CDC to expand the MI project across all 50 states and replicate the program to eliminate other types of healthcare acquired infections.**
   Support collaborative efforts among CDC, AHRQ, and states to work to eliminate the major causes of healthcare acquired infections within 10 years. It is neither effective nor efficient for individual hospitals to go it alone. Fund research under AHRQ so that rather investing a penny in quality for every dollar in basic and clinical research we have a more balanced

portfolio; Imagine the gains in quality and reduced costs if we increased the ratio to a quarter for every dollar.

2. **Create an Institute for Healthcare Delivery**
   This institute, similar to the human genome project, should link provider organizations, insurers, payers, and regulators to design, implement, and evaluate interventions to improve quality, reduce costs of care, and implement Health Information Technology. This institute would inform the science of healthcare delivery. Though the focus on comparative effectiveness is important and needed, it will do little good to know what therapies to use if we do not couple that with science to ensure that patients actually receive them.

3. **Coordinate public and private efforts to improve quality of care**
   A "supra agency" should be established to facilitate and monitor integration of inter-agency activities to address deficits in the quality of U.S. healthcare. The agency should report directly to the Secretary of HHS. Such an agency could coordinate setting national priorities for quality of care and patient safety, creating measures toward those goals, summarizing evidence, developing strategies, and monitoring progress toward the goals.

4. **Build capacity**
   Support training in quality improvement methods for physicians, nurses other clinicians and administrators in order to improve the delivery of healthcare across the U.S. At most academic medical centers, there are hundreds of faculty who can teach genetics, hundreds who can teach physiology, yet a precious few, if any, who can teach safety. This needs to change if we are to make and sustain progress.

5. **Develop national standards for the reporting of healthcare quality data.**
   The federal government should do for the reporting of quality data what the SEC did in 1934 for the reporting of financial data: ensure its accuracy.

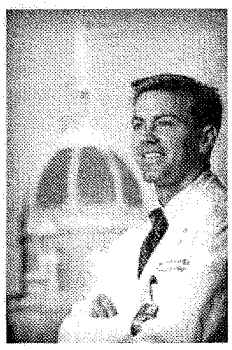
The health care community nationwide from the federal government to state and local governments to hospitals, providers, corporate purchasers, and the insurance industry has some learning disabilities that time and research have uncovered. Those disabilities have real, lasting, and deep consequences for patients, health care providers, and all of the third party payers. Any efforts to improve, revise, or strengthen the way health care is delivered in the US that do not address these disabilities will be far less effective than if fixing them were a central part of reforms. The administration and Congress have seen that investments in IT for example will help to address some of the challenges long term. However, if the people in and operating the systems cannot take the data available from IT improvements and learn from it, the investments will not pay off. With standards from the healthcare SEC, they can require HIT vendors to collect accurate data about healthcare quality.

President Obama suggested the new administration would restore science to its rightful place... raise health care's quality... and lower its costs. To achieve this goal, programs that work -- such as the model to reduce blood stream infections -- should be expanded, and those that do not work should end. Paraphrasing our president, those of us who provide healthcare, and those who

manage the public's dollars need to spend wisely, reform bad habits, and do business in the light of day. Healthcare business is now conducted the dark of night.

Substantial improvements in healthcare quality and costs are possible. For too long we have lacked clarity of purpose and the commitment to invest the necessary resources to make this vision a reality. We can save 100,000 lives a year, we can build capacity to address other ills, and we can reduce costs. We have a model in MI. We need to your support to spread it to all 50 states and to create a healthcare SEC so that quality is accurate and transparent. Courageous leadership must hold all stakeholders accountable for results. My hope and expectation is that together we find this courage.

Peter J. Pronovost, MD, PhD, FCCM



Director of Division of Adult Critical Care Medicine
Director, JHU Quality & Safety Research Group
Medical Director, Center for Innovations in Quality Patient Care

Peter J. Pronovost, MD, PhD is a practicing anesthesiologist and critical care physician, teacher, researcher, and international patient safety leader. Dr. Pronovost is a Professor in the Johns Hopkins University School of Medicine (Departments of Anesthesiology and Critical Care Medicine, and Surgery); in the Bloomberg School of Public Health (Department of Health Policy and Management) and in the School of Nursing. He is also Medical Director for the Center for Innovation in Quality Patient Care, which supports quality and safety efforts at the Johns Hopkins Hospitals. In 2003 Dr. Pronovost established the Quality and Safety Research Group to advance the science of safety. Dr. Pronovost and his research team are dedicated to improving healthcare through methods that are scientifically rigorous, but feasible at the bedside. Dr. Pronovost holds a doctorate in clinical investigation from the Johns Hopkins Bloomberg School of Public Health.

The author of more than 200 articles and chapters in the fields of patient safety, ICU care, quality health care, evidence-based medicine, and the measurement and evaluation of safety efforts, Dr Pronovost is also a frequent speaker on the topics of quality and safety leadership and implementation of large scale change. He chairs the JCAHO ICU Advisory Panel for Quality Measures, the ICU Physician Staffing Committee for the Leapfrog Group, and serves on the Quality Measures Work Group of the National Quality Forum. He also serves in an advisory capacity to the World Health Organizations' World Alliance for Patient Safety, and is leading WHO efforts to improve patient safety measurement, evaluation, and leadership capacity globally. He has won several national awards for his research, including the 2004 John Eisenberg Patient Safety Research Award.

Dr. Pronovost has been chosen by the editors of Time Magazine as one of their 100 most influential people for 2008. His work in innovating ways to improve patient safety and care are changing the way, not just the US, how the world thinks about medical care.

Dr. Pronovost is currently leading several large national and international safety projects. To learn more about his work visit the Quality and Safety Research Group website: www.safetyresearch.jhu.edu.

## Subcommittee on Labor, HHS, Education and Related Agencies

## Witness Disclosure Requirement – "Truth in Testimony"

Required by House Rule XI, Clause 2(g)(4)

| Your Name: Peter John Pronovost | | |
|---|---|---|
| 1. Are you testifying on behalf of a Federal, State, or Local Governmental entity? | Yes | No<br>x |
| 2. Are you testifying on behalf of an entity other than a Government entity? | Yes | No<br>x |
| 3. If your answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 2005:<br><br>Note: I was invited to provide expert testimony and am doing so as an individual. I am and have been, however, the recipient of federal grants and subcontracts and the list of all such awards received since October 2005 is attached for your reference. | | |
| 4. Other than yourself, please list what entity or entities you are representing:<br><br>None | | |
| 5. If your answer to question number 2 is yes, please list any offices or elected positions held or briefly describe your representational capacity with the entities disclosed in question number 4: | | |
| 6. If your answer to question number 2 is yes, do any of the entities disclosed in question number 4 have parent organizations, subsidiaries, or partnerships to the entities for whom you are not representing? | Yes | No |
| 7. If the answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which were received by the entities listed under question number 4 since October 1, 2005, including the source and amount of each grant or contract: | | |

Signature: _____ Date: 3/27/09

Please attach this sheet, along with you curriculum vitae (résumé), to your written testimony.

**P50HL0739994** Brower (PI) 12/01/03 – 06/30/09 2.4 calendar months
NIH NHLBI $269,733
Project #2: Long-Term Outcomes of Specific Ventilator Strategies of SCORR Grant: Ventilator Associated Lung Injury: Molecular Approaches

The overall goal of this study is to improve outcomes for patients with ALI, we must understand the barriers to compliance with CVLP, long-term mortality and other outcomes associated with ALI, and the constellation of factors and other therapies that may be associated with those outcomes.
Role: Principal Investigator for Project 2

**1R01HL088045** Pronovost (PI) 09/30/08 – 06/30/2013 2.4 calendar months
NIH NHLBI $466,499
Improving Long Term Physical and Mental Health After Acute Lung Injury
The overall goal of this study is to improve outcomes for patients with ALI.
Role: PI

**R21 AG029955-01** Nelson (PI) 06/01/07-05/31/09 .24 calendar months
National Institute of Health (NIH) $145,000
Exploring Measurement of Palliative Care Quality in ICUs
Mt Sinai Medical Center
The overall goal is to improve the quality of palliative care across a broad range of ICUs and the millions of critically ill patients and families for who they provide care.
Role: Principal Investigator for Sub-Contract

**8481-S-04** Pronovost (PI) 09/24/2008 - 09/23/2012 .84 calendar months
AHRQ/WESTAT INC $117,862
Patient Safety Organization Network Of Patient Safety Databases
The overall goal of this project is to develop a network of patient safety databases in order to better share and streamline the accessibility of patient safety data and the effectiveness of its applications. The subcontract is a time and materials contract for review of processes and measures.
Role: Principal Investigator for Subcontract

**1 K12 HD049104** Powe (PI) 09/23/04 - 7/31/09 .12 calendar months
NIH/NICHD $2,083,420
Multidisciplinary Clinical Research Career Development
Mentored Clinical Scientist Development Program Award
Role: Mentor No funding

**1U54RR023561-01A1** Ford (PI) 06/01/08 – 5/31/09 .6 calendar months
Department of Health & Human Services $125,216
National Institute of Health
Institute for Clinical and Translational Science Research (**CTSA**)
The overall goal is to enhance both the process and benefits of clinical and translational research by bringing together the diverse resources of the Johns Hopkins Medical Institutions and creating a new model for carrying out scientific research. This model will create a new paradigm for conducting multidisciplinary research by addressing critical barriers that currently impede the progress of basic science discoveries to the clinic.
Role: Principal Investigator for this module of the grant.

0036905 **Pronovost (PI)** 10/1/2008-9/30/11 2.4 calendar months
HRET (The Health Research & Education Trust
AHRQ (Agency for Healthcare Research and Quality)
Title: "National Implementation of the Comprehensive Unit-Based Safety Program (CUSP) to Reduce Central Line Associated Blood Stream Infections (CLABSI) in the ICU"
The overall goal of this proposal is to reduce Central-Line Association Blood Stream Infections in the U.S. by working with hospitals to adopt the evidence-based CUSP strategy and related patient safety tools. During a three year period we will spread the patient safety program across 10 states.
Role: Principal Investigator

**AHRQ-2009-10001** Shekelle (PI) Sub-contract 1/08/09 – 1/18/10 1.2 calendar months
RAND $39,129
Assessing the Evidence Base for Context-Sensitive Effectiveness and Safety of Patient Safety Practices: Developing Criteria
Based on the framework and criteria,this study will identify the types of research and evaluation models and methods experts judge to be most useful in advancing the field of patient safety. .
Role: Co Principal Investigator

**COMPLETED**

UHC1HS014246 AHRQ Pronovost (P.I) 10/1/03-9/30/05 2.4 calendar months
Statewide Efforts to Improve ICU Care
The goal of this quality improvement research was to improve the culture of safety and reduce catheter related blood stream infections and ventilator associated pneumonia infections in intensive care unit patients across the state of Michigan

**PENDING**

AHRQ R18 Pronovost (PI) 10/1/09-9/30/14 1.2 calendar months
Healthcare CAST (Collaborative Accountability Safety Team)
The overall goal of this proposal is to reduce preventable patient harm by improving the effectiveness and efficiency with which healthcare learns from its mistakes. Specifically we will develop a scientific approach to minimize health care hazards by adapting the Commercial Aviation Safety Team (CAST) model, including quantitative methods for prioritizing risks and selecting interventions to mitigate harm. We will integrate ethics and public health foundations into our approach and will test the resulting model on three ubiquitous safety hazards.
Role: Principal Investigator

**1 R01 OD006208-01** Berenholtz (PI) 09/01/09 - 08/31/14 .6 calendar months
NIH
Title: "Accelerating the Translation of Evidence into Practice: Reducing Intensive Care Unit Acquired MRSA and VRE "
The goal of the proposed research is to apply a novel integrated model for behavior change to the prevention of healthcare acquired MRSA and VRE in the intensive care unit (ICU).
Role: Co Investigator

MS. STRICOF'S OPENING STATEMENT

Ms. STRICOF. Hi. Chairman Obey, Ranking Member Mr. Tiahrt, and the rest of the Subcommittee members that are still here, my name is Rachel Stricof, and I am very thankful to be able to be here today. I am the Director of the Healthcare-Associated Infections Program for the New York State Department of Health.

Within our program, we do have healthcare-associated infection reporting and also outbreak investigation and guideline development. But we are a unique State in that there are some dedicated resources for these efforts.

Just to give you a little background, in July 2005, legislation was passed requiring hospitals in New York State to report select hospital-acquired infections to the Department of Health. Our legislation had some unique features that may be different than other States, and I think some of those were very important in being able to really evaluate the data that we are seeing and to be able to use it.

First of all, it gave us flexibility to decide what kind of reporting system we wanted and whether to use existing data or the National Healthcare Safety Network or our own. It provided us time to implement the reporting system in such a way that we could train the hospitals and we could truly standardize the way they were interpreting definitions, the way they were conducting their surveillance so that we would not be penalizing hospitals that had better surveillance systems and therefore were reporting higher infection rates.

It also gave us the authority and ability to conduct audits in the hospitals to determine whether the reporting that we were seeing was accurate and reliable or not. It gave us the ability to consult with technical advisors and to be able to modify the system before we started collecting data that would actually be hospital-identified data that would go to the public. It also provided for grants for infection prevention and control collaboratives as a result, not only as a result of our legislation, but related to healthcare-associated infections.

So our first challenge was really to say—and I know this is still a struggle at the national level—how are we going to report these infections. And at the time we were doing this, we were the seventh State to have legislation; none at the time had enrolled in the NHSN or actually selected the NHSN for reporting purposes, so we were the first State to do that.

And I have to mention that this was really a challenge because there was a lot of pressure on us as a department to do one of two things: it was either to use an already existing data set, basically the hospital administrative data for billing purposes, and say you can use that data to really determine hospitals' infections rates. There was a lot of pressure to do that because it was an existing data set, it would not cost additional money, it would not take additional resources from the hospitals.

The trouble is, for decades, we have been evaluating that data source and have found it to be very unreliable when it came to the actual infection rates that they were reporting, because that sys-

tem was not developed to determine what you acquire in the hospital versus what came in from the community.

Then we had another challenge even within our own department, because some of you may know that New York likes to do things their own way and likes to be totally in control. So we looked at whether we should develop our own unique data system or whether we should go with the National Healthcare Safety Network.

I will tell you we ended up taking nine months, almost as long as to have a baby, to make this decision. Well, about the same. There were many reasons that went into this, and I think it is important for you who are going to be decision-makers as to how we implement this to hear some of our reasons as to why we picked the NHSN.

One, it was recognized and respected worldwide; two, hospitals said that they were using the CDC criteria for measuring infections, but as we all know, if all of a sudden that information is going to be made public, all those infections get open to a lot of interpretation unless those definitions are truly standardized and the interpretation of the definitions are standardized.

Ten percent of our hospitals were already using the NHSN. We had another 10 percent of sister facilities that were waiting to use it and another 5 percent of facilities that were on a waiting list to use it. So we knew there was interest in the hospital community to use it as well.

It did have, again, the standard definitions, surveillance methods, and risk adjustment to make the rates more comparable between hospitals if you were going to compare infection rates. There were considerations into how to risk adjust for patient care statistics.

The things that made it, I think, the most critical to me, as an individual who works with the hospitals on a daily basis, being in the Health Department, is that the data provided by the NHSN is timely, it is immediately available not only to the hospital, but to the CDC and to the State health department the minute it is entered, and it is useful and actionable data for the hospital themselves. The minute they enter the data, they can compare themselves with national rates; it can be generating reports for specific hospital units to report back the outcome indicators related to their quality improvement efforts; and I also knew that if we developed our own system in New York, it would be to give us the data, but not necessarily to make it meaningful and useful to the hospitals themselves.

The other thing that went into that was it became really clear to me, when I was asked by the Presbyterian Network to come and speak to them about what we were planning to do, and in that case, just to give you a little background, the Presbyterian Network has 23 hospitals in four States and two countries: New Jersey, New York, Connecticut, Texas, and in Europe. So we sat there and said, boy, if we have legislation in New York and we develop our own reporting system and our own definitions, then the hospitals in our neighboring States and in Texas, in the same network, would not be able to communicate. They may have different definitions, they may have different methods of surveillance. Everything would be

different and they could not even compare themselves for quality improvement purposes.

So that, to me, was an aha moment to say, really, we have to use a standardized system; we need that foundation to come from a national level so that every State is not creating their own silo and they cannot communicate with one another.

And a little bit of icing on the cake was indeed that we did not have to pay for the cost of developing the system nor maintaining it, and that the hospitals themselves could use the system not just for the indicators that we mandated, but for a full array of infection indicators. They did not even have to share that data, necessarily, with us, but they could use it given their local infection control risks and problems that they identify within their own hospital, which I think is a key issue as well.

This is not just one kind of infection, and all of our infections are not easy to measure, and do not come away from here thinking this is nothing, this has no impact on the hospitals. Everything they are doing takes major resources to monitor and monitor the infections well.

Again, we were able to measure and to ensure that our hospitals were indeed finding the infections as well, because our legislation provided for an audit and validation process. So we have gone into every hospital at least once, we have been in 90 percent of our hospitals twice in the last two years. We have audited them to find out, one, how they are using the definitions. We have looked at cases that were reported to make sure that they were reporting accurately; and also individual records of patients who did not have infections. We were looking at those to say should they have been reported, were there infections that were not reported.

But also we are looking at those records to say why are some patients getting infections and others not. We use this as an opportunity to look at prevention strategies that the hospitals are using, to look at risk factors in the patients, and to turn that information into usable information, provide feedback to the hospitals, and also to better enhance the National Healthcare Safety Network.

Beyond the reporting, we have had a definite commitment to not just importing data, collecting data, and reporting it out, but to prevention projects in New York; and we were given, from the State funds, we were given dollars to provide for collaboratives in the State. Since 2007, we have initiated nine healthcare-associated infection prevention projects.

Yes, we have looked at central line infections, but we have also looked at them in other than ICU settings, where, quite frankly, now there are just as many central lines being used on the overall floors and not just in ICUs.

We have looked at our regional perinatal centers, which take care of our highest, highest risk infants, the newborns who are born premature, and they are looking at infection reduction strategies in those units. We are looking at a full array of multi-drug resistant organisms in our public hospitals, not just MRSA, not just VRE, but these totally resistant strains of acinetobacter and Klebsiella that are killing our patients; and in some of our hospitals they have had to cut off all antibiotic use in some ICUs in order to get the organisms back to being resistant to some of our

antibiotics. They have had to say forget it, no antibiotic use now, because we have made all of our antibiotics obsolete.

We have looked at ventilator-associated pneumonias. We have a major prevention project looking at Clostridium difficile infections. We had over 42 hospitals participate. It has now been expanded to nursing homes in the State. Do not think that everything is in hospitals as well. We are also looking at other measures in addition.

So we have demonstrated remarkable reductions in an array of healthcare-associated infections; not just one bug, not just one type of infection, but it has come from the local community to say this is our pressing infection control issue, these are the major risks we are seeing in this region, please help support us with that particular type of infection.

We think that flexibility is very important in order to involve people and to get the involvement not just from the top down, which is also critical for every one of these efforts, but from, I would say, the bottom, from the people who are actually delivering the care, to say this is what we need in our hospital, this is what we should target, and to make sure you involve and motivate all those individuals.

I think it is critically important that there is national leadership on this effort, not to just direct exactly what you are going to look at, but more to give us that foundation; to give us the foundation of the NHSN to truly support it to be able to utilize that system better and more quickly. It does need enhancements in order to make it more flexible and in order to meet new and emerging infection threats that we have not projected right now.

We, as States, I think, need to be involved in the decisions as to what is a major problem for our hospitals, and that foresight has to come from the local and State level, and not just a national imposition of this as being the priority for every hospital in the Country.

Given that more than 70 percent of the infections are now occurring outside the hospital environment, many of you may be aware of the numerous hepatitis outbreaks that have been reported recently. They are not just occurring in hospitals or ambulatory surgery centers, they are occurring in basic doctors' offices, where invasive procedures are now being performed; and there is absolutely no oversight in those facilities. There are no regulations of those facilities. We are now mandating accreditation in New York State, but we still do not regulate those settings.

We receive over 1,000 outbreak reports a year in New York State in our healthcare facilities. It is not just hospitals, it is our long-term care facilities and these other sites.

We need to be able to monitor things not just with the NHSN, but there are other electronic solutions that can be there, that are available in a few States. New York happens to have an extensive electronic laboratory reporting system, but this needs to be across the Country and not just in New York State. Even our public health labs do not have electronic reporting; less than half of them do.

Our IT systems need to work together. You have already heard from others on that. We have mandatory infection control education in New York. I will tell you, every four years, every provider

has to go through this. I cannot tell you that they all listen, that they all hear and they all implement everything that they do. I think so much of their training has already been ingrained.

And if you think there is a major component in the medical school and nursing school curriculum on infection prevention and control, you are mistaken. That has gone on the wayside. Why? Because we have more technology to teach, we have more this, more that. Infection control is not a priority and absolutely needs to be.

When manufacturers are making these new stellar devices that can go to all parts of the body through a small hole, that is great. But they are not putting infection prevention and control in the design of that piece of equipment. Infection prevention and control has to be a priority in medical device design, in the way we manufacture medications, the way we dispense medications. To me, it is despicable that we have individuals using multi-dose vials on multiple patients, and the inadvertent reuse of a single needle or syringe can lead to infection in 50, 100 or more patients just by one error. We have to build these errors out of the system. We have to engineer them away.

Anyway, we have only had a short time. I hope I have given you some idea of what a State can and should be doing. But there are not the resources to do this. We really hope that we can work together to achieve success in this area.

Mr. OBEY. Thank you.

[The information follows:]

Statement of

RACHEL L. STRICOF
DIRECTOR
BUREAU OF HEALTHCARE-ASSOCIATED INFECTIONS
NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF EPIDEMIOLOGY

before

COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES
House Appropriations Subcommittee

Labor, Health and Human Services,
Education and Related Agencies

on

National and State Efforts to Reduce Healthcare-Associated Infections

April 1, 2009

**New York State Approach to Healthcare-Associated Infection Surveillance, Prevention and Public Reporting**

Chairman Obey, Ranking Member Tiahrt, and distinguished Subcommittee members:

Thank you for inviting me here today to discuss New York State's challenges and accomplishments in addressing healthcare-associated infections (HAIs). As you are aware, healthcare-associated infections are an all-too common cause of preventable morbidity and mortality. They are costly for payers, the hospital system, and patients. While New York is indeed a leader in these efforts and great strides have been made, there is still much to be done.

Let me begin with a little background. In July 2005, the New York Legislature passed legislation that the Governor signed into law requiring hospitals to report select hospital-acquired infections to the New York State Department of Health (NYSDOH or the Department). The explicit wording of the legislation with subsequent amendments has provided a sound basis for New York's activities.[1] The key elements of the legislation include the provision of a "pilot phase" to develop the reporting system; training hospitals on its use; standardized definitions, methods of surveillance and reporting; audit and validation of the hospitals' infection data; consultation with technical advisers; modification of the system to ensure that the hospital-specific infection rates, when released, would be accurate and reliable; and importantly, grants to hospitals for infection prevention and control.

**Selection of the National Healthcare Safety Network (NHSN) for HAI Reporting**

Long before this legislation was passed, NYSDOH had explored using existing data sources to monitor hospital or healthcare-associated infection rates. This option would have been inexpensive, with data readily available but, unfortunately, for HAIs, the data were to be unreliable. Recent studies have found that only 8 percent to 20 percent of infections identified through administrative discharge databases actually meet the criteria for being healthcare-associated.[2,3]

This was one of the many reasons the Department chose to use the CDC's National Healthcare Safety Network (NHSN) for reporting. Other reasons include:

- The NHSN and its predecessor, the National Nosocomial Infection Surveillance Survey (NNIS), are recognized and respected worldwide.
- Most facilities use the CDC criteria for surveillance definitions.
- Approximately 10 percent of New York hospitals were already using the system, and the rest would be granted access.
- Standard definitions, surveillance and risk adjustment methods had been established and could be used to measure compliance and data integrity.
- The information, once entered, is available and actionable: it can be immediately used by the facility to generate reports, compare to national rates and be used on the hospital units for patient safety and quality improvement efforts.

- CDC and New York State have immediate access to the data and can perform ongoing monitoring for accuracy.
- Health care facilities in networks that cross state jurisdictions could use the system to share data; collaborate on quality improvement, prevention and patient safety initiatives; and evaluate effectiveness.
- A separate system would not have to be established, and the costs associated with development and maintenance would be averted.
- NHSN can be used for an array of infection surveillance and quality improvement activities and is not limited to those mandated by NYSDOH.

New York was the first state to use the NHSN for reporting. Now, at least 19 states have committed to using the network for mandatory reporting, and it has become the national standard. There are more than 2,100 healthcare facilities in all 50 states using the system on a voluntary or mandatory basis. Due to this rapid growth, the NHSN system can be extremely slow, and additional resources are critically needed to enhance capacity and performance.

**Ensuring Data Accuracy and Validity**

To ensure the completeness and accuracy of self-reported hospital data, the New York State legislation called for the development and implementation of an audit process. Six experienced infection preventionists were hired and dedicated to monitor compliance, audit the hospitals, evaluate risk factors for infection, and survey prevention activities. All reporting facilities have had at least one on-site audit, and 90 percent of facilities have had two. These audits included surveillance and prevention practice surveys and medical record reviews.

Accurate data are essential to identify and monitor target areas in need of improvement and evaluate the effectiveness of interventions. States have the authority and responsibility to ensure compliance with reporting requirements, and New York took regulatory action to ensure complete, timely and accurate reporting from a few non-compliant hospitals. Without these efforts, we know the quality of the data would be compromised and not be uniform across hospitals.

**Commitment to HAI Prevention**

The Department is committed to not merely collecting, analyzing and reporting infection rates, but also to actively provide support and resources for HAI prevention initiatives. New York State has created a close working relationship with leaders in the HAI prevention community: healthcare associations, infection preventionists, hospital epidemiologists, clinicians and consumers. Many groups, including the Greater New York Hospital Association, United Hospital Fund, Healthcare Association of New York State, Society for Healthcare Epidemiology of America, and Association for Professionals in Infection Control and Epidemiology, have been actively involved and supportive of the implementation of the legislation. They provided critical evaluation of the Department's efforts and fostered patient safety and quality improvement efforts.

Since 2007, nine HAI prevention projects have been funded. One of the criteria for funding is the use of the NHSN to measure infection outcomes. Thus, the system is used as a monitoring tool for facility participation, evaluation and quality improvement. The following infection prevention initiatives are in progress:

- To reduce the incidence of central line-associated bloodstream infections throughout the hospital (i.e., all units including those outside the intensive care unit setting),
- To reduce the incidence of central line infections in regional perinatal centers across the state, with expansion to all neonatal intensive care units,
- To determine the prevalence and incidence of multidrug-resistant organisms in public hospital intensive care units,
- To reduce the incidence of ventilator-associated pneumonia in intensive care units,
- To reduce the incidence of *Clostridium difficile* infections throughout the hospital and expanding to include nursing homes,
- To describe the prevalence, incidence and transmission patterns of methicillin-resistant *Staphylococcus aureus* (MRSA) in select hospitals,
- To evaluate the use of chlorhexadine bathing on the incidence of bloodstream infections in intensive care units, and
- To provide a five-day training program for new infection preventionists across the state.

New York State has already demonstrated a measurable reduction in HAIs through some of its early projects: central-line associated bloodstream infections were reduced by 75 percent, ventilator-associated pneumonias by 50 percent, and very preliminary data have shown a 15 percent reduction in *C. difficile* infections. These efforts would not have been successful without the support from hospital executive staff members and the commitment and resolve of the involved healthcare delivery team.

**Importance of National Leadership**

Along with CDC, the NYSDOH is actively involved in working with other states as they embark on implementation of legislation. The federal government can and should take a leadership role by providing a national standard and the foundation upon which states can build, rather than each state creating its own separate system and reporting process. The following elements should be considered for a meaningful, reliable and useful reporting system:

1. The selected mechanism and system for reporting must use standard definitions, methods of surveillance and risk adjustment for differences in the population served if the information is to be used to compare one facility to another.
2. States should have the ability to adapt the NHSN to their needs and establish their own reporting requirements based on local infection risks and priorities.
3. Data analyses must be conducted regularly in order to be actionable and enhance patient safety.
4. The system needs to be designed and maintained to provide flexibility and adaptability in addressing new and emerging infection events.

5. Existing infection indicators must be refined.
6. The system must be responsive to the needs of the users – payers, states and healthcare facilities.
7. The federal government should provide the reporting framework to eliminate redundancy and promote economy of scale.
8. The various agencies in the Department of Health and Human Services should ensure that information technology systems are interoperable and should eliminate to the extent possible redundant reporting requirements by healthcare facilities and the states.
9. Information technology tools need to be developed and deployed to enhance the electronic capture of critical data and eliminate the current need for labor intensive data capture, entry and analysis.
10. Ongoing oversight and evaluation of these efforts are imperative to ensure resources are used judiciously and without negative consequences on healthcare.

**Future Directions**

The NYSDOH HAI Reporting Program was established in 2006. Our achievements to date could not have been realized without the availability of the NHSN, along with support from the CDC, and the significant financial, technical and administrative support and resources from the Governor's office, executive staff and the Legislature. Within a very short time, demonstrable reductions in infection rates have been evidenced. This success was achieved in part by the commitment of resources at every level – federal, state and our hospitals.

In spite of these early successes, there is so much more that needs to be done:

- The infection rates that are monitored and evaluated and the prevention efforts are just the underpinnings of the greater endeavor.
- The NYSDOH continues to receive approximately 1,000 outbreak reports a year from regulated healthcare settings, but many outbreaks go undetected and unreported.
- In addition, there is no systematic evaluation and monitoring of non-regulated outpatient settings where the majority of invasive procedures are now being performed.
- The prevention projects are the first step forward. Resources and dedication need to be maintained and expanded to include the full spectrum of healthcare settings and infection events.
- Other public health infectious disease surveillance systems, which can support HAI reporting, need further development. For example, electronic laboratory reporting (ELR) of infections to public health is easily achievable with current technology. Yet, a national 2007 survey showed that only 14 jurisdictions have implemented ELR that is at least 50 percent operational and that only 28 out of 56 public health jurisdictions responded that their public health laboratory could report via ELR.[4]

Looking ahead, activities need to become proactive and not reactive by focusing on:

- Education and training of personnel in all healthcare delivery settings prior to providing patient care, handling equipment or performing housekeeping or engineering services.
- Medical device and medication manufacturers need to give priority to infection prevention during research, design and development of their products.
- Infection prevention needs to be integrated into healthcare delivery and not merely considered a tangential process.

I hope that the information shared with you today is helpful in better understanding the role of public health agencies in addressing Healthcare-Associated Infections. As noted earlier, significant progress has been made, but there is a vast amount of work yet to be accomplished. The New York State Department of Health looks forward to partnering with you, other national organizations and states to build an effective surveillance, reporting and prevention system to address this critical issue.

Thank you.

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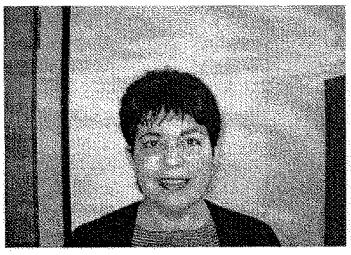

**Rachel L. Stricof, MT, MPH, CIC**

Rachel Stricof is the Director of the Bureau of Healthcare-Associated Infections, New York State Department of Health (NYSDOH) and Assistant Professor at the State University of New York at Albany's School of Public Health in the Department of Epidemiology and Biostatistics. She received her undergraduate degree in Medical Technology and Masters Degree in Public Health in Epidemiology and Biostatistics from the University of Michigan in Ann Arbor, MI.

Ms. Stricof has more than 30 years of experience in infection prevention, control and epidemiology. She has been instrumental in the design and development of the New York State Department of Health's Hospital-Acquired Infection Reporting Program, TB Control Program, Regional Epidemiology Program, HIV seroprevalence studies, and has participated in guideline development at the state and national level.

She has served in numerous leadership roles at the local and national level of the Association for Professionals in Infection Control and Epidemiology (APIC). She is currently the APIC liaison to the Centers for Disease Control and Prevention's (CDC) Advisory Council for the Elimination of Tuberculosis (ACET) and ACET's liaison to the CDC Healthcare Infection Control Practices Advisory Committee (HICPAC).

## Subcommittee on Labor, HHS, Education and Related Agencies

## Witness Disclosure Requirement – "Truth in Testimony"

Required by House Rule XI, Clause 2(g)(4)

| Your Name: Rachel L. Stricof | | |
|---|---|---|
| 1. Are you testifying on behalf of a Federal, State, or Local Governmental entity? | Yes X | No |
| 2. Are you testifying on behalf of an entity other than a Government entity? | Yes | No X |
| 3. If your answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 2005: | | |
| 4. Other than yourself, please list what entity or entities you are representing:<br><br>New York State Department of Health | | |
| 5. If your answer to question number 2 is yes, please list any offices or elected positions held or briefly describe your representational capacity with the entities disclosed in question number 4: | | |
| 6. If your answer to question number 2 is yes, do any of the entities disclosed in question number 4 have parent organizations, subsidiaries, or partnerships to the entities for whom you are not representing? | Yes | No |
| 7. If the answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which were received by the entities listed under question number 4 since October 1, 2005, including the source and amount of each grant or contract: | | |

Signature: Rachel L Stricof Date: 3-27-09

DR. HYZY'S OPENING STATEMENT

Mr. OBEY. Dr. Hyzy.

Dr. HYZY. Good morning, Mr. Chairman. I am Dr. Bob Hyzy. I am a pulmonologist and critical care medicine doctor at the University of Michigan Health System in Ann Arbor. I also chair the steering committee of the Michigan Health and Hospital Association Keystone IC project. And along with the work of dozens of people, I implement a Keystone at my office and work with the State association to provide local expertise in conjunction with national leaders, such as Peter Pronovost, who I am proud to share the table with.

You have already heard today a little about Keystone ICU. It was a multi-faceted project. The landmark accomplishment, of course, being the reduction in catheter-associated bloodstream infections. The specialized catheter we use in intensive care because the patients are too sick and cannot tolerate the Perfil catheters.

You have heard how our median catheter rate has gone down to zero and you have heard about the notion of saving 1500 lives and almost $200,000,000.

At my own hospital, we have dropped our rate 74 percent. We are doing a lot more at my hospital. Sanjay Saint, a national leader, is working with ureter catheter infection reduction through State. We heard a little bit about medical schools. I am working with some of our people with regard to our third year medical student curriculum with respect to patient safety education program.

But I want to speak a little bit about Keystone and maybe kick the tires a little bit to make some suggestions with regard to what works and why. There are a number of facets to Keystone. I think first and foremost is leadership at the local level, at the hospital. The hospital administration had to get involved, they had to be supportive of what transpired in the critical care unit. The quest remains, certainly, some data collection elements required some money for full-time equivalents for collection. So their support was critical.

I think most importantly—and I am sort of a bottom-up guy working in the field—you had to engage everyone with the experience. I think quality is everyone's business; you cannot just rely on some external agency. Our infection control committee is going to assess us and tell us what to do. You have to own it. And I think that is the key piece here. You have to have data; you have to have good data. You have to measure; you manage what you measure. You have to have reliable information that you can share and compare and benchmark.

The MHA, I think, was also instrumental in this. One of Peter's key insights for this program was to choose the State as a logical entity for a collaborative, and you might be a little bit surprised. We compete with one another for business. We have got our billboards on the freeway, but, yet, at the State level, this program worked. Competitors came together to try to improve quality, created a bandwagon effect, in essence, where no one wanted to be left behind and not participate.

So MHA was very instrumental in supporting us with leadership, clinical expertise, information about how to change culture. Our

meetings that we have every year, 300 to 400 people in the room, critical opportunity to interact with one another; the conference calls that we have with 100 or more people on the phone throughout the State with Peter or our local leaders to help move care forward are all key elements.

I also wanted to point out that the original AHRQ grant ended in 2005, four years ago, and I guess it is additional testimony to Dr. Pronovost that we are still doing it, we are still going on. And the key word there is culture. I think what the original Keystone ICU project did have happen is a permanent change in culture, at least in our critical care units, and this is what we have been able to keep going now four years later. So when we talk about the lives saved and the cost-avoidance, we are still doing it. The levels are still low and, like I say, the AHRQ grant ended four years ago. So it is a change in culture I think that is so critical to work from the bottom up.

And it is true the hospitals across the Country are very interested in this program and want to participate. With AHA's Health and Research and Education Trust and the money from AHRQ, Peter has now embarked on a 10-State rollout being called On the CUSP: Stop BSI.

So the idea here, and I think it is a great one, is to take that nidus, that beachhead, that Keystone ICU has created to try to roll that out, to get that same cultural change. Yes, it is a checklist. Yes, you have to do the right things. But without the bottom-up approach to culture, I do not think you can be successful over the long haul. If you teach the test, if you just accomplish a task, if you just have reporting, I do not think you impact medical culture on a permanent basis.

And I know from my experience, meeting people across the Country, they come up to me and ask if they can be one of the States. I say, I am sorry, you have to talk to this guy; that is not up to me.

So I think the idea, then, would be to take this beachhead, roll it out first with BSI, as we intend to do. And I think there is an opportunity across the board for other kinds of infections: surgical infections you have heard about, urinary catheter infections, and then maybe also beyond the infection HAI sphere.

So what can Congress do to help? Well, one thing they can not do is impose additional reporting burdens on top of what we already have. You know, the AHA has got the hospital quality lines. There are 4,900, I guess, of 5,000 hospitals already volunteer reporting. I think reporting is important, but I think not only outcomes, but process reporting. It is not just a question of what your infection rate is, it is also a question of are you doing the right thing.

I work in a tertiary care hospital, solid organ transplants, bone marrow transplants, a lot of immuno-suppressed patients. My hospital is not necessarily the same at all as a community hospital 20 miles down the road, which has a six-bed ICU. We have over 100 ICU beds. So the process measures are equally important, to know that you are doing the right thing.

So I see this as an opportunity, then, to not overburden with additional reporting, but to create an organic system that spreads

throughout the land, and I think it is a huge opportunity. So what can Congress do? Well, we have already heard mention, I guess with the support with the Recovery Reinvestment Act, the money that is going forward to help this next step that Peter has in mind.

I mean, obviously, I am a little bit biased. I was involved with this project. I am involved with trying to continue its success. He has asked me to help out to whatever extent I can with this rollout and, quite honestly, it is a pleasure. This is what he does; I do lots of things. This is more of a labor of love.

This is not the main focus of my academic ivory tower career; this is an important thing. I am the medical director of an ICU. When Peter and Chris Goshel decided on this project five years ago, the second I heard about it I said we are in, count us in, this is important, we need to be part of this.

And just to give you an example of the cultural change, my ICU nurses are getting a little tired of me trying to impact care and change everything. They first sort of rolled their eyes at me and said now what does he want me to do. I said, no, no, you have got to stay with me on this one, I think this is really good and going to be really important. And I think that certainly the facts have borne out the case.

So I appreciate the efforts being made by Congress's support of research and quality and rolling things out. I think that is the way forward. Again, I am biased. I think Keystone worked; I think it continues to work. I think there is a core element of truth there, the operative word being culture. Checklists are important; documenting that you do the right thing, process measures are important; but without the change in culture that is organic and bottom-up, I think ultimately you do not accomplish anything over the long haul.

So I thank you for the opportunity to speak with you today. I would be happy to answer any questions and would like my written document entered in the record. Thank you.

[The information follows:]

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**Testimony**
**of the**
**American Hospital Association**
**before the**
**Subcommittee on Labor, HHS and Education**
**of the**
**House Committee on Appropriations**

**"Healthcare-Associated Infections"**
**April 1, 2009**

Good morning, Mr. Chairman. I am Bob Hyzy, M.D., a board certified pulmonologist and critical care medicine doctor – what some call an intensivist – at the University of Michigan Hospitals and Health System in Ann Arbor. My title at the University is Associate Professor of Medicine, Division of Pulmonary and Critical Care. I also am Director of the Critical Care Medicine Unit at the University of Michigan Hospital and Chair of the hospital's Critical Care Committee. And I chair the steering committee of the Michigan Health and Hospital Association's (MHA) Keystone Intensive Care Unit (ICU) project.

I am pleased to be here today to represent the American Hospital Association (AHA) and its nearly 5,000 member hospitals, health systems and other health care organizations, its 38,000 individual members, and the dedicated hospital leaders, doctors, nurses, pharmacists and other health care workers who care for patients every day in our hospitals. I will share with you our thoughts on how prevention strategies and best practices are reducing healthcare-associated infection (HAI) rates, and how the hospital field is working collaboratively to implement these strategies more broadly.

I have not only had the responsibility of implementing the Keystone project at my own hospital and health system, I also have worked with the staff of the MHA to provide local clinical expertise to complement the national expertise of Dr. Peter Pronovost, the project's director, whom I am proud to share this table with. It was his work at the Johns Hopkins University Quality and Safety Research Group that created the underlying system from which the Keystone ICU project has grown.

**THE KEYSTONE ICU PROJECT**

The MHA Keystone Center for Patient Safety & Quality was created by Michigan hospitals in March 2003. It brings together hospitals, state and national patient safety experts and evidence-based best practices to improve patient safety and reduce costs by improving the quality of care delivered at the bedside. Through the MHA Keystone Center, Michigan hospitals have voluntarily improved the safety and quality of health care through the application of the scientific method and the implementation of evidence-based best practices that are saving lives and reducing health care costs. The Center has been funded to date by the Agency for Health Care Research and Quality (AHRQ), MHA-member hospitals, federal and state grants, and Blue Cross Blue Shield of Michigan. The Center, and its collaborative work, reflects the commitment of hospital leaders and others to voluntarily improve the safety of the care they provide, including reducing infections.

The Centers for Disease Control and Prevention has estimated that 2 million Americans contract an infection while receiving medical treatment. Hospital infections are believed to cost Americans between $4.5 billion and $6.5 billion in extra health care costs annually.

In the past, some levels of infection were seen as inevitable, and we were doing well to keep the level low as more "superbugs" emerged. Then, Keystone and similar projects came along. Its key focus has been on central-line associated blood stream infections ... that is, infections related to catheters that are inserted directly into a blood vessel with a direct line to the heart because these patients are very sick and unable to have a catheter stuck into a peripheral vein. Using the Keystone protocols, what was once an infection rate of approximately 2.7 per 1,000 catheter days has been driven down to near zero, a remarkable achievement, especially considering these are among our sickest patients.

However, to achieve those results required the dedication and commitment of leaders and caregivers at individual institutions, as well as the leadership of an effective coordinating body.

We estimate that, last year, Michigan hospitals saved nearly 1,500 lives and $175 million by participating in the Keystone ICU project. Senior officials at AHRQ describe the project as among their most successful initiatives, and would like it to be a model for the dissemination and implementation of other evidence-based safety and quality initiatives.

At the institution level, specifically my hospital, our success has been gratifying. My Critical Care Medicine Unit has decreased our catheter-associated bloodstream infection rate 74 percent over the course of five years; the rate is now nearly zero. More importantly, we have created a culture of change that is self-sustaining and that recognizes that good is simply not good enough and that our practice of critical care is not static; we can always improve. We now have monthly interdisciplinary patient safety rounds where a recent case is examined by staff and resident physicians, nurses and respiratory therapists.

Other members of my institution are taking leadership roles in statewide quality initiatives: Dr. Sanjay Saint, a nationally recognized expert in HAIs, is leading our state's effort to decrease urinary tract infection in Michigan hospitals. Finally, we are working to enhance our medical school curriculum in order to ensure that all students graduating from the University of Michigan Medical School understand, as the quality guru W. Edwards Deming said, "If you can't describe what you are doing as a process, you don't know what you are doing."

Our success depended on our ability to do a number of things:

- Provide the internal organizational and clinical leadership to create the right culture for success, and to allocate the necessary resources;
- Engage everyone in the work; infections were everyone's responsibility, not just that of the infection control committee;
- Test the changes we made in our care processes, capture the data that lets us know if those changes yield better results, and cement those changes into place when they work or discard them if they don't; and
- Share information with our patients and with the broader community that we serve.

The Keystone Center was invaluable to us because it provided:

- Access to clinical expertise and system change expertise;
- Ideas, strategies, and tools to be used at all levels of the organization;
- And infrastructure that enabled information to be shared among all involved; and
- Data aggregation, feedback and benchmarking.

**WHERE ARE WE HEADED?**

Mr. Chairman, hospitals are hungry for the kind of change that initiatives like the Keystone project can bring, and the AHA is taking the lead in helping to meet that demand. Through its Health Research and Educational Trust (HRET), and with $3 million in funding from AHRQ, "On the CUSP: Stop Bloodstream Infections" is being implemented in 10 states ("CUSP" stands for Comprehensive Unit-Based Safety Program"). By putting the program in place in at least 100 hospitals across the country, the goal is to reduce the average rate of central-line infections in those hospitals by 80 percent, from the national average of five infections per 1,000 catheter days to one infection for every 1,000 catheter days, and to improve the patient safety culture by 50 percent.

Another key aim of the initiative is to build a multi-disciplinary infrastructure for sustaining this and future patient safety improvement innovations.

The following 10 state hospital associations and patient safety groups were selected to participate in the infection reduction program:

- California Hospital Association, in collaboration with the California Hospital Patient Safety Organization
- Colorado Hospital Association
- Florida Hospital Association
- Massachusetts Hospital Association
- Nebraska Hospital Association
- The North Carolina Center for Hospital Quality and Patient Safety
- Ohio Patient Safety Institute, in collaboration with the Ohio Hospital Association
- Hospital & Healthsystem Association of Pennsylvania
- Texas Hospital Association
- Washington State Hospital Association

HRET and its partners at Johns Hopkins and MHA will work with these organizations to choose at least 10 hospitals from each participating state, and will develop an educational toolkit and other resources to encourage adoption of the specific, evidence-based steps hospitals can take to reduce these infections in ICUs.

In addition, a second project is spearheaded by the Johns Hopkins Quality and Safety Research Group in partnership with the MHA Keystone Center and is funded by donations and the Sandler Foundation of the Jewish Community Endowment Fund. The following organizations have been selected to participate in this project:

- Arkansas Hospital Association
- Connecticut Hospital Association
- Georgia Hospital Association
- Coordinating Agencies of Hawaii
- Illinois Hospital Association
- Indiana Hospital Association
- Minnesota Hospital Association
- Missouri Hospital Association
- New Hampshire Foundation for Healthy Communities
- New Jersey Hospital Association
- New Mexico Hospital Association
- Healthcare Association of New York State
- Oklahoma Hospital Association
- Oregon Hospital Association
- South Carolina Hospital Association
- Tennessee Hospital Association
- West Virginia Hospital Association
- Wisconsin Hospital Association

Together, Mr. Chairman, these two efforts greatly expand the unprecedented opportunity to reduce these infections across the country, and will allow us to triple the reach of the original project.

A key goal in all of this is to ultimately replicate with other types of infections the success we have had reducing central-line infections. Surgical site infections are likely our next opportunity because of work that has already been done by the Surgical Care Improvement Project (which I address below), the National Surgical Quality Improvement Project, and the Surgical Checklist developed by Atul Gawande and adopted by the World Health Organization. Then we would likely tackle catheter-associated urinary tract infections, and as we meet with success, move on to other areas of care that currently seem intractably problematic.

**OTHER FIELD RESOURCES**

Mr. Chairman, please do not let me give the impression that the Keystone Project, and the initiatives underway to implement it more broadly, is the extent of the field's work on infection control. Much more is being done, by individual hospitals as well as by the associations that represent them.

The Surgical Care Improvement Project (SCIP), a national quality partnership of the AHA, American College of Surgeons, Centers for Disease Control and Prevention, The Joint Commission, Centers for Medicare & Medicaid Services (CMS) and many others, aims to reduce the most common surgical complications, including surgical wound infections and pneumonia, by 25 percent by 2010. The project promotes clinically proven prevention steps that every hospital can adopt to improve the care of surgical patients, such as maintaining normal body temperature and glucose levels, and clipping, not shaving, the incision skin area. SCIP is one of many initiatives that hospitals are undertaking to reduce and prevent HAIs as well as other adverse complications from surgery.

In addition, late last year, for the first time, five leading health care organizations came together to publish practical, science-based strategies to help prevent the six most important healthcare-associated infections. The AHA joined with the Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, the Association for Professionals in Infection Control and Epidemiology, and The Joint Commission, to release the *Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals.*

The compendium brings together practices and sciences that we know are effective in preventing infections, and provides recommendations that are understandable, easy-to-use and that stress accountability. Six of the most important preventable HAIs with the greatest impact on morbidity and mortality were identified, including central-line infections, with recommendations prioritized into two categories:

- Minimum basic practices that should be adopted by all acute-care hospitals; and

- Special approaches for use in locations and/or populations within the hospitals when infections are not controlled using basic practices.

Two sections focus on preventing the spread of specific organisms, including staph; and four sections focus on device-and procedure-associated infections, including central-line infections, ventilator-associated pneumonia, catheter-associated urinary tract infection, and surgical site infection.

The AHA Quality Center helps hospitals accelerate their quality improvement processes. The Center is a one-stop shop that consolidates information that is continually refreshed and updated with essential knowledge from across the hospital field. It includes the AHA Quality Call Center, which with a toll-free number connects hospital leaders to the quality and patient safety resources that can help them meet their quality leadership challenges. The Quality Center also collaborates with leading quality and patient safety organizations to sponsor educational sessions to disseminate demonstrated practices and emerging concepts, and offers an online Opportunity Assessment to accelerate quality and patient safety improvement.

**WHAT CAN CONGRESS DO?**

Mr. Chairman, let me begin with what we urge Congress *not* to do.

The AHA supports sharing information about HAIs with the public. That information must be meaningful for consumers and must be based on solid data and good measures, target infections that have the highest potential for the greatest harm, and focus on areas where clinically proven prevention efforts exist.

Specifically, the AHA supports voluntary reporting through the Hospital Quality Alliance (HQA) of surgical infection prevention measures, surgical wound infection rates and Central-line blood stream infection rates.

Since 2002, the HQA has worked with hospitals to share with the public reliable, credible and useful information on hospital quality. The AHA, the Association of American Medical Colleges and the Federation of American Hospitals invited government agencies, professional organizations, purchaser alliances, consumer organizations and others to forge a shared national strategy for accurate quality measurement and public accountability. Initially, the effort began as a voluntary one to share data with the public. Congress, recognizing the importance of this initiative, began linking submission of data requested by the HQA to receipt of the full Medicare market basket update for hospital inpatient payment. The effort has expanded to include new measures each year.

The HQA's Web site, www.hospitalcompare.hhs.gov, helps the public better understand how care is provided by their hospitals. More than 4,200 acute-care hospitals now display data, and hospital leaders and clinicians also use the data to identify organizations with stellar performance so they can learn from these outstanding practices.

The work of the HQA depends on having scientifically sound and meaningful measures that have been endorsed through the National Quality Forum's (NQF) consensus development process. To ensure that the NQF can continue to assess and endorse measures that will lead to important information being available to the public, the AHA and our partners in the HQA support legislation that would ensure the federal government gives core support for this public-private entity that provides a vital public service.

The HQA provides a firm foundation for further transparency. However, hospitals face multiple requests for quality data from insurers, employer groups, accreditors and government agencies. These myriad demands create confusion and frustration for hospitals and the public, rather than illuminating key aspects of quality. We strongly urge that quality data should be reported in just one way to just one place: the Hospital Quality Alliance. It is a proven system; it works.

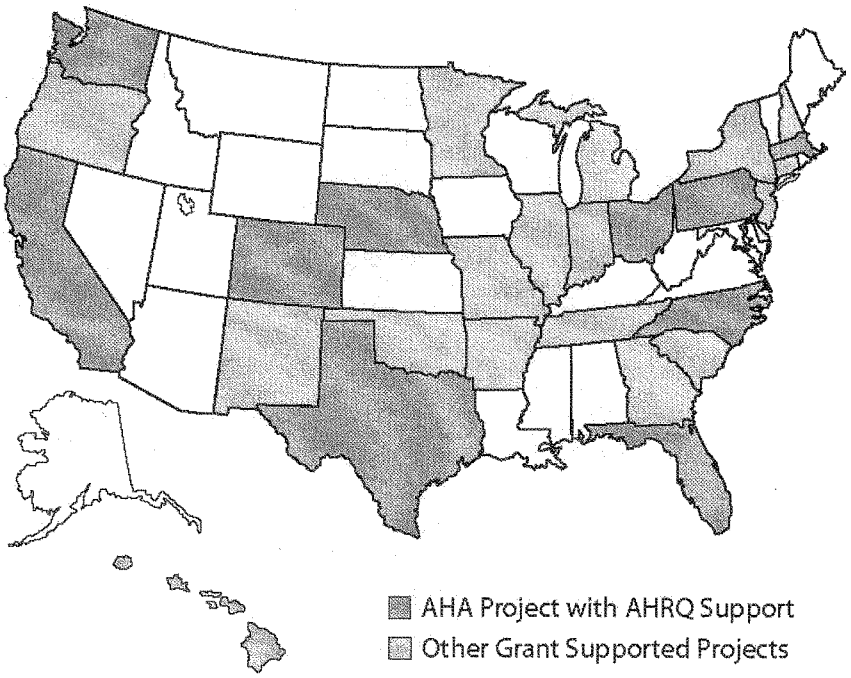
Now, Mr. Chairman, what *can* Congress do? Invest in quality! Funding from AHRQ has been, and continues to be, a vital lifeline to hospitals' ability to improve infection rates through these programs.

In the fiscal year 2009 omnibus appropriations bill and the *American Recovery and Reinvestment Act*, Congress devoted resources for states and hospitals to create HAI reduction plans and implement prevention strategies. We agree with the subcommittee that eliminating HAIs should be a national health priority, and we deeply appreciate your willingness to invest in these life-saving and resource-saving programs.

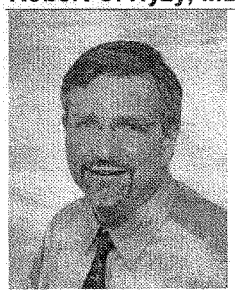
**CONCLUSION**

Mr. Chairman, we stand at the CUSP – pun intended – of great change in health care. Health care reform is being demanded by policymakers as well as the public. At the same time, behind the scenes in hospitals across the country, people are hard at work making other kids of changes … some little, some more sweeping, but all with the goal of making care better and safer for patients. Our efforts to improve infection rates have brought about what some originally thought was impossible improvement. But through the hard work and dedication of hospital leaders and those on the front lines of care, we have been greatly successful, and we are very proud of the way the field has embraced these initiatives. Now, there is much more work to do to build on this success. We appreciate your interest in this important topic, your support for our efforts, and we look forward to working with you as we make health care as safe as possible for the patients we serve.

## States Replicating the Keystone Project



**Robert C. Hyzy, MD**



Dr. Robert C. Hyzy is an Associate Professor of Medicine, Division of Pulmonary and Critical Care, at the University of Michigan in Ann Arbor. Dr. Hyzy is a graduate of Kenyon College and received his medical degree from New York University School of Medicine in New York City. Dr. Hyzy completed his residency in Internal Medicine and fellowship in Pulmonary and Critical Care Medicine at the University of Michigan. He is Director of the Critical Care Medicine Unit at the University of Michigan Hospital and Co-Chair of the University of Michigan Hospital Critical Care Committee.

Dr. Hyzy's research interests are in the area of critical care medicine, including ARDS, ventilator associated pneumonia, and sepsis. He is the principal investigator of an NIH funded trial examining the efficacy of GM-CSF in patients with Acute Lung Injury. He has published multiple articles and chapters in medical journals and textbooks and has been a reviewer for the American Journal of Respiratory and Critical Care Medicine, Chest and Critical Care Medicine. In addition, Dr. Hyzy contributes eleven topics on mechanical ventilation to the web based medical resource UpToDate.

Dr. Hyzy has been active in the Michigan Health and Hospital Association Keystone ICU project since its' inception in 2003. He presently chairs the Steering Committee of the Keystone ICU Project and serves on the Advisory Committee of the MHA Keystone Center. He also is a member of the Quality Improvement Committee of the American College of Chest Physicians and has spoken nationally on the subject of quality improvement in the intensive care unit.

## Subcommittee on Labor, HHS, Education and Related Agencies

## Witness Disclosure Requirement – "Truth in Testimony"

Required by House Rule XI, Clause 2(g)(4)

| | | |
|---|---|---|
| Your Name: **Robert C. Hyzy, M.D.** | | |
| 1. Are you testifying on behalf of a Federal, State, or Local Governmental entity? | Yes | No **X** |
| 2. Are you testifying on behalf of an entity other than a Government entity? | Yes **X** | No |
| 3. If your answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 2005: **None** | | |
| 4. Other than yourself, please list what entity or entities you are representing: **American Hospitals Association** **Michigan Health and Hospitals Association** | | |
| 5. If your answer to question number 2 is yes, please list any offices or elected positions held or briefly describe your representational capacity with the entities disclosed in question number 4: **None** | | |
| 6. If your answer to question number 2 is yes, do any of the entities disclosed in question number 4 have parent organizations, subsidiaries, or partnerships to the entities for whom you are not representing? | Yes | No **X** |
| 7. If the answer to question number 2 is yes, please list any federal grants or contracts (including subgrants or subcontracts) which were received by the entities listed under question number 4 since October 1, 2005, including the source and amount of each grant or contract: **None** | | |

Signature: _____ Date: 3/24/2009

Please attach this sheet, along with you curriculum vitae (resume), to your written testimony.

Mr. OBEY. Mr. Tiahrt.

Mr. TIAHRT. Thank you, Mr. Chairman.

INFECTION DATA REPORTING TRANSPARENCY

Dr. Hyzy, in your written testimony there seems to be a difference of opinion as to what systems hospitals should use in reporting infection data, whether the reporting should be mandatory or voluntary. You, I think, favor the voluntary.

Am I correct? And if so, could you elaborate why you think there is a difference in this conflict and why voluntary is more important?

Dr. HYZY. Well, again, I think, personally, the transparency is important, and I think that hospitals who legitimately take quality to heart would be the first ones to want to step forward and report how they are doing. So I see that as an opportunity. I see that as something that hospitals are increasingly embracing.

Arguably, the quality movement, if you date it back to the IOM report in the end of the 1990s, the emphasis in the hospital culture has not been in this direction for all that much time historically, 10 years or so. So I think hospitals are increasingly coming to recognize that stepping forward and being voluntary with these activities is required. It is maybe a bandwagon effect. I do not think they need to be dragged kicking and screaming to the alter of culture of quality any more; I think that they want to do this and they want to demonstrate the quality.

So that is why I think voluntary reporting is key. I think standardizing it—at this point, hospitals get it from lots of angles, as I understand; everyone is making a demand for this or that, and I think there needs to be some standardized approach that everyone can agree on is a recognized mechanism.

This particular issue is not my forte. There are a lot of agencies out there competing for the attention of the hospitals and reporting, and I think ultimately, though, it needs to be decided. I think voluntary is the way to go, but I think some kind of agreeable approach between these hospitals ultimately has to be decided upon.

Mr. TIAHRT. Do you think the American Hospital Association, would all its members be willing to participate in a voluntary system?

Dr. HYZY. Well, I believe at this point they say 4,900 are. So, again, I certainly am here representing MHA and AHA. I can give you my opinion. I am not of the AHA so much, but at least as I understand it that is coming to fruition, where these hospitals are stepping forward on a voluntary basis.

HEALTHCARE PROVIDER LIABILITY

Mr. TIAHRT. We heard earlier that several members of this Committee think that when an infection occurs or HAI, that a lawsuit should result. Have you assessed the risk in reporting these types of infections?

Dr. HYZY. Congressman, I can speak to that on two levels. One is my own experience, which is to say in the real world, physicians are human. We are doing the best we can, and when you do make a mistake, my own personal bias, and what I tear my house staff is to come forward and be transparent; say this is what we were

doing, this is why, and this is what we attempted and this is what happened, and we are sorry, etcetera. So on that one level I think that transparency is important.

On the other level, you know, the question ultimately becomes, with regard to what they are calling hacks, is any event of this nature always constitutes a deviation from the standard of care, which is what malpractice is. That is why I think process measures are very important, to be sure that you are demonstrating that you are doing the right thing.

Again, I am not trying to take a copout. Everyone always claims their hospital is different. But I can assure you, in a population of bone marrow transplants, solid organ transplants, when I say in my document our infection rate is near zero, that is true. But occasionally our patients will get a vancomycin-resistant enterococcus in their bloodstream because they are on five immunosuppressant drugs and that counts as a CABSI, because we have no other reason for it and there is a line. Yet, that may not be the source; it may be the immuno-suppression.

So it is important that you do the right thing, but on occasion things still go wrong. But a bona fide mistake, I believe in the hack notion. I mean, if you operate on the wrong side of the body, that is inexcusable. Are we here to now say that a bloodstream infection from a catheter will never, ever, ever happen again, and if it does it is malpractice? I think that is wrong. What you can do is do the right thing by the patient and play it smart and demonstrate that you are doing the right thing, and that, at the end of the day, is all you can hope for in medicine with regard to infections or any aspect of medicine.

Mr. TIAHRT. Ms. Stricof, in New York, is there any waiver of liability through the reporting process, or is it just at-risk when you do report these things?

Ms. STRICOF. Well, there are confidentiality provisions and——

Mr. TIAHRT. It is nonspecific in reporting? The data are aggregate enough that it is nonspecific?

Ms. STRICOF. The way we report it out is such that no individual can be identified. Our data also are protected under the highest level of protection in New York State law, Public Health Law 206(1)(j). You do not need to know that, but what it says is that we cannot release this data on any individual; we can only put out aggregate data. So no one can even subpoena from the State Health Department with regard to an individual.

That does not mean that aggregate data are not available, and it also does not mean that a patient, if a lawsuit is to ensue, cannot go to the hospital and get the information that they report. But we as a State health department are protected from providing that information; and that is another feature of our law that I think is very important.

Mr. TIAHRT. I think that is good information. I think we ought to pursue it. I sure would like to know before I go to a hospital.

Ms. STRICOF. No, we give the infection rate data. We do not say whether patient X developed an infection, because that would be a breach of confidentiality for that individual.

Mr. TIAHRT. I think there has to be some level of security at these institutions so that they are free to give us this information so that it is provided accurately and fairly.

Dr. PRONOVOST. It would be wrong to assume that lawsuits are not occurring now. There is a class action suit in New Jersey for people who have been infected. They happen all the time. The consumer movement and the legal movement is responding to that. I would be cautious, though, of thinking that that is going to be an exceedingly effective lever to improve quality of care in this Country, because its main goal is to either justly compensate people who have been wronged, and they ought to be, and, as an incentive, to improve safety, and it does both of those exceedingly poorly; people are not compensated very well and there is very little feedback.

As Rachel said, at the aggregate level, it is not patient identified, it is a rate. I think the far greater risk is misinformation or partial truth that the data are not accurate; they are using administrative data or billing data that is more likely to mislead than really inform the public.

Mr. TIAHRT. I just think with 1.7 million occurrences, that 1.7 million lawsuits would not be helpful.

Thank you, Mr. Chairman.

Mr. OBEY. I am trying to remember the words to the old Tom Paxton song about 1 million lawyers, but I will not recite it here.

Mr. Ryan.

NURSE AND HEALTHCARE WORKER SHORTAGES AND OPERATING COSTS

Mr. RYAN. Thank you, Mr. Chairman.

I just have one question. A lot of the previous panel and now the second panel have talked a lot about kind of standardized procedures and kind of the technical engineering the problems away, and I just have one question, if you all could just kind of give your opinion on it.

What effect does the shortage with nurses and healthcare workers have on this? And if there is any way to quantify what percentage of these situations are a result of the shortage and the nurses that are overworked and the overall shortage in healthcare, because it is not just in hospitals that this happening.

Dr. PRONOVOST. I will begin with that. Congressman Ryan, I think that is a substantial issue, and let me give you a concrete example. In our program, we require a hospital to say nurses will assist the physicians putting in these catheters and ensure that they check it off. So the nurse is essentially the police person or the auditor to say, yes, you are doing it correctly.

And we get, including at my own hospital, a well-resourced Johns Hopkins substantial push-back to say there is no way I could afford a nurse to do that, and they are absolutely right. We are making tradeoffs about allocating our resources all the time, and it plays out, with nursing shortages, that you now have agency nurses or temporary nurses who may not know the protocols being the ones caring for your patients who do not have that culture of teamwork to question me when I will inevitably forget something. They do not know the protocols and they are stretched doing a million other things.

So I think it is a factor. And you heard many of us say about the cost savings, and there is no doubt there are cost savings for quality of care. But what is often neglected is there first needs to be an investment in resources to collect data, and that is an expense that has to be incurred. And the savings are down-streamed. Quite frankly, most of them get passed on to the insurer, they do not stay with the hospital, which is why many of us believe they ought to be the ones funding a lot of this work because they are the ones who ultimately save the most financially.

But without some investment in hospital resources, I think it is a significant barrier to doing this work.

Dr. HYZY. I would only echo what Peter said. At the ground level, what it is, when you are short, you hire an agency, and the agency people are not involved with your program; they parachute in for a shift and you have to pay them more, so it increases your costs. But that is where the problem is. If you want a culture and you want to sustain it, you have to have people who are more invested than just come in for one shift.

Ms. STRICOF. I would agree, and it is not just—I think the way you phrased it was a shortage of nurses, and even if we were to overcome the nursing shortages, which I think we are almost on our way to doing, it really is what are the staffing resources and what are we willing to pay for healthcare delivery.

I think one of the factors, I believe it was Ms. Lee; I may be mistaken—who said I had to be there 24 hours when my family member was in the hospital. What is the education and background of the individuals that are now providing care, and how extensive is that care? How much time are people able to spend? And, quite frankly, part of this is no one would go into an OR and not scrub and not gown and not do that. When you are on the floor and you are covering 15 or 30 patients on a night shift, and somebody calls for you, it is really hard to go from patient 1 to patient 2 and ideally put on a new gown and gloves and perform hand hygiene.

If it were simple, if it were leisurely, if it was available, we do not go into healthcare and try and harm our patients. It becomes a matter of the system and the infrastructure that is there to support doing the right thing and knowledge.

Mr. RYAN. Do you have like a percentage that you—I know part of this is for us to figure out exactly how this is all happening. Do you have any ideas, 1 in 10, 2 in 10 is affected by the nurses parachuting in and out? I will let you just answer those questions. I think this speaks to the point that this is not a single shot where this is the only issue. This is about nursing education; this is about community colleges; this is about Pell grants; this is about student loans. This is about all of those things and addressing this in a comprehensive way, not just—although what you are talking about is extremely important and vital to solving the problem, this is, I think, about all of us figuring out how we address this from all sides.

So if you could just give me your opinion, even if you are lying to me, just give me——

Ms. STRICOF. I will honestly tell you that I do not know. And I do not think you can make that up because part of the problem with any pre-established number is it assumes that everything is

stable and the same, that all the patients on the unit require the same level and intensity of care. It also means that every individual, just because they are an RN or even an LPN or even a patient care tech, has that same level of education, training, and capability and that they know their hospital system, that they are already ingrained so the educational level, their familiarity with where they are, and a lot of places do things very differently.

I wish I could give you that, but I was actually thrown out of a lot of conversations at the State Health Department level because I wanted to seek adequate staffing levels and we could not come up with them.

Dr. PRONOVOST. I would be guessing, but I would say it is a substantial portion. I would say it is certainly more than 10 percent. It happens all the time at my own place, where someone gets pulled away so there is no one there to audit the checklist. And what I applaud you for is to recognize that this has to be a comprehensive approach that includes education, that includes payment reform, that includes measurement; and I think the plans outlined by Dr. Wright under the Secretary's plan for infections are in that correct direction.

Right now, I have a medical student with me from Johns Hopkins who is doing work with us. We are one of three medical schools that requires a safety course in this Country right now. It is appalling, and yet we are getting graduate medical education dollars from CMS and we are putting out people who can look at pathology slides, but not necessarily know how to standardize and deliver safe care or work as part of a team, and I think that needs to change.

HEALTHCARE INVESTMENTS

Mr. OBEY. Let me ask just a couple questions before we wind this up.

Dr. Pronovost, you, a number of times, have said that we needed to invest in science of health delivery. When you are talking about investing, what is it that you mean? I mean, what is it that we should be doing in the Congress in this regard?

Dr. PRONOVOST. When I say that term, I look at the shortcomings in quality and safety, and they have been the subject of many of these hearings, and the approach is often I get angry and I tell people to try harder. It is better management. And our CEO has really called to task department chairs for not getting their infection rates down, and they come to me and say, Peter, I wish I knew how to do that; I do not have a clue. What is the science to guide me? And I think the mistake that we have made is thinking the delivery of healthcare is just trying harder, it is pure management.

There is no doubt there is a management component, but there is a science of how do you do behavior change. What is the impact of payment policy? How do you measure these things accurately? And we spend a penny on the science of healthcare delivery that we do finding new genes and new drugs.

So specific things I would say build capacity. I, at a place as well endowed as Johns Hopkins, am one of one or two people who could actually teach this stuff. We have probably 200 people who can

teach genetics, because there has not been funding programs to train people in the science of healthcare delivery.

When you look to get funding to say, okay, let us develop a new Michigan program for urinary tract infections or blood clots, there are, frankly, little places you can go to get funding, compared to if I wanted to study a new gene, I can go to the NIH and there are enormous resources. And I am not saying we do not need those resources, we do, because I think we want to keep being the world's leader in science. But we have to shore up the other ones because there is just not a pipeline for doing these things.

And then I think for when we do find good programs and the science that works, like we have in Michigan, what is the investment to spread them? Because, again, there is some management component and making these measures public is going to be a part, but States are struggling, and I think payment reform alone is likely going to be pretty anemic. At least the evidence to date shows us that it has some role, but it is not going to be a blockbuster. We need to also do wise investments to not just put these programs in, but what lenses are we taking to learn, so that there is some study of what we are doing with this now 10 or hopefully greater State project, so at the end of it we can sit at the table with HHS, CDC, AHRQ, the States, researchers and say, okay, what did we learn that is going to allow us to do the next program more efficiently and effectively?

Right now, what we have is hospitals doing their own thing; they are all summarizing their evidence, they are all trying to develop their own measures, they are developing their own curriculum and it is, frankly, a waste of resources.

I will give you a concrete example that we did. In this Country, in every hospital each year some patient gets an epidural catheter that is often used when women are having babies or for pain—you may have had one after your knee surgery—connected to their IV catheter, and that epidural medicine is potentially lethal, could kill you. And the solution is to tell nurses to be more careful or doctors to be more careful, to re-educate them. And we modeled it out. Given that—AHA experts, correct me—there are somewhere around 1.9 million nurses work at the hospital, and say that that education takes an hour and it is $50 for an hour of a nurse's time. That is about $75,000,000 a year spent on doing something that has a zero probability of working. That is insane, and we do it all the time.

What makes much more sense is to say, well, why do we not design that catheter so it cannot fit together? Yes, there are going to be some up-front costs, but we would lick the problem. Just like you cannot stick a diesel gas pump into your gasoline-powered car. But we have not invested in the science of how to do that, so we keep plodding away, every hospital inefficiently doing their own way.

And I am not for taking away that innovation, but I think, just like with financial reform or education reform, it is not a choice of whether you take a regulatory or a market approach. What we ought to say is what makes wise, what is more efficient to standardize and centralize? And I think standardizing the science and the measurement, and then letting hospitals work on what are

their main problems and innovate, and being held accountable for doing it. But we need that balance and we do not have it right now, I think because we do not even know what to measure. There just has not been an investment like we have in other areas of science.

Mr. OBEY. The two of you represent approaches that have been very different. If you take a look at New York and Michigan, you have, in New York, reporting on a mandatory basis, and you do not. Give me the pluses and minuses, the ups and downs of both of those approaches.

Ms. STRICOF. I do not think they have to be exclusive of one another. Maybe you see them as very different, but I think we have taken different approaches but integrated some of the same thing. We mandate the reporting of data. What I—and I do not want to speak for this, but by not auditing the data that has been reported by the Michigan hospitals, I do not really know that all the hospitals are measuring things in the same way. I do not know that the patients—all the facilities who say they have had zero ventilator-associated pneumonias—and I am picking that because I think there is nobody who can systematically diagnose that properly. So I am going to tell you that I do not know the impact of that because I do not even think every hospital is doing it the same way.

So I think a combination of efforts can be very important and achieve the same thing. I think to put a lot of meaning into a sign on the door that says my hospital rate is such-and-such, when the hospital is in total control of defining what that infection is and how to count it, then I say that is meaningless, because I will tell you, when I talk to the cardiac surgeons, none of their infections are infections, and when I talk to the colorectal surgeons, theirs are not infections; they were all patients who came in infected, that was there to begin with. You are not going to count that against me; we need an objective view.

If I am going to give the public the data, I want to know. If that is what is mandated from me, then I am going to make sure that that report is as accurate and meaningful as possible. And while trying to do that I want it to be useful to the hospital as well.

So I think what he has done has done miraculous work, and we have tried to copy and emulate what he has done. I am just saying that maybe I do not trust the data as much, but I think they have made a remarkable impact. So if it is not by this percent, it is by this percent. That does not matter as much to me.

Dr. HYZY. I think that ultimately a volunteer participation and culture is the better way to get accurate information. You know, I think it is actually wrong to state that we are not attempting to standardize our approach and what definitions of infection is, either it is a vap or a cath-associated, that is exactly not true. We actually do standardize our approaches and, in fact, rigorous data collection is one of the greatest strengths of what we have and it is not just every sort of hospital for itself to decide what is and is not an infection.

I think by creating a culture and getting voluntary participation reporting, you are far more likely to get transparency and accuracy than when you engage in sort of, again, the top-down punitive manner. So it is actually the active engagement of our institutions

that has given this legs, has made this sustainable, because people take it to heart.

But do not think for a second, Mr. Chairman, that we do not have a fairly rigorous approach to data definitions and data collection, because without that we know we are nothing; and we have that. And that was actually one of the great successes that we have had is data. Without the data, we are nothing. And data definition. So that is I think what gives us credibility, is that we do have data and it is meaningful.

Mr. OBEY. Last question. What is the biggest single barrier at the hospital level to seeing this job done the way it ought to be done?

Dr. HYZY. I think it is often money in a certain way, because I sit in the ACCP, American College of Chest Physicians, a quality improvement committee, and we have looked at an array of performance measures that the National Quality Forum has advocated for, and they have got criteria about feasibility. Feasibility. Well, if you look at these performance measures, you are having an unfunded mandate on the hospital to collect data. Who is going to collect that data? Collecting data at this point requires people.

Now, until we all have electronic medical records where you can create a little computer program and all this data is getting entered and you just push a button and spit out a performance measure, until that point, it is people, and people are salaries and benefits, and that is extremely expensive.

That is why one of the key components with regard to Keystone success was support by the hospital administration leadership. And our nurses would say, when we go to our meetings, they will say because of Keystone's reputation, the ICU head nurse would say I need this or that because Keystone wants it. With the support of the administration, then they are willing to make a little extra effort to spend that money that is required. But it is a money issue. You cannot have data at this point. I wish we were at a point where we could just push a button, but we are not. It is people going bedside to bedside collecting data, and that is not cheap.

Ms. STRICOF. I just think with each—they have made a commitment to select infections, which I think is absolutely critical. They found ways to work and to try and reduce those selected infections. The question is what do we as a society or the public want to know about. I would say how many—you know, is it this infection or that infection or you know, everything is a matter of resources. It is where do I dedicate resources.

Ideally, quite frankly, I was not 100 percent a proponent for mandatory healthcare-associated infection reporting. The fact was we passed legislation. I think we have also seen the effect of mandating these select indicators, because for our select indicators collaboratives evolve. The minute they knew and they put on there that we were going to monitor central line-associated bloodstream infections in ICUs, we had every hospital—well, not everyone in Greater New York got to sign on of 37, then added another 19 hospitals among their 90-some odd members who volunteered to participate because they knew that that particular infection indicator was going to be monitored by the State and was going to be made available to the public.

I think that both can work hand in hand. I am not such a separatist. And I am not saying that—I am just not sure that there is one answer to everything.

Dr. PRONOVOST. I think there are resources, but that it is solvable; that the hospitals should be provided methods to accurately monitor data. It is crazy that every hospital develops their database. I think things like NHSN are a model for how to do that. They ought to be provided what the evidence is in a digestible format.

I completely agree that the public ought to be ensured that data is accurate. There ought to be auditing. I wish I had authority to audit data in Michigan. It was a voluntary thing, but the reality is reporting of healthcare quality in most hospitals is like Enron. That is the normal reporting rather than the exception in the world, and the public deserves better.

I do believe there are resources because we have cut margins so much in healthcare that staff have time to do the work barely. But managing the work takes effort. So someone has to collect data; someone has got to train people and educate them. And we have ratcheted down the reimbursement so much that at my hospital we have cut all those positions, so the nurse is at the bedside, but there is no time for you to work on these projects. And it is kicking out resources, as I said, but it is staying in, likely, the insurer's pocket; and I think we have to think about reinvesting those so that hospitals do have the resources to collect data to participate in these programs and the society will see the cost savings that we all hope for.

The investment in health IT is an enormous opportunity, but I hope it is linked to measuring quality and reducing costs. If it is divorced from that, I doubt you are going to get the returns that are anticipated in the budgets. You will have a very expensive medical record, but not improvements of quality if we do not build standards for these measures and cost reductions into it.

Mr. OBEY. I just wish this were as simple as guaranteeing that my Uncle Dan's patients, when he was a dentist, would have received quality treatment. The best way to guarantee that was to see to it that they saw him before 2:00 in the afternoon, before the Jack Daniel's got to him. [Laughter.]

Mr. Tiahrt.

Mr. TIAHRT. Thank you, Mr. Chairman.

Dr. Pronovost mentioned that one of the reasons we have not had more progress on this is these 100,000 deaths a year are invisible, and I think the record should show that the visibility that you are giving this issue actually started behind closed doors in conference committee last year, and I want to thank you for your leadership, because it is an injustice that we want to correct. And I think making it visible is going to get it a long way down that road to stopping 1.7 million HAIs. So thank you for bringing this hearing together and thank you for your leadership on this issue.

Mr. OBEY. Thank you.

And let me thank you all for coming. I appreciate it. Keep doing what you are doing.

HEALTHCARE-ASSOCIATED INFECTIONS

Mr. Jackson: Dr. Besser, thank you for your testimony today. Dr. Peter Pronovost, from John Hopkins, is another panelist giving testimony today. I would like to read a few passages from his statement: This is page three of his prepared testimony. "Our public investments in the science of health care delivery are woefully inadequate .:. We generally invest a penny on health services research for every dollar we spend finding new genes or new drugs. The public is paying for this lack of investment with their lives." One of his recommendations is: We need to invest in the CDC to help monitor and reduce infections. "

Please inform the subcommittee of the research the CDC has already conducted in terms of demonstrating changes in the practices at Hospitals and in healthcare settings that can be implemented to reduce HAI's. What more needs to be done?

Dr. Besser: CDC is working to identify new strategies for the prevention of healthcare-associated infections (HAI) and to increase adherence to existing prevention recommendations. CDC supports the identification and evaluation prevention strategies and funds extramural research through a network of academic centers, called the Prevention Epicenter Program. The Epicenters collaborate to identify new ways to prevent HAIs and improve healthcare quality, assess the effectiveness of existing prevention strategies, including the prevention of Methicillin-resistant *Staphylococcus aureus* (MRSA) and other resistant organisms, and pilot new implementation tools to include CDC guidelines. Research activities include the development of new methods for electronic data collection, as well as assessing new strategies to decrease MRSA and bloodstream infections. Partnerships among the Epicenters have resulted in improved detection of surgical site infections, decreased inappropriate use of antimicrobial agents, reduced bloodstream infection rates in ICUs and decreased infections caused by MRSA and vancomycin-resistant enterococci (VRE).

Other research projects include:

- CDC funded and provided technical assistance to the Pittsburgh Regional Healthcare Initiative to prevent central line–associated bloodstream infections among intensive care unit patients in southwestern Pennsylvania, resulting in a 68 percent reduction in bloodstream infection rates.

- CDC also partnered with the Pittsburgh VA Medical Center to prevent MRSA infections through the implementation of CDC recommendations. These efforts led to greater than 60 percent reduction in MRSA infections. Influenced by their success, other hospitals in southwestern Pennsylvania are now collaborating with CDC in a regional MRSA prevention initiative. The Veterans Health Administration has also launched a national MRSA prevention initiative involving every Veterans Health Administration hospital in the country.

- The prevention successes demonstrated in southwestern Pennsylvania has also served as the model for other national and regional initiatives, including a similar initiative in Southeastern Pennsylvania and a statewide initiative coordinated by the Maryland Patient Safety Center. Hospitals in Pennsylvania, Maryland, Montana, and Kentucky funded by the Robert Wood Johnson Foundation to prevent MRSA infection, and a national initiative by members of the Voluntary Hospital Association (VHA) have also benefited form this model.

- In order to increase adherence to CDC recommendations, CDC is working with several groups to assess the effectiveness of strategies such as using Positive Deviance methods. Positive Deviance is designed to engage front line healthcare workers and encourage "ownership" of the problem of HAIs, addressing barriers to optimal practices by identifying latent solutions implemented by so-called "positive deviants"- those that have found creative ways to overcome barriers.

- CDC is working to reduce endemic rates of *Clostridium difficile* infections (CDI) in Ohio healthcare facilities, by implementing a set of tiered prevention strategies. CDC Prevention Epicenter investigators at Ohio State University are leading this effort in conjunction with the Ohio Hospital Association to detect and track CDI. This builds on the work of the Ohio Department of Health which, working with CDC, demonstrated the tremendous scope and burden of CDI in Ohio. This is one of the first and largest CDI prevention collaborative to date, and is intended to demonstrate the preventability of CDI among a large cohort of hospitals while helping to define the most effective strategies for prevention.

CDC's National Healthcare Safety Network (NHSN) is a powerful prevention tool developed to allow hospitals to track their progress toward HAI elimination. Hospitals participating in CDC's NHSN have been able to demonstrate reduction of central line-associated bloodstream infections by 40-50 percent during the last decade among patients in intensive care units. In most major intensive care unit types in those hospitals, rates also decreased 50 percent for central line-associated bloodstream infections associated with MRSA. Since 1990, facilities reporting to NHSN have also seen significant reductions of up to 70 percent in rates of catheter associated urinary tract infections (CAUTI) in ICUs. The combined use of CDC's guidelines and NHSN monitoring has been the basis for these and other successful HAI prevention initiatives. These and other prevention implementation examples demonstrate the tremendous potential savings, in terms of lives and healthcare costs, which could result from national implementation of evidence-based CDC HAI prevention recommendations.

CDC has also partnered with other HHS agencies to implement changes in practices in hospitals and in healthcare settings to prevent HAIs. CDC and AHRQ are collaborating to prevent MRSA by proposing several community-wide (regional) MRSA projects utilizing electronic data and active surveillance to increase our understanding of the problem and demonstrate how best to contain, control and prevent MRSA infections.

The focused efforts described above have demonstrated remarkable and measureable success in preventing HAIs; those efforts must now move beyond ICUs into other wards and non-hospital settings. Prevention guidelines must be applied not only to prevent bloodstream infections, but also to prevent ventilator associated pneumonia, urinary tract infections, and other important HAIs. As prevention and monitoring efforts move beyond hospital settings into outpatient settings (including long-term care facilities, ambulatory surgical centers, dialysis centers and infusion centers), reliance on traditional hospital-based detection and prevention strategies will no longer suffice.

Electronic reporting efforts are underway at CDC to foster greater use of electronic data stored in healthcare databases to detect HAIs and monitor antimicrobial use, resistance, and quality care indicators in hospital and ambulatory care settings. These efforts focus on automated healthcare data transmission and data quality validation, and are essential to detect HAIs in non-hospital settings and to reduce the reporting burdens placed on healthcare personnel and state health authorities. By moving to fully electronic data reporting systems and e-surveillance, enabling capabilities like electronically transmitted lab data and pharmacy messages, and algorithmic detection of HAIs, the impact of HAI prevention efforts can be amplified in both hospital and outpatient settings.

Mr. Jackson: I would like to ask a multi-part question about some of the information you and others have presented:

First, there is evidence that simple procedures implemented in all health care facilities in the US, and I'll give examples, would decrease the number of these Hospital Acquired Infections. Some of the simple procedures I have learned of include: rigorous hand wash procedures for hospital staff with aggressive monitoring; testing and treatment of Hospital Staff for infections commonly re-transmitted to patients in their hospitals; and requiring more frequent (in other words more than daily) changes of medical scrubs for hospital personnel.

What has prevented physicians and health care workers from implementing many of these procedures or others you know of in their own Hospitals? How does the medical system as a whole have to change to make improvements in these areas?

Dr. Besser: Adherence to infection control practices is essential for prevention of healthcare-associated infections (HAI). Several factors contribute to the failure of healthcare personnel to adhere to recommended practices. These include a lack of knowledge, lack of recognition that everyone working in a healthcare environment (including non-medical personnel) has an important role in infection control and, finally, many recommended practices require consistent, ongoing behavior changes by a large number of personnel.

CDC has several collaborations to create and promote a culture shift to increase recognition of the role of all healthcare personnel in HAI prevention. For example, CDC is collaborating with several groups to assess the relationship between use of a culture-

change approach known as "Positive Deviance" and successful reduction of MRSA infection and colonization in healthcare facilities. " Positive Deviance" is designed to engage front line healthcare workers and encourage "ownership" of the problem of HAIs, addressing barriers to optimal practices by identifying latent solutions implemented by so-called "positive deviants"- those that have found creative ways to overcome barriers. Facilities then promote diffusion of successful solutions throughout the facility. Providing feedback information to healthcare personnel about their adherence to infection control and prevention strategies has been an important element in successful interventions. CDC's National Healthcare Safety Network (NHSN) has modules for healthcare facilities to collect such information. In addition, CDC is currently funding two projects to identify better and easier ways to track adherence to infection control practices, including methods to monitor compliance with isolation precautions and using radio-frequency-identification to monitor hand hygiene adherence among healthcare personnel.

There are other important opportunities to improve adherence to recommended practices. The potential impact of such opportunities is demonstrated by the success of local efforts and pilot projects. These projects focus on education and tracking behavior to promote adherence along with environmental and system changes that make it easier to adhere to CDC recommendations, including:

- *The Development of Training Tools* - CDC is developing an interactive infection control curriculum that will be available for state health departments and healthcare facilities to reinforce personnel training. CDC has partnered with non-profit and professional organizations to produce educational campaigns for hand hygiene and other basic safety elements such as safe injection practices. In addition, CDC guidelines are the basis for the 'checklists' developed and implemented by multiple groups for the prevention of HAIs. One example of such a 'checklist' project was the Keystone initiative in Michigan, supported by AHRQ, which dramatically reduced the rate of central line blood stream infections in intensive care units across the state. That project is now being expanded to other states with the support of both AHRQ and CDC.

- *Creating a new environment for success* - CDC has addressed one of the barriers to hand hygiene adherence by working with a multi-agency task force to promote the use of alcohol-based hand-rub solutions in specific clinical situations as an alternative to soap and water. Pocket carriage of these solutions combined with bedside dispensers, has been shown to result in substantial improvement in adherence to CDC hand-hygiene guidelines.

- *Injection Safety Campaign* – CDC is an active partner in the Safe Injection Practices Coalition. In February 2009, the coalition launched the One and Only Campaign to raise awareness and educate healthcare personnel as well as patients about safe injection practices. The Campaign focuses on a simple message: *one needle, one syringe and only one time.* The Campaign also utilizes posters to creatively convey messaging to healthcare providers and patients to adhere to

these basic infection control recommendations. Additional print material for patients and healthcare personnel are being developed.

- *Hand Hygiene Education* - CDC created and launched a new online Hand Hygiene Interactive Training Course for healthcare personnel that reviews the key concepts of hand hygiene and other Standard Precautions to prevent healthcare-associated infections and includes a self-paced navigation program that allows users to learn through both text and image-based pages. This course is now being implemented by healthcare systems across the United States as part of their continuing education and training programs. CDC also led the development of a new hand hygiene video to educate and empower patients and visitors in hospitals. The video teaches two key points to help prevent infections: the importance of practicing hand hygiene while in the hospital and the appropriateness of asking or reminding healthcare personnel to practice hand hygiene. To date, more than 60,000 copies of the DVD and accompanying materials have been distributed in healthcare facilities across the United States.

Mr. Jackson: It has been a year since the Government Accountability Office (GAO) completed its review (March 2008) of healthcare-associated infections (HAIs) in hospitals. Since then, has the Department of Health and Human Services (HHS) seen any improvements in HAI rates?

Mr. Wright: In 2008, HHS developed the Action Plan to Prevent Healthcare-Associated Infections. The Department will be monitoring the impact of prevention activities on the rates of HAIs in the future using the metrics in the Action Plan, many of which use the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) as their data source. NHSN data is immediately available to users at local and state levels for use in prevention activities.

National data for 2008 is currently being compiled by CDC, so we do not yet have rates of HAIs for 2008. NHSN's most recent annual report was published in November 2008 and contains summary data on HAIs for 2006 through 2007. We have seen success in reducing rates of bloodstream infections (BSIs) in intensive care units (ICUs) over recent years due to HAI prevention efforts. For example, in hospitals participating in the NHSN system between 1997 and 2007, rates of BSIs from approximately 600 hospitals from 43 states including approximately 1,700 reporting intensive care units, decreased 50 percent, indicating approximately 10,600 BSIs and at least 1,300 deaths prevented.

The Office of Public Health and Science within the Office of the Secretary of HHS is exploring options for measuring national HAI rates and identifying the impact of prevention strategies on these rates.

What specifically are hospitals, clinics, ambulatory surgical centers, and nursing homes required to do to reduce HAIs? And what has been their compliance?

The Centers for Medicare & Medicaid Services (CMS) utilizes a variety of tools within its statutory and regulatory authorities to prevent HAIs. These tools can be broadly classified as regulatory oversight, financial incentives, transparency and associated initiatives, or some combination of these.

Conditions of Participation (CoPs) [or with respect to Ambulatory Surgery Centers, Conditions for Coverage (CfCs)] are the federal health and safety requirements that hospitals and other providers must meet in order to participate in the Medicare and Medicaid programs. CoPs/CfCs are evidence-based guidelines intended to ensure that providers meet basic standards of care. These guidelines serve as the foundation for improving quality, and they require infection control practices for all hospitals, ambulatory surgical centers, and nursing homes. The CMS Survey and Certification interpretive guidelines and enforcement activities serve to ensure adherence to the CoPs and CfCs. All providers that participate in Medicare and Medicaid are required to satisfy these health and safety requirements.

In the hospital setting, CMS is currently implementing the Preventable Hospital-Acquired Conditions Provision, Present on Admission Indicator Reporting, and Hospital Pay-for-Reporting. Specifically, since October 1, 2008, CMS no longer assigns an inpatient hospital discharge to a higher paying MS-DRG if a selected condition (including specific infections) is listed on the claim but was not present on admission. CMS also currently collects present on admission data to determine whether diagnoses were present on admission or acquired by patients during their hospitalization. In addition, as part of CMS' transparency initiative, CMS is currently implementing the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, also known as hospital pay-for-reporting. RHQDAPU provides financial incentives to participating hospitals that report data on quality measures, including several infection measures. These measures are then publicly reported on the "Hospital Compare" website to promote transparency and provide information on hospital quality of care to the public.

As part of another infection control initiative, CMS is working to reduce hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) infection and transmission rates as part of the 9th Statement of Work (SOW) for the Quality Improvement Organization (QIO) program. Through this unique collaboration between the Agency for Healthcare Research and Quality (AHRQ), CDC, and CMS, CMS is utilizing the expertise of the QIOs to provide assistance to hospitals with MRSA reduction efforts.

## KEYSTONE PROJECT

Mr. Jackson: Dr. Clancy, I am interested in AHRQ's funding of the expanded Keystone project developed by Dr. Pronovost and the John Hopkins University Research team which implements 10 hospitals in each state. In a state as diverse mine, it is easy to realize the range in size, provided services, and endowment of hospitals throughout the state. Because of this, I am concerned with how hospitals are selected to participate in the program.

It is easy to imagine that the complications and challenges faced at a small, rural community hospital in southern Illinois are very different than those of a large, research University Hospital in downtown Chicago. How does the Keystone project select hospitals to participate within each state and do you feel that the selected hospitals adequately represent the diverse hospitals and patients they serve throughout the nation?

Dr. Clancy: Thank you so much for your questions related to the AHRQ's 10-State project to Reduce Central Line-Associated Blood Stream Infections in Hospital ICUs. The ten state hospital associations have now been selected. The states are California, Colorado, Florida, Massachusetts, Nebraska, North Carolina, Ohio, Pennsylvania, Texas, and Washington. In addition, the California Hospital Patient Safety Organization, the North Carolina Center for Hospital Quality and Patient Safety, and the Ohio Patient Safety Institute will participate in the project.

The hospital associations and patient safety groups were chosen to participate based on their capability, infrastructure, and readiness to implement the safety protocols being tested in the project. In addition, they provide a broad geographic representation. You asked about the difference in complications and challenges between a small, rural hospital and a large research institution in Chicago, and certainly their resources to address problems are vastly different. A remarkable aspect of the original Keystone project was its success in a broad array of hospitals across Michigan – from small rural hospitals to community hospitals to major academic medical centers. The smaller hospital may be able to offset a resource disadvantage, however, due to the relatively fewer persons who need to learn best practices and gain appreciation for the importance of a culture of safety. The Central Line protocol is relatively straightforward, and hospitals of all sizes are able to improve their performance once they make it a priority.

While Illinois is not one of the states that will be participating in the AHRQ-funded, 10-state effort, there is a second project spearheaded by the Johns Hopkins Quality and Safety Research Group, in partnership with the MHA Keystone Center for Patient Safety & Quality. It is funded by donations and by the Sandler Foundation of the Jewish Community Endowment Fund. The Illinois Hospital Association (IHA) will be participating in this effort, and it will use the same protocols as those being used in the AHRQ ten-state project. Below is relevant information from the IHA's web site http://www.ihatoday.org/issues/safety/collaborative/overview.pdf

Illinois Hospital Association
2009 Patient Safety Collaborative
"Stop Central Line Associated Blood Stream Infections"
Registration begins March 15
For more information contact:
Becky Steward, Manager, IHA Patient Safety Collaborative
630-276-5585 or bsteward@ihastaff.org

I hope this information is of help to you.

INFECTION PREVENTION EDUCATION

Mr. Jackson: Dr. Hyzy, as one of the practicing physicians testifying today, I would like to ask you a question about patient, family and hospital visitor participation and the prevention of infections. Given that most hospitalized patients are quite ill and given that most nurses oversee the care of many patients at one time, and given that their priority is direct patient care: What is the best method to educate patients, families, and their visitors with respect to infection prevention? Whose responsibility should it be and what are the best ways to monitor these efforts?

Dr. Hyzy: There are many ways in which hospitals work with patients, families and visitors to help them participate fully in our efforts to keep patients safe from infections and other potential hazards. Through information packets, posters and in conversation with their nurses and doctors, patients are encouraged to ask questions about what is being done to protect them from potential harm. Hospitals encourage their clinicians, family members and visitors to wash hands or use a cleansing gel to prevent transmission of germs. Many hospitals have even posted signs and conducted community education about not visiting patients in the hospital if you have a cold or other potentially infectious disease.

Hospitals in Michigan publicly talk about the work they are involved in to reduce infections in improve safety. This is in intended to show our communities that we are involved.

For the patients we treat, we are also responsible for sharing with them all of the appropriate information about how they can heal and retain their health after discharge. This would include showing them how to prevent infections from occurring during their recovery and providing them with the necessary prescriptions. While we take this responsibility very seriously, we also know that we are not the only ones responsible for assisting patients in knowing how to care for themselves. Their primary care physician, home health nurse, and other providers from whom they seek care are vital partners in this effort. Further, the patient and family members have a responsibility to adhere to the directions they have been given to the best of their ability. Working together is the best way to prevent infections.

TUESDAY, MAY 12, 2009.

# U.S. DEPARTMENT OF LABOR

## WITNESS

## HON. HILDA SOLIS, SECRETARY, U.S. DEPARTMENT OF LABOR

### CHAIRMAN'S OPENING REMARKS

Mr. OBEY. Well, good morning, everyone.

Mr. LEWIS. Good morning.

Mr. OBEY. Good morning. I am pleased to welcome our former colleague and new Secretary of Labor to her first appearance before this subcommittee. Madam Secretary, you face some pretty daunting challenges. The country is experiencing the longest and the deepest economic downturn since the Great Depression. More than 5.7 million jobs have been lost during the recession. And that understates the true gap between how many jobs there are today and how many are jobs needed simply to keep up with the growing population.

The economy needs to add about 127 thousand jobs each month. That means the economy is nearly 8 million jobs below where it needs to be just to maintain pre-recession levels of employment for the American workforce. Nearly 14 million unemployed Americans are actively looking for work, with 3,700,000 people out of work for more than 6 months. That is 27 percent of the unemployed persons in April, the highest proportion of long-term joblessness on record.

That indeed is something to worry about. And I think the crisis is magnified for the American workforce because their problems are not solely the result of the current economic downturn. The earnings disparity between the working class and the wealthiest workers has been growing for the past three decades. Between 1979 and 2000, real after-tax incomes grew by 256 percent for the top 1 percent of households. That compares with 21 percent growth for households in the middle fifth, and 11 percent growth for households in the bottom fifth of the income spectrum. One of the primary drivers behind that growing earnings disparity is the inability of workers to reap the economic benefits of their increased productivity. And that is at least, in part, a result of the decline of unionization.

During our post-World War II economic expansion, the so-called heyday of the American economy, union membership fluctuated between 30 and 35 percent of the workforce. By 2006, it had fallen to 12 percent, including only 7.4 percent in the private sector. And according to the Economic Policy Institute, the gap between pay and productivity growth is the result of economic and employment policies that shift bargaining power away from the vast majority and toward employers and the well off. I would hope that to confront this rising income disparity, this administration will refocus

on programs and policies that help our Nation's workers and strengthen the middle class, the foundation of our Nation's economy.

I am pleased to see a number of items in your request, including investments in green jobs, YouthBuild, and the Career Pathways Innovation Fund. I am pleased to see a request for increased funding for state unemployment insurance operations. I am also pleased to see the Department renew its focus on workplace health and safety. In 2007, 5,657 workers died as a result of job-related injuries, an average of more than 15 deaths a day. And as many as 8 million to 12 million workers sustain job-related injuries or illnesses each year. Approximately 50 thousand workers die each year from illnesses in which workplace exposures were a contributing factor. Let me put it this way: While I am positively impressed by most of your budget, I am concerned about a couple of items.

As you know, the Congress included $250 million in the Recovery Act to train workers for high growth jobs, especially in the health care sector, which continues to add jobs, one of the few sectors of the economy that does. The BLS reported last week that the health care industry added 17 thousand jobs in April, in line with its average monthly gain since January. In 2008, the average gain was 30 thousand jobs per month. However, your fiscal 2010 budget does not appear to continue any targeted investment to address the critical shortage in the health care workforce, including a long-term need for 2.8 million nurses and nearly 2 million allied health workers.

It seems to me that if we are serious about significant health care reform that we have to build the capacity of the system, and we are falling short in this area. I am also, frankly, disappointed by the administration's proposal to freeze the number of participants in Title V Community Service Employment Programs for older Americans. There are a lot of good reasons why this program ought to be expanded. The most important reason, in my judgment, is that the unemployment rate for seniors age 65 and up is at its highest recorded level since the Federal Government began tracking this figure after World War II, according to a recent report by the Urban Institute.

Let me simply conclude by saying that, on balance, I think you are presenting a strong budget, certainly one that I think represents a much greater effort to meet the needs of workers than the budget we received a year ago. But I still think that there are gaps that the administration needs to be aware of and consider, and I look forward to working with you as we deal with these issues in the coming weeks. Mr. Tiahrt.

## RANKING MEMBER'S OPENING REMARKS

Mr. TIAHRT. Thank you, Mr. Chairman. I know you have been quite anxious to get moving forward on the administration's budget request and begin the committee's work. First, I would like to welcome our new Labor Secretary, our former colleague, Hilda Solis. Congratulations. And I hope you enjoy your experience on the other side of the dais. Today more than ever, Americans eagerly await the news from the Department of Labor, hoping for good news

about job growth. And our task in Congress is to ensure that you have the tools necessary to help our fellow citizens realize their dreams. It is in this vein that I am sure all my colleagues, as well as myself, examine the Department's budget request. Last Friday, the Department of Labor's Bureau of Labor Statistics announced that the Nation lost 539 thousand jobs in April, and that the unemployment rates rose to 8.9 percent from 8.5 percent in March. In addition, the Bureau reported that for the 12-month period ending April 30th, the Nation lost 5.24 million jobs, a decrease of 3.8 percent. We can only hope that this news could be the first indication that the pace of job loss may be slowing.

Remarkably, in April of last year, the unemployment stood at only 5 percent. Today, Americans are facing the kind of economic conditions that would have seemed unfathomable a couple of years ago. In fact, since the recession started, the Nation lost 5.7 million jobs, the deficit soared to over $11 trillion, and Congress faces daunting choices. In the last 100-plus days alone, the deficit has increased with the administration's spending spree in the stimulus bill, the omnibus, and the supplemental. We are printing more money than we can keep up with. And I am concerned about the long-term effect on our economy, especially jobs.

Let me start by saying I appreciate that on the discretionary side, you have requested only about a 3 percent increase over the fiscal year 2009 non-Recovery Act budget authority. Nevertheless, prior to considering this budget request, it seems only logical for Congress to ask what has become of the $4.8 billion in discretionary budget authority that Congress provided to the Department of Labor in the Recovery Act. How much of the funding has been expended? What has been accomplished so far? It has come to my attention that the Recovery Act reports, while featured prominently in the Department of Labor's Web site, have since their inception been decreasing rather than increasing in program level obligation and expenditure detail. Naturally, I have concerns about this fact. This seems to be the antithesis of transparency that the American public was promised.

Furthermore, the Department of Labor seeks appropriations that will maintain funding for some programs at levels more similar to the augmented fiscal year 2009 levels. Congress needs to consider whether program levels can be justified at this time. One example is the YouthBuild program. The Budget in Brief states few studies of YouthBuild demonstrate promising results. And it designates significant increases in budget authority for both YouthBuild program level and its evaluation. Saying a few studies detected merit with respect to YouthBuild raises questions about the studies which have not found merit.

In fact, our own government's evaluations have identified a number of shortfalls in this program. Seeing as how YouthBuild just received an infusion of $50 million in Recovery Act and in light of the Department's tepid, if not cryptic, acknowledgement of YouthBuild's lack of notable success, I am curious as to why the Department seems to want to gamble on YouthBuild's track record with a $45 million increase in program level funding. That is about a 64 percent increase over fiscal year 2009. This seems to be counterintuitive.

I would think that there would be more than enough activity generated by the additional Recovery Act funds to support a thorough evaluation of this program. And that evaluation would be more properly conducted prior to the appropriations of significant increases to the budget. Another concern I have is the notion of green jobs. The President desires to simultaneously create new green jobs, stimulate the economy, and wean America off foreign oil. This is a social experiment that appeals far more to environmental interests than our own workforce community.

A study conducted by King Juan Carlos University in Spain found that based on the European or Spanish model cited by President Obama as the model for green policies, they are likely to destroy upwards of nine conventional jobs for every four green jobs created. I find myself quite reluctant to support policies underlying the need for green jobs training. This poor timing of the scheme cannot be overstated, in my opinion. I am further concerned that these jobs will be just temporary, and too few in number, and will fail to justify the level of government intervention being directed at them. The net reduction in the budget request for the Office of Labor-Management Standards also concerns me.

The Office of Labor-Management Standards is the lone Federal agency with the job of protecting workers' interests in how their unions are managed. I am not pleased that the Department of Labor has already signaled it will not enforce compliance with current conflict of interest disclosures in addition to recommending that we slash funding for this extremely important division, all the while announcing its desire to increase worker protection. The fact that from 2001 to 2008, the Labor Department secured more than 1,000 union fraud-related indictments and 929 convictions proves that the workers deserve protection from more than just employers in many cases.

I oppose the reduction in funding for the OLMS, and intend to watch very, very closely to ensure that the mission of this important agency is not being diluted. With regard to the mission area increases, I would like to take note the of the Department's request for a large increase in the area of worker protection. The budget request includes 9.9 percent increase in the area of worker protection. I think we can argue that safe and fair workplaces should never be a luxury.

Yet I am curious about the evidence on which the Department of Labor has based its request for such a significant increase, especially when the Office of Labor-Management Standards has been reduced. I look forward to hearing the background on this.

Finally, on a personally directed note, I just want to mention my desire to work with the Department of Labor to rectify a situation that has impacted some of my constituents over the last year. In fiscal year 2007, the Department of Labor awarded by competitive bid a Garden City community college in Garden City, Kansas, a community-based job training grant. The grantee had intended to use the grant to train workers in the construction of two coal-fired power plants. Unfortunately, last year the governor of my State blocked the construction of these power plants, and created a delay which made it impossible for the grantee to comply with the terms of the grant.

Recently, however, our current Democrat Governor of Kansas permitted the construction of the plants to move forward. While I am aware there may be some hurdles to overcome with respect to the grant at this time, I look forward to working with the Department to find a way for this important job training opportunity to get back on track. I want to thank the Department in advance for its cooperation on this project.

Madam Secretary, at the end of the day, I am sure we all want the same thing, high quality, high paying jobs for all Americans. And it is your Department's responsibility to see that we are prepared to fill those jobs. Let us know how we can work together towards that common goal. Thank you, Mr. Chairman.

Mr. OBEY. Mr. Lewis.

Mr. LEWIS. Mr. Chairman, outside of welcoming the Secretary, I am anxious to hear her testimony and participate in the questions. Congratulations, Madam Secretary, and I look forward to working with you.

Secretary SOLIS. Thank you.

Mr. OBEY. Madam Secretary, why don't you proceed.

Secretary SOLIS. Thank you. Thank you, Mr. Chairman, and Ranking Member Tiahrt, and the subcommittee members that are here this morning. I especially want to say a thank you for your gracious welcome, Mr. Chairman and the ranking member. It is good to be able to see friends here in the House. This is the first time that I am actually testifying before a committee. So it is with a great deal of privilege and an honor for me. So with that, I will begin my statement.

And as I would like to suggest, if I would like to provide a summary of my remarks and ask that my written testimony be entered in the record.

Mr. OBEY. Sure.

## SECRETARY'S OPENING STATEMENT

Secretary SOLIS. The total request for the Department of Labor is $104.5 billion. And $15.9 billion is before the committee, and $13.3 billion of the request is for discretionary budget authority. Our budget for DOL requests funding programs for the Recovery Act. And we all know that families right now are struggling. We see this economic crisis every single day. Investing in our Nation's workforce and creating new jobs is a critical component of President Obama's effort to jump-start our economy. The Department of Labor is using its Recovery Act resources to help ease the burden of unemployment and to put people back to work. And I would like to highlight some of our recovery activities, which include the following: Providing new training and employment opportunities for unemployed adults, youth, and seniors; enhancing and expanding the Unemployment Compensation and Trade Adjustment Assistance Act; and also launching a new COBRA premium assistance outreach program; and fourth, initiating additional worker protections to ensure that economic activity spurred by the recovery occurs in workplaces which respect workers' rights, which provide safe and healthy environments.

And then building on the recovery efforts, the Department's fiscal year 2010 budget features three overall priorities: First, worker

protection. We are beginning to restore the capacity of our programs that protect workers' health, safety, pay, and benefits.

Secondly, a green recovery. We are implementing new and innovative ways to promote economic recovery by working toward energy independence and increasing the competitiveness of our Nation's workforce.

And third, accountability and transparency. We will ensure that our programs are carried out in a way that is accountable, transparent to our stakeholders, and to the public. And in all these efforts, I am committed to fostering diversity and to ensuring that our programs are accessible to previously underserved populations, including those in rural America. And I am particularly proud that fiscal year 2010 begins to restore programs to protect workers. These programs enforce laws governing minimum wage, overtime, family, and medical leave. They also protect workers' pensions and their health benefits, while ensuring workplaces are safe and healthy. They ensure equal opportunity in Federal contracting. And in fiscal year 2010, the Department is requesting $1.7 billion for worker protection programs, an increase of 10 percent above fiscal year 2009. By adding a total of 878 full-time employees such as investigators, inspectors, and other program staff, the budget will return worker protection efforts to a level not seen since fiscal year 2001.

Increasing our capacity so dramatically in a single year, as you know, is unprecedented. And it illustrates, again, the President's commitment to America's workers and the workforce. And I can assure you that we have developed an aggressive, comprehensive, hiring plan which will be implemented as soon as fiscal year 2010 funding is available. The plan prioritizes the hiring of multilingual inspectors and investigators to enhance our enforcement outreach. We will provide additional $35 million to add 288 FTE for the Wage and Hour Division, which protects over 135 million workers in more than 7.3 million establishments.

These additional resources will allow the Wage and Hour to improve compliance in low wage industries that employ vulnerable workers and youth, increases its focus on reducing repeat violations, and strategically conducts complaint investigations. The increase for OSHA will allow it to also add 213 new staff such as enforcement personnel, standards writers, technical support, and bilingual staff to address the changing demographics in our workplace. In recognition of the work of our State partners, the budget request includes nearly a $14 million increase in State program grants. The number of enforcement staff in the Employee Benefits Security Administration will also be increased by 75 FTE, allowing the agency to conduct an additional 600 investigations.

To help promote equal opportunity in Federal contracting, we will expand the Office of Federal Contract Compliance Programs and the number of compliance officers and other field office staff by 213 personnel. By returning to fiscal year 2001 levels, there will be a reduction in the Office of Labor-Management and Standards. And I can assure you that the resources requested will allow the agency to accomplish its core mission, and that the reduction in FTE will occur through the transfer of staff to other protection pro-

grams which we have seen a drop in levels of enforcement over the past 8 years.

The increases in our enforcement programs will also require legal services and support from the Office of the Solicitor. To help meet these needs, the budget request includes an increase of $14,800,000 to support additional 82 FTE. And I am hopeful that this Congress will endorse our worker protection program request and allow the Department to revive these programs to meet our responsibility to all American workers. The DOL is also currently using Recovery Act funds for a range of other activities, to provide transitional benefits, job training, and placement assistance to unemployed workers.

And I want to thank the Congress personally for providing these dollars. The fiscal year 2010 budget request supplements the Recovery Act funding through targeted investments in employment and training programs, and I am very pleased and excited about the use of innovative strategies and programs that are designed to increase the skills and competitiveness of all our workforce. Our $71 million increase in the Dislocated Worker National Reserve Account will help fund national emergency grants, allowing for targeted response to large scale worker dislocations. $135 million for a new Career Pathways Innovation Fund, which will provide fund grants to community colleges and other educational institutions to help individuals advance up the career ladders in growth sectors in our economy.

The Career Pathways program involves a clear sequence of course work and credentials, each leading to a better job in a particular field, such as in health care, in law enforcement, and in clean energy. The budget requests an additional $50 million for enhanced apprenticeships and competitive grants for green jobs. And we are pursuing those strategies to ensure that all of our training programs are equipped to provide training for the new green economy. And have included funds from the Bureau of Labor Statistics to produce valuable information on defining green jobs. Within our request for pilots and demonstrations, the budget includes a new 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 YouthBuild program to train low income and at risk youth. This is an increase of $44 million over the fiscal year 2009 level, and will allow us to build on the Recovery Act funding for the program. In addition, the request is also made for $255 million for the Veterans Employment and Training Services program known as VETS, which contains strategic investments to allow the agency to do the following, to reach out to homeless women veterans, to make employment workshops available to families of veterans and transitioning service members, and to restructure existing training grants to focus on green jobs.

These innovative strategies supplement our core workforce security programs that are extremely sensitive to economic conditions. Thus, in the budget you will also see 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 unem-

ployment insurance to support the increased demand on State systems. In addition to providing States with the funding they need to cover these increased workloads, our approach includes an increase of $10 million to expand reemployment and eligibility assessment to help claimants return to work as soon as possible. I believe that spending tax dollars wisely helps the Department achieve our mission on behalf of American workers and builds trust among our stakeholders.

A number of other fiscal year 2010 budget proposals support these goals. For example, the budget request also includes a $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 for job training program evaluation to help us understand which job training approaches are more effective, and will help inform the direction of future programs. And a new $5 million program evaluation initiative to help the Department of Labor examine all programs, not just those in employment and training. I would like to just say a few words about the programs at the Department. First, the budget does provide $10 million for the Office of Disability Employment Policy.

The increase will allow us to build on the lessons that we learned through the Work Incentive Grant demonstration programs. It will allow us to promote opportunities for individuals with disabilities, particularly our youth, in employment, in apprenticeship, pre-apprenticeship programs, and community service activities. Fiscal year 2010 budget also includes the program known as Add Us In!, a new grant program with the Agency's base budget to help minority youth with disabilities who are interested in entrepreneurship. And secondly, the budget request provides an increase of $5.3 million, 12 FTE to the Bureau of International Labor Affairs, known as ILAB. With these funds, ILAB will be able to step up its monitoring and oversight of labor rights through close monitoring, reporting on labor conditions worldwide, particularly with our trading partners. Through these efforts we can help reduce instances of child labor, forced labor, human trafficking, and violations of worker rights. Fiscal year 2010 budget will also maintain the child labor and worker rights technical assistance activities at the same level of 2009.

In conclusion, I am committed to ensuring that these new efforts, along with all the programs supported by the Department's fiscal year 2010 budget, will help to demonstrate that we are working to meet the needs of all American workers and their families, and I ask for your support and look forward to answering your questions. And thank you for having me here this morning. Mr. Chairman.

Mr. OBEY. Thank you.

[The information follows:]

**STATEMENT OF HILDA L. SOLIS**
**SECRETARY OF LABOR**
**BEFORE THE**
**SUBCOMMITTEE ON LABOR,**
**HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES**
**COMMITTEE ON APPROPRIATIONS**
**UNITED STATES HOUSE OF REPRESENTATIVES**

**May 12, 2009**

Chairman Obey, Ranking Member Tiahrt, and members of the Subcommittee, thank you for the invitation to testify today. I appreciate the opportunity to discuss the President's Fiscal Year (FY) 2010 budget request for the Department of Labor.

The total request for the Department in FY 2010 is $104.5 billion and 17,477 Full-Time Equivalent employees (FTE), of which $15.9 billion is before the Committee. 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;
- 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 FY 2010 budget will build on and leverage the efforts begun this year with the Recovery Act. The Department's FY 2010 Budget will promote continued economic recovery and strengthen the health, safety, and competitiveness of our nation's diverse workforce.

**FY 2010 PRIORITIES**

While building on the efforts begun under the Recovery Act, the Department's FY 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 FY 2009 enacted level, and returns the worker protection programs to their FY 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 FY 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 FY 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 FY 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 non-immigrant visa programs, and prevailing wage requirements of the Davis-Bacon Act and the Service Contract Act. The Wage and Hour Division protects over 135 million workers in more than 7.3 million establishments.

The FY 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 FY 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 FY 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 FY 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 FY 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 FY 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 FY 2009 level. OFCCP is responsible for ensuring equal employment opportunity and non-discrimination in employment for businesses contracting with the Federal government. In FY 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 FY 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 non-compliant contractors and improve the effectiveness of OFCCP's enforcement activities.

**Office of Workers' Compensation Programs**

The FY 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 FY 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 FY 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 FY 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 FY 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 FY 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 FY 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 FY 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 FY 2010 request supports *an additional*:

- 130 safety and health inspectors (a 10 percent increase from FY 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 FY 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 FY 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 FY 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 FY 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 FY 2010 budget requests $464.1 million and 931 FTE, an increase of $19.3 million over the FY 2009 level. In FY 2010, PBGC will strive to prevent unnecessary and avoidable terminations of under-funded 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 3 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 two years.

## INNOVATIVE WORKFORCE TRAINING STRATEGIES

The FY 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 FY 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 (NEGs). This will enable ETA to provide additional, targeted resources to aid in the reemployment of dislocated workers, as current projections indicate that there will continue to be high levels of unemployment into FY 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 (TAA) 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 FY 2010 budget requests $135 million for the Career Pathways Innovation Fund, which is a $10 million increase over the amount awarded in FY 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 health care, 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 FY 2010 Budget includes $114 million, an increase of $44 million, or 64 percent, over the FY 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 FY 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 FY 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 non-custodial 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 FY 2010 budget requests $115 million, an increase of $6.5 million over the FY 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 FY 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 reemployment 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 FY 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 FY 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 FY 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 FY 2010 Budget request is $255 million and 234 FTE. The FY 2010 Budget includes $35 million for the Homeless Veterans Reintegration Program (HVRP), an increase of $9 million (34 percent) above FY 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 service members 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 FY 2010 budget supports those goals.

**Workforce Data Quality Initiative**

The FY 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 FY 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 FY 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 FY 2010 Budget includes an increase of $8.0 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 FY 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 FY 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 FY 2010 Budget also proposes "Add Us In!" -- a new grant program 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 FY 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 FY 2010 budget will maintain ILAB's child labor and worker rights activities at the FY 2009 level

**Women's Bureau**

The FY 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 FY 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 FY 2010. I am happy to respond to any questions that you may have.

Thank you.

U.S. Department of Labor
Office of the Secretary

Secretary of Labor Hilda L. Solis

Secretary Hilda L. Solis was confirmed as Secretary of Labor on February 24, 2009. Prior to confirmation as Secretary of Labor, Secretary Solis represented the 32nd Congressional District in California, a position she held from 2001 – 2009.

In the Congress, Solis' priorities included expanding access to affordable health care, protecting the environment, and improving the lives of working families. A recognized leader on clean energy jobs, she authored the Green Jobs Act which provided funding for "green" collar job training for veterans, displaced workers, at risk youth, and individuals in families under 200 percent of the federal poverty line.

In 2007, Solis was appointed to the Commission on Security and Cooperation in Europe (the Helsinki Commission), as well as the Mexico — United States Interparliamentary Group. In June 2007, Solis was elected Vice Chair of the Helsinki Commission's General Committee on Democracy, Human Rights and Humanitarian Questions. She was the only U.S. elected official to serve on this Committee.

A nationally recognized leader on the environment, Solis became the first woman to receive the John F. Kennedy Profile in Courage Award in 2000 for her pioneering work on environmental justice issues. Her California environmental justice legislation, enacted in 1999, was the first of its kind in the nation to become law.

Solis was first elected to public office in 1985 as a member of the Rio Hondo Community College Board of Trustees. She served in the California State Assembly from 1992 to 1994, and in 1994 made history by becoming the first Latina elected to the California State Senate. As the chairwoman of the California Senate Industrial Relations Committee, she led the battle to increase the state's minimum wage from $4.25 to $5.75 an hour in 1996. She also authored a record seventeen state laws aimed at combating domestic violence.

Solis graduated from California State Polytechnic University, Pomona, and earned a Master of Public Administration from the University of Southern California. A former federal employee, she worked in the Carter White House Office of Hispanic Affairs and was later appointed as a management analyst with the Office of Management and Budget in the Civil Rights Division.

She was nominated by President Barack Obama to serve as Secretary of Labor on January 20, 2009.

Mr. OBEY. Mr. Tiahrt.

ADVOCATE FOR A SAFE WORK ENVIRONMENT

Mr. TIAHRT. Thank you, Mr. Chairman. There is an overall philosophical, I think, debate maybe or question that we should ask with the idea of enforcement. Our current philosophy is one of adversarial contact. When you think of how the public sector interacts with the private sector, it seems to be on an adversarial basis in each case. I had an instance that happened in Wichita that I think could give us some grounds for a good debate on how we view the philosophy of our interface between the public and private sectors. OSHA targeted three counties in Kansas in the home building industry. This is 3 years ago. They came into Sedgwick County, where Wichita is located, and literally shut down the home building business. All the agents that OSHA had in Kansas came to that area, and they started writing citations and fines. And I got a call and asked to come back and meet with the Wichita area builders. I met with them, and I think it was all summed up by a framing contractor who said I just recently got a $5,000 citation for having a Styrofoam cup on the front step of a house that I was framing. He said my normal profit for a framing job is about $2,500, so it does not pay for me to go to work while so many of the agents are in town. He was one of about 6,000 people in the home building industry that currently were not working.

So I met with the regional, or I called the regional office of OSHA, and they agreed to meet, which is in Kansas City, they agreed to meet in Topeka. And together they came up with a plan that I thought was very interesting. They decided that they would announce when OSHA would be at a job site. They would meet with the superintendent or the contractor of that job site. They walked through the area. They made a list of violations or potential violations. They agreed to the list, without any fines and citations. And then OSHA gave them 6 weeks to comply. While OSHA gave them that time, the Wichita area builders hired an expert out of the insurance industry that focuses on workplace safety. He came in and conducted training at each major job site. And they brought people in from the other sites. When OSHA returned, they went around the job sites, and they didn't find any violations. And the common goal was achieved, a safe workplace.

When I talked with the contractors, you know, many of them hire friends and family, and they do not want anybody to get hurt on their job. The last thing they want to do is report at a family reunion why somebody lost a finger or broke a leg, because quite often it is their own family that is involved. So I thought this is an interesting philosophy change, where OSHA actually worked with the private sector to achieve a common goal of a safe work environment. They were an advocate for a safe work environment instead of an adversary to the private sector. And that worked for a couple of years.

And then when the OSHA office here in Washington, D.C. found out what was going on, they said, no, you've got to go back to the old method of enforcing regulations, which is this adversary method. Are you open to discussing how we could change our philosophy in the regulatory scheme to advocate for a safe work environment

instead of being an adversary to those people who are keeping and creating jobs here in America?

INCREASE IN FUNDING FOR ENFORCEMENT

Secretary SOLIS. Thank you, Mr. Tiahrt. I appreciate your concern and sharing that. That is the first time I have heard of a citation for a Styrofoam cup. I will certainly take that information back to my Department. But I do want to say that one of the reasons that you are seeing an increase in funding for enforcement is because, quite frankly, over the last eight years OSHA and Wage and Hour have not received sufficient funding. In fact, OLMS has received more substantial funding over the course of the last 5 years. So there was not a balance. And one of the things I know that the Congress is particularly concerned about is the fact that there have been very serious, fatal injuries on the job, whether it is in construction, the mining industry, or in other service-related areas. And my concern is not to drive down industry or business, because what we are talking about here is really making it more feasible for people to go to work and to be able to come home.

That is my goal. One of the things that I intend on providing through our offices in Wage and Hour and in OSHA is enough technical assistance, not just compliance information, but to actually provide on-the-job and on-the-site assistance to those businesses that are open and may not even be aware of some of the laws and safety concerns and regulations that they must abide by. I do not expect that we are going to go out of our way to just create a problem for businesses. Right now we know that we need to have jobs. And one of the things is, my highest priority is to make sure that we find people employment. Secondly, the goal of the DOL, Department of Labor, is to provide safety and protection for them to be able to come home. I have traveled to different parts of the country where I have heard stories where people have lost family members, have lost their lives because there was perhaps an employer not just once or twice, but repeatedly did not abide by citations or particular penalties. That, to me, is egregious and should not be—that should not be tolerated. I think that we do not have enough resources in our budget to go after everybody so I have asked my staff to come up with a plan to work more strategically. We do not have time to waste taxpayer dollars. But I will not tolerate when I see someone abusing periodically, time and time again, their workers in a way that puts them in harm and then causes——

Mr. TIAHRT. I think we would agree—my time is almost out, excuse me, Madam Secretary—I think we would agree that when you have somebody who egregiously violates, they should be reprimanded at the most severe levels. But I would hope that in the future we would work with companies that are trying to comply, educate them in the regulatory scheme.

Secretary SOLIS. And I would be happy to work with you on coming up with a program that looks at that.

Mr. OBEY. Mr. Jackson.

REDUCING UNEMPLOYMENT DISPARITIES

Mr. JACKSON. Thank you, Mr. Chairman. And let me also congratulate Secretary Solis for an extraordinary job that she is at-

tempting to do at the Department of Labor under extraordinary economic circumstances. I have two questions. One I think is thoughtful because my staff helped prepare it, the other of which I am trying to formulate. But let me start with the thoughtful question. Earlier this month, the Bureau of Labor Statistics reported the national unemployment rate at 8.9 percent. The unemployment rates for white Americans stood at 8.0 percent, 11.3 percent for Hispanics, and a high of 15 percent for African Americans. Currently, African American workers are experiencing close to double the rate of unemployment as white Americans in the United States. In my 14 years representing the second district of Illinois, I have worked to increase access to high quality education, to reduce health disparities, and increase job opportunities for minority communities, for which my district is mostly comprised.

What is the Department of Labor and this administration doing to reduce unemployment disparities? Can you point to specific programs and job training programs that will work to reverse these trends given the density of some urban communities and the nature of unemployment? And then I have a second question.

Secretary SOLIS. Thank you, Congressman Jackson. And I appreciate that question, and, of course, your leadership and also Congresswoman Barbara Lee's continued leadership on this effort. I too have a great, great concern that we are not seeing enough minority representation in programs that are currently being administered by the Department of Labor. And I have taken a strong approach to see how we can integrate this goal in any type of guidance that is being provided, especially for funding that is going to be made available within the next month. And I am talking not just about the summer youth employment programs, but I am talking also about the opportunities through green jobs and through the health care industry. We have several programs that help to provide incentives.

One of the things that I am trying to cast here is that we provide stakeholders who have traditionally not been a part of the makeup of these organizations and infrastructure that we do our best through our reasonable offices to contact these local CBOs, these various faith-based groups, various nontraditional groups that have not been a part of the discussion. And that has been a very clear signal that I have given to my staff, as well as any correspondence or speeches that I am making out in public. So I have the highest concern that you do. It is unacceptable to have a 15 percent unemployment rate for African Americans and over 11 percent for Hispanics. And we traditionally see that cohort continually being affected when we are in recessionary times, and we have to turn that around. So I know that we have much to do and we have to prove that these programs can work. So I will be very diligent in how we administer the money, that it is accountable, and it is also transparent.

JOBS IN MANUFACTURING

Mr. JACKSON. We seem to be the last hired and the first fired in difficult economic times. And so any attention that your administration and your Department could give to these troubling statistics would be helpful. Let me try and formulate another question. I

spoke this weekend at the college commencement of Lincoln College in downstate Illinois. Approximately 194 graduates at Lincoln College this past weekend. 2 million college graduates will graduate during this graduation season from colleges and universities across the country. And I found this year's commencement address to be particularly difficult to deliver in part because at least for me, the economic outlook for those students entering the workplace is profoundly troubled by the highly competitive nature, the fact that so many Americans with college degrees have been laid off, have been displaced, have suffered during the economy. That as these students leave college at one level or another optimistic about their hopes and about their chances, they are also entering probably the most competitive job market in a generation. That does not include the millions of high school students who are graduating, many of whom will not attend college, but also enter the workforce looking for jobs.

My question turns, I think, on manufacturing. It was brought to my attention this morning that there is a Ford plant—and as you well know, Ford did not take advantage of any of the Federal bailout moneys for the automobile industry—there is a Ford plant in Brazil that makes four different models of Ford. Not a single model touched by a human hand from the beginning of the car to the completion of the car. Not a single model. The plant is so modern that they have to change nothing to produce different cars on the exact same assembly line. That is, they do not have to stop making the Ford Taurus to produce a Ford F–150. An F–150 can be there, a Taurus can be there, another car can be there, and four different cars on the exact same assembly line. I realize that my time has expired.

Can you quickly tell us and share with us the administration's thoughts on what we are going to do to try and save U.S. manufacturing jobs here in the United States? Thank you, Mr. Chairman.

Secretary SOLIS. Thank you. I will try to be brief. But I think one of the urgent matters right now is trying to provide assistance to dislocated workers. And we have been doing that through the National Emergency Grant Program as well as through the dislocated worker program. That program, as you know, provides assistance to people who are unemployed, but it also provides a safety net. It also allows you to get training. It also allows you, in some cases, to get health care. I have just returned yesterday from Michigan, visiting a battery plant that is going to be producing batteries for the new latest electrical vehicles. Most of the equipment that I saw that was needed there was imported.

That is another area that we have to focus in on, on providing a workforce that can create and manufacture the supplies, and also the educational wherewithal so that we can produce these cars that many in the public want. We are making a tremendous investment here. We know that things are not looking good. We know that it is not just about statistics, it is about real people that are not able to make home payments, cannot send their kids to college, and do not have any luxury of finding a good job at this time. We are promoting that by providing incentives. I know we are working in collaboration with the Department of Energy right now as they give

out monies for research and development in these high-tech, renewable energy areas.

We then couple our programs for training so that we can get the up-skills available for those people that are off the assembly line from the auto industry, or perhaps they have been working as a banker and they need to look at an entirely different career. This is going to take a lot of courage on the part of the public as well as this administration to try to move folks in a direction where there will be job growth. We did not talk a whole lot about health care, but that is one additional area of growth, as well as IT, and obviously the renewable energy industry.

Mr. JACKSON. Thank you, Madam Secretary.

Mr. OBEY. Mr. Lewis.

JOB TRAINING DOLLARS

Mr. LEWIS. Thank you very much, Mr. Chairman. Madam Secretary, Southern California has been particularly severely hit with unemployment. You and I have experienced that in our home districts. The region of the Inland Empire suffered as greatly as any section of the country relative to housing foreclosures in no small part because of crazy housing policies developed by Democrats and Republicans over a 30-year period that really kind of forced the marketplace with our goal to have everybody have a chance to buy a home. But as the marketplace changed, we found people going into homes they never should have been in in the first place, they could not afford them. And in the meantime, the vacancy is there. And I understand that there are still hundreds of billions potentially of dollars of homes that could be in a very similar circumstance.

So that problem and its impact on unemployment is going to extend itself over a considerable time. As we go about trying to train and retrain those people, I certainly do not have any bias myself about green job advocacy. I think you may know I sponsored the Air Quality Management Act in Southern California years ago. In the meantime, though, my local Workforce Investment Boards are saying in our region, looking at the unemployment problem, being forced to push money or training in the direction of green jobs could very well have us spending dollars in a direction where there really is not the problem and will not solve the relatively short term circumstance for these communities.

So the question they are asking is, is it feasible to have more flexibility and giving the local communities a stronger voice relative to the way those job training dollars will be applied?

Secretary SOLIS. Thank you very much, Congressman Lewis. That is a very good question. I do believe that there is enough flexibility, at least in the guidance that we are going to be providing, to allow for that growth in the green collar industry, but also to provide assistance for those folks that maybe need an additional skill, maybe an IBEW worker, an electrician or a plumber wants to now better understand and get into wind power and help develop that industry, or perhaps just upgrade their skills, maybe entering into an apprenticeship program or a community college program.

I believe the regions do have the ability to control where monies can be sent, and certainly would want to hear what their greatest concerns are. I do not think we necessarily need to do that from Washington, D.C. I think that we have to attack this program on a regional level and want to see discussions about that. As we are seeing the automobile industry being affected, you are talking about regions across the country where workers are being dislocated. California, it is the hotel-restaurant industry, it is the service sector, and we ought to be looking at how we can be flexible to make that arrangement. So I am willing to work with you on that, and I believe our administration, our President is very open to that.

IMPACT OF RECOVERY ACT MONEY ON PROGRAMMING

Mr. LEWIS. Thank you very much for that response. Madam Secretary, the stimulus package has caused many an agency suddenly to find themselves awash in money, with a good deal of flexibility given to the directors, and yet that leads to a tendency to want to expand programming. And clearly you are expanding programming. If the levels that the stimulus raised us to in many a sector are not reflected with a similar level of growth from the 2009 to the 2010 years and the 11th year and the 12th year, will that cause serious impact upon your agency? Have your people helped you to begin to evaluate that question? And I would appreciate first your responding, but then beyond that, responding further for the record.

Secretary SOLIS. I think, Congressman Lewis, you bring up a very good point, because we realize that the Recovery Act money is somewhat of a one-time opportunity for us. And we have not seen this unprecedented level of support. But by way of saying that, it is very important that the programs that we have funded through the recovery program where we were able to make some initial funding and growth and expansion in dislocated worker programs and also the other programs that provide assistance in the UI program because of the tremendous unemployment, the financial crisis, there was a need to provide that safety net. However, in upcoming fiscal budget rounds, I am certain that we are going to see some tightening of the belt. And I am sure that we will be looking at programs that have not worked efficiently, and where we can find and cut down on any type of fraud or misuse of funds. I believe in competitive grant making as well. I do not believe that anyone should have an opportunity to sole source a contract out. I think the public spoke very clearly about that to many of us.

Mr. LEWIS. Secretary Solis, I have other hearings going on, so I am going to have to run in a while, but in the meantime, congratulations on your new assignment. And I look forward to working with you.

Secretary SOLIS. Thank you very much.

Mr. OBEY. Mr. Moran.

PUBLIC TRANSIT BENEFIT AT DOL

Mr. MORAN. Thank you very much, Mr. Chairman. I will try to continue to get here early. I appreciate the incentive. Madam Secretary, a few years ago, I put a provision into the bill to encourage

people to use public transit in Federal agencies. It was a public transit benefit of $100 a month. Every Federal agency embraced it but one. And that particular Secretary said that all of her employees were eligible unless they joined a union. But if they were a member of a Federal employee union, they would not be eligible to receive any public transit benefit. Of course, that being the Secretary of Labor, I found it somewhat ironic. Now, I understand that you fixed that. That is the question. I trust that everyone is eligible whether or not they join a Federal employees union?

Secretary SOLIS. Yes, Congressman Moran, thank you for your question. And yes, we have made that available to our employees.

WIA REAUTHORIZATION

Mr. MORAN. Thank you. The second question, I hate to be parochial, but you know, we all have to deal with our own economic situations. In the BRAC closure, the Base Realignment Closure of 2005, Arlington County lost 17,000 jobs that were to be moved out. That is the equivalent to four major military bases. And there is a program in the Department of Labor that is specifically designed to help with relocation. There are emergency grants that are made available. And but that money was not made available until December of 2008. In other words, just a few months ago. And now I understand that you have decided to terminate the program this July.

So in other words, there would only be a period of six or seven months where the money might be available, but all of the people have to move out by 2011. So this is the time, the fiscal year 2010 budget, when the money would be most needed. So I wanted to ask you about that. Can we get an extension or—it just seems as though the timing is not particularly consistent with the demand that all of these people be moved out of the community.

Secretary SOLIS. I realize that many of our States are going through this readjustment, and to be honest, this is something that is inherent in the legislation. It is part of the formula that is actually made available by Members of the House. They set that schedule for the formula for the allocation of these funds that you are talking about. And we are finding that while your State may have been hit hard earlier, before the recession, obviously 2 or 3 years before, now that we see other States coming on board with very high unemployment rates, that money is not as easily available at the same amount that it was to prior years. I do believe that we are making every effort, though.

We do have a contingency fund of about $200 million for dislocated workers. And we also have revenue, I hope that will be approved by this committee, to the tune of at least $71 million that can also be available to help with the dislocated worker national reserve money. So there will be, I think, our ability to make these kinds of adjustments. And I certainly will want to work with you and your staff on this. But know that I too am well aware that we have a problem, and I hope that this might be something that could be taken up when we reauthorize the WIA reauthorization.

Mr. MORAN. Thank you, Madam Secretary. So in other words, you are saying we found the source of the problem, and it is us rather than you. I cannot say I am surprised at that. Thank you

very much. I know so much of the Department is mandatory in origin given the authorizations. Very little of it is actually discretionary. I hope we can fix that imbalance a little bit, give you a little more discretion to meet the specific and the most intense needs around the country. But again, it is very nice to have you as Secretary, and thank you, Mr. Chairman.

Mr. OBEY. Mr. Cole.

H–1B AND L VISA FRAUD

Mr. COLE. Thank you very much, Mr. Chairman, and let me add my congratulations. It is always a great thing when somebody from our body goes to the other side and can explain this to one another. You mentioned in your written testimony that the administration was going to be seeking changes in the H–1B and L visa fraud prevention fees, statutory changes. And I have two questions along those lines. One, could you acquaint us to what the nature of the changes are going to be? And two, as somebody that frankly favors raising the limits on H–1B and H–2B visas in terms of the numbers of people that we allow to come into the country, are you comfortable you are going to have what you need in terms of enforcement and fraud if Congress does indeed at some point raise those numbers?

Secretary SOLIS. I would like to answer the latter part of the question first. We are going to, I think, be diligent in seeking a better assessment of how the program is operated because we know there have been abuses. And I think that is the number one. We want to make sure that we get to those bad apples. And that sends a signal, right there. I think also we want to do an evaluation to make sure that we are actually assessing the area most impacted, if we are, in fact, doing our best to inform American workers who might be eligible for these jobs. That is one of our priorities that the President and I both have. So we want to do what we can to help make sure that there is ample information, that those surveys are reflective of the working pool that is available, and then begin, if there is more need, to have further discussion and have a bigger debate with all the stakeholders.

Mr. COLE. Okay. And can you tell us what the nature of the changes are going to be in the easing of the statutory limits on the using of the fee at this point?

Secretary SOLIS. I think it is somewhat premature at this time, but I will certainly get back to you on that.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

Mr. COLE. Thank you. I appreciate that. Secondly, I am very pleased to see your efforts to expand expenditures in YouthBuild. I am a little concerned that we are not seeing a comparable increase in Senior Community Service Employment Program. That is a great program. And I think you are going to see, frankly, sadly, more need for that program in the current economic teams. We have got a lot of people who are being forced out of jobs early in their 50s and 60s, and they are going to need some sort of bridge to retirement, or people again that just simply need the supplemental income, they are post–65. Are you comfortable we have got what we need there?

Secretary SOLIS. Well, I know that the recovery program did give us a bump up, and that was helpful. But looking into this next program year, fiscal year, it is going to be a challenge. And I know the chairman and I have spoken about this. I have a strong commitment and support to our senior citizens and our elder population. When you think about it, in a short time we are seeing so many people that have been displaced. They are 55, 60 years old even, and we are seeing a larger number of people who really do need this kind of program. I have seen it work very effectively in my own State in California. In East Los Angeles, there is a health program actually that helps to retrain seniors.

I met a woman that was 77 years old who was a bookkeeper. Spoke Spanish. But it was tremendous that she was able to have that as her fulfillment and extra earnings that she could have. So I do want to enter into that discussion with the committee members. And I am very, very pleased to hear that from you, Congressman.

Mr. OBEY. Would the gentleman yield?

Mr. COLE. I certainly will, Mr. Chairman.

Mr. OBEY. Let me simply say to the gentleman that I think he can count on that program being one of the programs that receive a bump up when we get to markup.

PENSION BENEFIT GUARANTY CORPORATION

Mr. COLE. I appreciate that, Mr. Chairman. I am glad to hear that. Because it is a great program. Let me ask you another area where I am a little worried that we may have undershot rather than overshot is the Pension Benefit Guaranty Corporation. Again, I think we are going to see a lot of pressure. We are already seeing a lot of pressure on that. And there is nothing worse than being at retirement age and all of a sudden losing—you do not have the time horizon to recover.

So are you comfortable you have the tools you need to make sure that when companies have guaranteed workers pensions that they have got the wherewithal to back up the commitments they have made and you are sort of on top of it and able to monitor it?

Secretary SOLIS. I think that this is one area where the funding for this particular program has been somewhat stable. We have not seen the dramatic decreases, as we did in enforcement in other agencies in the Department. I do think this will be an area that will be of continued concern as we see big corporations going under and the effects that it will have, and really getting more staff involved to help look at those cases where there is fraud or where there has been embezzlement or things of that nature. I think at this time, we are prepared to kind of stay the course where we are. But when it is appropriate, I would like to have those discussions with you and with other members of the committee.

Mr. COLE. I see my time is up, Mr. Chairman. So I will hold for later. Thank you very much, Madam Secretary.

Mr. OBEY. Ms. DeLauro.

OPPORTUNITIES FOR WOMEN IN THE WORKFORCE

Ms. DELAURO. Thank you very much, Mr. Chairman, and welcome, Madam Secretary. What a joy, what a joy. We miss you here.

We all feel that way. But we are so delighted that you are at the helm of this Agency, because we know at your core about your concern and your caring about what is happening with working Americans, and also the balance that you spoke about before between workers and business in order to create the best environment and atmosphere so that people will have jobs and businesses will be strong. Your budget makes it clear that this Department is in capable hands, and that there is a kind of a renewed sense of purpose at this Department.

And we want to help people build their skills and face a recession with the assistance they need. I will make a point and then get to my questions. I, for one, am so delighted to see what you are done at the core of your mission with worker health and safety. The funding increases for regulatory enforcement agencies such as OSHA, Wage and Hour, Office of Federal Contract Compliance Programs. For too long, my view, we have had a group of folks that relied solely on voluntary compliance.

And it is fair to say that with this budget that those days are over. Let me kind of frame my one question, but it is with 3 pieces. I have a concern with the Recovery Act and a fair chance for women in their employment, and I think we need to find ways to ensure women, minorities, economically disadvantaged job seekers are provided with equal access to training. So first question, and I will give you the other two and then let you answer. Given the number of new jobs that are going to be created, how do you see the role of the Office of Federal Contract Compliance in ensuring that the contractors who received Recovery Act funding have a plan, a concrete plan to recruit, retain women, people of color, veterans, and people with disabilities?

How would the funding be used to create guarantees so that we are not going to be with the contract compliance office of identifying contractors who have not done enough of a good job after the fact, that is after they have the money to do that? So that office. Secondly, with regard to the Women's Bureau, I think women are—this is a tough recession for everyone. I think women are the hardest hit. There are circumstances undergirding all that is they are paid $0.78 on the dollar. But the hidden gem, I think, at the Department of Labor is the Women's Bureau. We know from this committee that the prior administration tried to weaken it, ultimately tried to eliminate it, and this committee prevented that from happening.

Let me ask you this: How you see the role of the Bureau as we move forward. Personally, I would like to see the funding doubled, but that is me personally. But I think it is a powerful agency. And if you could just give us some insight into how you plan to reinvigorate that.

Last piece of this question is, I do not know if you are familiar with the Pathways Advancing Career Training legislation. And you probably are. The PACT Act. It is Congresswoman Linda Sanchez, Jared Polis, Mary Jo Kilroy, and myself. This would prepare women for employment in high wage/high skill fields. My hope would be that with regard to the Women's Bureau we would be willing to open a dialogue about how the policies can be imple-

mented both under current law and as we consider new legislation. Let me ask you to respond.

Secretary SOLIS. Thank you, Congresswoman DeLauro. It is a pleasure to be here with you. And I know you understand my personal commitment to women, having served on the bipartisan Women's Caucus with your leadership and so many members of the committee here. I continue to feel the need for us to move the Department of Labor so that every aspect of our agencies reflect not only the goals of achieving better representation for women, but making sure that there are opportunities at every level. The Women's Bureau, for example, is one part of that. But we should have a seamless system where if OFCCP has a mandate and guidelines set forth, where they are following through on making sure that there is nondiscrimination occurring with protected classes and groups, but also women.

And we are looking at pay equity. That is something that we are going to require a lot of help on. I think the Women's Bureau can play a role there, helping us to gather the data that are going to be necessary, because there is going to be a lot of Federal contracting opportunities. Here is our chance to open up that door and have better relationships, but also let people know that this is a priority of the Federal Government, and DOL will work with them on that. In terms of Office of Contract Compliance, I know there are many issues there. We have not been as diligent as in the past.

And I have not yet identified our leader for that particular position. We are interviewing now. So I hope to soon have someone who will lead that charge. And you know from personally working with me that I am very, very concerned about making sure that there is equal representation with respect to Federal contracting. With respect to the Women's Bureau, I, too, want to see a more robust program there. They will be involved in helping us identify women in nontraditional fields. We just had a roundtable a month ago with 35 women from around the country to talk about the notion of green jobs, whether it is in high-tech, and whether it is other low level apprenticeship programs, community college, and women who are just entering the workforce after leaving TANF or welfare.

So there are many, many opportunities, and I can see us working very closely with you. With the last item you mentioned, the PACT Act, I believe that was introduced before, and I think I had supported it. And certainly the concept is something that I know has to be something that we need to be involved in.

So my office would work very closely with you on providing any technical assistance and information that you need to help support your legislative agenda in that respect.

Ms. DELAURO. Thank you and congratulations.

Mr. OBEY. Ms. Roybal-Allard.

## CHILDREN IN THE WORKFORCE

Ms. ROYBAL-ALLARD. Thank you, Mr. Chairman. And welcome, Madam Secretary. Let me just associate myself with the comments that were made by Rosa DeLauro and others about how pleased we are that you are at the helm of the Department of Labor, because we know of your commitment to the working men and women of this country. And I know that one area of concern for you has al-

ways been the children in the workplace. And I would like to bring your attention to the plight of children in agriculture. While only 8 percent of children work in agriculture, according to a Human Rights Watch study, approximately 40 percent of all workplace deaths, and nearly half of all workplace injuries suffered by children occur in agricultural jobs.

And unfortunately over the past few years, little attention has been paid to these children by the Department of Labor. For example, of the 1,344 child labor investigations the Department undertook in 2006, only 28 were in agriculture. Do you anticipate increasing investigations into the injuries and deaths of these children? And will the Department increase its oversight of children working in agriculture?

Secretary SOLIS. Thank you, Congresswoman Roybal-Allard. Yes, as I mentioned earlier in my testimony, we plan to have I would say a very robust Wage and Hour enforcement. And that also lends itself to providing more inspections in this area. I, too, am very saddened by the number of investigations that have not occurred, quite frankly. And this is an area that we do need to focus in on. And I do know that there need to be more opportunities for our young farm-worker youth. And there are incentive programs available to help them with that. We hope to expand that. I hope to work very closely with our regional offices to make sure that they go out, identify those programs that have the capability of taking on this project, but also knowing that we have to have good enforcement and good data to report so that you send a signal that this is something that will not be tolerated.

Ms. ROYBAL-ALLARD. Madam Secretary, I will be introducing a bill known as the CARE Act in June that extends the same child labor protections afforded other children to the 400,000 youth working in agriculture, who are four times at risk of fatal injuries than children working in other industries. And I look forward to working with you as that bill moves forward.

### PROTECTION OF HEALTH CARE WORKERS IN THE EVENT OF A PANDEMIC FLU

For several years, health care workers have petitioned OSHA for an enforceable standard to protect health care workers in the event of a pandemic flu. And this standard would require hospitals to provide respirators to protect hospital workers while they treat sick patients. The CDC has warned that it is simply a matter of time until we face a pandemic flu. And the H1N1 flu reminds us that that threat is real. Will your Department direct OSHA to issue enforceable guidelines to protect hospital workers in the event of a pandemic flu? And what steps will the Department of Labor take to ensure that our Nation's health care facilities have in place enforceable and appropriate standards for infection control and respiratory protection?

Secretary SOLIS. Thank you, Congresswoman. This is a very timely question, and one that just a week ago or two we had a discussion with our internal office, OSHA, and they have prepared discussion points and guidelines to work alongside with CDC. We know that the respirator option here, wearing what they call an N

95 respirator is what we would want to see occur for health care workers. It provides better protection for them.

Typically, the masks that you see being used right now, for example, do not prevent someone from being contaminated with the H1N1 virus, or any virus. So that is, I think, a better way of moving towards that protection. We are coordinating with all the other agencies in terms of getting out our directives so that we can protect all the workers that are providing services, that are front line workers, first responders, and obviously health care workers. So we are doing our best. It is something that I know that we do have addressed in our budget. I know the President has an additional request for money there. And I think we are satisfied with that amount that he is asking for.

WAGES FOR JOB CORPS INSTRUCTORS

Ms. ROYBAL-ALLARD. Okay. As you know, the Job Corps program, which provides at risk youth with critical occupational and employment skills, relies on a cadre of dedicated teachers. However, the Job Corps instructors are paid on average 30 percent less than public school teachers, even though they have the same credentials and are required to work year round. And this makes it incredibly difficult for Job Corps centers to recruit and retain the staff needed for this important program. And unfortunately, after several years of flat funding, Job Corps, I understand, faces a $127 million operational shortfall, and there is not enough money, unfortunately, in the President's budget to provide the centers with the resources that they need for the staff. Do you have any plans to review this issue and to find ways to address the high turnover rates and the recruitment difficulties that plague the Job Corps program given the fact that, you know, we understand that there is not enough money to make up what is needed to retain the teachers?

Secretary SOLIS. Thank you, Congresswoman. I know that, you know, I came into the budget process when things had already started, when I finally was able to begin my work at the Department of Labor. So much of what was said in the budget was already agreed to. I know that the next round of discussions on the budget, this is an area that I will want to focus in on. And I am glad you are bringing it to my attention at this time. And I have asked my staff to look into it to give me an assessment. And once we do have a reordering also of where Job Corps will be. Currently, it was in the Secretary's office. We plan to put it back where all the employment training youth programs are. That is where it should be. It is a fine program. And congratulations, I know that we are going to be breaking ground in Los Angeles for the Job Corps facility there. And we should all be very proud of that. But I do intend on working with you and others to make sure that we are accurately paying satisfactorily the wages that are due to the instructors. Because they also provide a very meaningful part of the program so that these young people who need remedial education or other assistance get and are able to have qualified teachers get the pay that they deserve.

Ms. ROYBAL-ALLARD. I want to thank you for your help and support in the Los Angeles Job Corps program.

Mr. OBEY. Mr. Honda.

Mr. HONDA. Thank you, Mr. Chairman. And welcome, Secretary Solis. It is a proud moment for those of us who have known your work and followed your history, too.

Mr. OBEY. A California conspiracy.

EDUCATIONAL SYSTEM INVOLVEMENT

Mr. HONDA. Actually, it is our class also. And so they say that the budget is a reflection of our values. And certainly this budget is clearly quite different from the past administration's budget. And some comments have been made as to the increases in certain categories from one budget to another. And I think that it is worthy to note that some of the high increases are a result of great cuts that were experienced in the past. So this is about catching up also. So I appreciate your great work. And also some of the comments that you made about the kinds of workers, kinds of employees that the Department will be employing to work with the community, multilingual, culturally sensitive, things that will make the Department more amenable to the communities that we serve.

So I just wanted to share that with you. I also wanted to extend a personal thank you for your staff's swift attention to all the inquiries that were sent by my office to your Department. You know, my district has a significant lack of middle skilled workers. In the budget justification, you mention the ETA will be strongly encouraging the one-stop centers to take an expansive view of how to integrate the funds into the training system. Can you elaborate on some of the innovations local one-stops have proposed or ideas that the Department will be implementing to fill this kind of a need? And how will these ideas and efforts work with the community-based job training grant programs?

Secretary SOLIS. Thank you, Congressman Honda. It is good to see you. I understand your frustration with the past practices of these programs. And I am also looking forward, by the way, to working with individuals on the appropriate committees to help reauthorize WIA, because we know that there are some structural problems, and the fact that there may not be enough flexibility. And that has impeded, I think, the ability for stakeholders that you just described from actually being a part and participating in these programs. So what I am doing now, through the funding that is going out for the Recovery Act, is setting forth guidelines that say that we have to involve CBOs, community colleges, and that we should also look at other educational institutions and higher education as well. It does not just stop with the community colleges.

There is a role for every part of our educational system. We have a need for, for example, maybe more literacy for different segments of our population. The adult schools can do a good job there. We may have a need for allied health careers. That too I can see being fulfilled by a community college. But yet we also have a shortage of folks that are really prepared in the higher skill levels. So we need to also make sure that four-year universities are a part of this discussion. And I hope that we can generate regional support so that we look at the program more as something that we can solve on a broader level as opposed to just one source of funding going to one center. It should be a collaborative effort given that we do

not have a lot of funding available from all these other streams. We are going to have to work collectively. So that has been my priority.

INDUSTRIES WITH POTENTIAL FOR INVESTMENT AND GROWTH

Mr. HONDA. And we will look forward to doing that. Our city, San Jose, has made a serious effort to make itself the greenest city in the United States. And it just received a platinum certification. And the city has also partnered with local labor organizations like Working Partnerships USA to develop green jobs, programs that provide good paying, secure employment for workers. How is the Department going to foster and support partnerships like this through the Green Jobs Innovation Fund? And what are some of the primary industries in which you see significant potential for investment and growth?

Secretary SOLIS. Well, I know that we have a very ambitious program to provide and expand weatherization in partnership with the Department of Energy. And one of the things we want to target there is the fact that after you complete your certification for weatherization that you also be in a program that can allow you to grow, to get another step up into another career if possible, or the same career but more expansive responsibilities.

There has been a lot of discussion with some of our friends who work in that industry, and also some of our apprenticeship programs that offer that. We want to make sure that whatever opportunities are available that we really do kind of cross, I do not want to say cross-pollinate, but really get as many of those stakeholders involved that really have not had that opportunity to expand. And there is a lot of great demonstration programs out there now. We will be looking at those as models, and hopefully using our funding in a way that we can provide incentive to people to follow suit and use those as models that we can hold up.

Mr. HONDA. Very quickly.

Mr. OBEY. The gentleman's time has expired. I am sorry. Mr. Ryan.

WIA REAUTHORIZATION

Mr. RYAN. Thank you, Mr. Chairman. Welcome, Madam Secretary. It is great to have you here. I have a couple of questions and a couple of comments. As far as the questions go, some of the WIA dislocation or dislocated worker money, it seems like the formula, and we had dealt with this with demolition money, where States who have been having problems for a long time, Ohio being one of them, losing their manufacturing base, the formula is tilted towards States who have had recent decline because of foreclosures. And States like Ohio are going to get a 30 percent cut, where States like Nevada are going to get a 135 percent increase. So we want to work with you on trying to fix this, because Ohio has been dealing with this for a long time, as a lot of other industrial States have.

So we want to try to fix that formula. And also we know you have some ability with the national emergency grants. And one of the issues that if you can just comment on this, we want to work with the Department on States like Ohio having a little more flexibility with those kinds of grants. Because they are very specific to-

wards a specific industry or a specific business. So is there a way we can kind of work through this where if you do get the emergency grants there will be a little more flexibility for the States to work with the Department?

Secretary SOLIS. Thank you, Congressman Ryan. Earlier I was asked a similar question, and there is a problem I believe with the formula that drives the funding. And it is unfortunate that it does penalize States like yours that have been going through high unemployment and dislocation of workers for a long time. I know that this is something we probably want to work on as we go through to reauthorize WIA, which I hope we can do this legislative session.

Meanwhile, there is some Dislocated Worker National Reserve money available at the Department of Labor that is in the amount of about $200 million that we can work with your State and work with those officials there, because this has been brought to my attention by one of your Senators already. And likewise——

Mr. RYAN. I wonder which one that was.

Secretary SOLIS. And likewise, we do have, hopefully, through our request here for the 2010 budget, we are requesting an additional $71 million for the national reserve for this particular effort. There has to be a better way, though, of dealing with this financial crisis, because it is longer, it is more persistent, and I do not think anybody has seen anything like this for several decades. And there probably has to be some rethinking on how we do that. So I would love to be able to talk to you about that.

NEW WAYS OF ADDRESSING OLD PROBLEMS

Mr. RYAN. Great. I wanted to reaffirm that position as far as the formula is in and working. I have a couple of ideas. I think that you are new and you are from this body, and we have a new President, and I think we have to start looking at new ways of addressing some old problems that we have. I will give you an example. Our area we have a lot of auto in Youngstown, Ohio, a lot of Delphi workers. And a lot of Delphi salaried workers as well. And when Delphi hit tough times, we had a lot of engineers, we had a lot of tool and die workers who were in the area. And I know we have to try to retrain and move people into other jobs, but there is a talent pool in some of these communities.

In Ohio, Dayton and Warren have a lot of Delphi workers, a lot of engineers. I think we need to have a conversation and talk about how we not retrain some of these workers, but how to get them involved in creating new employment, how to plug them into incubators, how maybe the Department of Labor and maybe the Small Business Administration can create incubators in areas where there is a high talent pool that necessarily will not go and become nurses or get trained in a green collar job, although they could, but they are very talented, they are engineers.

So they could realistically start a company at some point with a little bit of assistance that would employ 50 people. And so I just wanted to throw that out at you just so we can continue to have a conversation maybe over the next few months and few years on how maybe we can put something together that would be innovative, but yet tap into the kind of talent pools that we have in some of these regional areas. And then another comment, as my time is

running down, along the lines of YouthBuild, there has been a tremendous success in this country with the FIRST Robotics program. And we see kids in high schools gravitate towards the robotics program. And it changes their whole perception and their whole approach to education. You know, instead of teaching them physics and all of the, you know, more sophisticated, having all the more sophisticated classes, that teachers throw a bunch of junk on the ground and they say build a robot.

And then they build the robot and then they teach afterwards. And it is just a different way of learning. And we have had some kids in some of our inner city schools who have just gravitated towards this. They got to kick them out of the schools at 10 p.m. So I think as much as YouthBuild is for construction, I think we should also talk about in the future about implementing some kind of robotics programs.

Mr. OBEY. If you want to respond very briefly.

Secretary SOLIS. I am glad you brought up YouthBuild, because we do have guidance to promote green jobs, but not necessarily the way you described it. We certainly want to have more math and science applied, and that can certainly help with this population. So I am very much in agreement to allow for that creativity to occur, and we would be interested in seeing those kinds of programs develop.

And then, secondly, I just want to tell you that, through our office, the recovery of the auto communities and workers is headed now by Dr. Edward Montgomery. He has been out I think in some of the different States that have been more dramatically affected by the downsizing of the auto industry and certainly will be helpful and I am sure will make himself available, as well as I, to see how we can try to provide that assistance so that that talent pool, that brain trust that we have does not leave and that we nurture it and that we do do some creative programs with SBA. We do have some training programs, too, for small businesses.

So those are some things that I am very excited about working with you on, because I have not seen that kind of support in the past.

Mr. RYAN. That is great.

Mr. Chairman, if I could just comment on that.

In these old——

Mr. OBEY. Very briefly.

Mr. RYAN. Very briefly.

In these old industrial areas, you know, all the young people have left. They went off, they got educated, their parents had good-paying jobs, they went off to school, and they left. So the only talent pool left were in those industries, the Delphis of the world, the auto industries. So I think it is critical that part of this comprehensive program is to try to keep that talent in that area, in that geographical area.

So thank you. Thank you, Mr. Chairman.

Mr. OBEY. Mrs. Lowey.

Mrs. LOWEY. Thank you, Mr. Chairman.

INCREASING TRAINING OPPORTUNITIES IN HEALTH CARE-RELATED FIELDS

And, Madam Secretary, I just wanted to tell you that I share the enthusiasm of my colleagues; and we look forward to working with you. Now, not only is Madam Secretary a friend, but she is also my neighbor. We leave so early, I think you are still there. Thank you.

I just want to begin by commenting that what we see in our health care systems in the U.S. in both private and public, we are facing a widening gap between the number of positions and the number of qualified applicants to fill them; and nowhere is this more evident than the shortage of nurses and nurse faculty. In fact, in 2008, almost 50,000 students were denied admission to schools of nursing, primarily due to an insufficient number of faculty.

We agree, I know, that we must create better training opportunities in the fields with the greatest needs in the coming years. So if you can comment on the Department's strategy for increasing training opportunities in health care-related fields, particularly through the new Career Pathways Innovation Fund, and what role can community colleges play in expanding career opportunities in health fields.

Secretary SOLIS. Thank you, Congresswoman Lowey.

Yes, while I did want to mention that earlier in my testimony I had pointed out that we did get $250 million through the Recovery Act to help us with high-growth occupations—and, obviously, the health care industry is a prime sector—I do believe there is a lot more we can do.

I think we need to also be collaborating now with the Cabinet Secretary of Health and Human Services. They also received a substantial amount of money, I believe it is about $200 million, to look at health careers and professions; and it just does not make sense for us not to be able to coordinate. We know there is a shortage in all, all parts of the country and particularly when you talk about underserved or rural areas. So I am very hopeful that we can utilize this money to look at not just the first tier but also developing the second and third tier of these career programs.

So we do have to work closely with our 4-year universities, community colleges to begin with, and then also make sure that we have the availability to have a classroom, first of all. Because I am hearing a tremendous amount of pressure being placed on the community colleges, that they do not have sufficient funding to open up a classroom and then pay the instructor or a particular professor there to be able to come in, because they make more money out in the field than they would as a faculty member.

That is something that has to be addressed I think at another level. But, nevertheless, it does impede our ability to get people into those programs to get trained.

And I have seen some very good programs, but they are very limited, and of course they are very rigorous. And for minority people who want to get into these programs, it becomes even more difficult. And I just feel that there does have to be more attention placed overall in the health care arena and be happy to work with

you and with the chairman on this to see how we can expand that area.

Mrs. LOWEY. Thank you.

IMPROPER BENEFIT PAYMENTS

I was shocked to learn, despite efforts of States to reduce improper benefit payments, more than $3.9 billion in unemployment benefits were paid erroneously in 2008. Now, the chairman probably recalls, because we have been talking about this—I have been around here for about 20 years—antiquated computers, processing systems in various States and within the Department. As far back as I can recall, we were told that the computers still do not talk to each other. So you can be on Social Security, and you can get unemployment benefits. You can get all kinds of things.

I just wonder whether the budget addresses this problem. How is the Department working with the States to reduce and recover improper or fraudulent payments? And as you are just beginning your important assignment, maybe this committee can help you and work with you to address the problems of computers that do not coordinate, do not talk to each other.

Secretary SOLIS. Congresswoman Lowey, you bring up an excellent point. It is one that I am very frustrated with myself. And, again, this is my second month into the job. I am not even there a hundred days yet. But I am learning very quickly where some of these gaps are, and I really do want to work closely with you and with the members of this committee to see how we can fix those gaps.

Not only the Federal Government has problems, but, of course, some of our bigger States, New York, California, Texas, others are having problems with also processing the amount of paperwork. And we are finding that some systems are 30 years old, the COBOL system. I remember that as an undergrad, that program.

But I am just saying that we do need to have funding to help upgrade our infrastructure; and that is probably one of the most neglected areas, just like our bridges, when we forgot to also provide I think the necessary support that is needed to help our IT system be up to date. Because there is no reason why we should not.

Mrs. LOWEY. Now I see my red light on, so I will not ask you for another minute. At another time I will like to talk to you, because I know how passionate you are about the International Labor Affairs Bureau. My colleague, Ms. DeLauro, just whispered to me that the worst abuse, the ILA has said in Agriculture, is in the United States. And so that is something that we have to work on.

Thank you, Mr. Chairman.

Mr. OBEY. Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

JOB OPPORTUNITIES

Well, a lot of the questions have been asked; and it is wonderful to, as Congressman Honda pointed out, to watch you blossom and grow. It is great to have someone from our class that we can now call Madam Secretary.

I think what I am going to do instead is kind of have a conversation about some things that I have seen out in the district and the challenge that I think we face as a Nation gearing up not only to come out of these difficult economic times but to prepare ourselves to be competitive in the future.

So I am going to start with we know we have got an unemployment problem. We know it could very likely go up. This is like the first time Minnesota, because we have such a diverse economy, has really faced hard unemployment that we know is going to be extended for a long time. We have high school students that we want to encourage to stay in high school. We have high school students that are graduating that had really no plans about continuing education. We have high school students who were planning on continuing an education, but their families are looking at the cost of college or voc tech school saying, you know, jeez, we are going to have to pace ourselves a little different doing this.

College students who are going to come on line now who I do not know how they are going to be recorded in the unemployment statistics because they have not lost a job, but they are not going to be able to find a job. High school students and college students competing with adult workers for part-time jobs, people underemployed. You know the picture.

But let me tell you about some of the solutions that I am seeing out there or I see as a possibility.

I was at Arlington High School just yesterday, very diverse high school. As you know, my district is very, very diverse. And they have a bioscience program in which one of the cornerstones of it is students who want to sign up for it can take this Red Cross class, which then at the end of it they are qualified or they are certified to be a type of medical helper. Pays $10 an hour. But, at the same time, those students are being reinforced with math, science. But it is broken down in bite-sized chunks that a lot of my new, vibrant immigrant population sees as a can-do possibility.

So I know there are opportunities in programs like that happening all over, and on page eight and nine of your budget summary that you have given us you are talking about you are going to work with the Department of Education to track longitudinal studies. So I think this committee wants—at least I want—to work with you on how we put that together.

Because if you look at the Department of Labor and its interrelations with the Department of Health for jobs, for training, as well as for workers' health, the Department of Education for jobs and training, the Department of Energy for jobs and training, how do we get everyone around the table talking so that we can, just as the computers are talking, so that we are creating incentives and opportunities as we reauthorize all these different programs? We are not doing them in silos? So let me kind of close with this.

OPPORTUNITIES FOR YOUTH

Another place I was recently in the district was talking about volunteering and community service, something that President Obama is very focused on. There are so many opportunities out there, whether it is YouthBuild or our Young Conservation Corps or something like that to do service, maybe not necessarily be paid

for it. We know cities are under a lot of stress with homes that need the grass cut, neighbors that need fix-up projects and that in homes. How do we look to create a youth service corps that creates educational opportunities, does exactly what Congressman Ryan was talking about, makes kids excited about learning? How do we help you with that not only in this budget but future budgets? How can we help you?

Secretary SOLIS. Thank you very much, Congresswoman McCollum. I am really excited that you are excited and that I am hearing so many enthusiastic voices about things that I know we have been struggling over for the last 8 years.

Youth are a very, very important element in our recovery effort. And I am very happy to say that, looking at this new round of funding that is going out now through the recovery program, that there is going to be some area for testing. So new models can also be interjected for students that go through our summer youth employment programs. For example, we will have guidance to say that we do want them to focus somewhat on green jobs, but that does not necessarily mean that it has to stay there. It can also go into maybe health, as you are saying, with the Red Cross or working volunteer. The program allows you to get instruction and also receive a small stipend if you fall under the category of being disadvantaged.

But I see where you are going, where we have to have more of a long-term program that is really extended throughout the year but has an educational component added to it. So I am working right now, and our staff is, with the Department of Ed, because we want to try to minimize where there are areas where we can work together and not duplicate our efforts. But I am very enthusiastic about the ability to see our young people really be a part of this growth that we need to see, badly need to focus in on our youth. Their unemployment rate is way above 21 percent.

Ms. MCCOLLUM. Thank you.

Mr. Chair, I think one area in which I am becoming more convinced than ever that we have missed the boat is we did not think we needed high school counselors any more because the jobs were out there and the economy was successful and everything was going smooth. By not having high school counselors, we do our economy a disservice, we do our youth a huge disservice, and I am hearing from parents a disservice, because they do not know about all the job opportunities that are out there to even have conversations with their children.

Thank you.

## CRITICAL POSITIONS

Mr. OBEY. Madam Secretary, let me ask a couple questions. And, incidentally, because of the time, when I finish my questions I am going to try to do a 2-minute second round for people so we can get Secretary Solis out of here as quickly as possible.

Madam Secretary, you have been on the job for about a month, as you said. If you look at the Department's roster of critical positions—Deputy Secretary, Employment and Training Administrator, OSHA Administrator, MSHA Administrator, et cetera, et cetera—can you tell me how many of the senior-level vacancies at the De-

partment of Labor you have been able to fill? I mean, how close are you to being in a home-alone situation?

Secretary SOLIS. Unfortunately, the process has been so cumbersome that I have had actually just two; and one of them is here with me today, who is overseeing my Congressional and intergovernmental relations, Mr. Brian Kennedy.

Mr. OBEY. So you are in the position of speaking for the Department, defending the Department, and so far you have no lieutenants in sight save one. Is that right?

Secretary SOLIS. Two.

Mr. OBEY. Two.

Secretary SOLIS. Maybe our colleagues in the Senate will heed your call and help us expedite.

Mr. OBEY. That would be nice.

FRAUDULENT CLAIMS

Secondly, I hope that in whatever meetings you participate in having to do with fraudulent claims, I hope you will convey the message to the executive branch that nothing is more important in budgeting than eliminating fraudulent claims. Because every single fraudulent claim that is paid discredits programs that are meant to provide badly needed benefits to the deserving. And I hope that the administration will put together a—I do not know, I do not care whether it is a task force or you name it. Whatever they call it, we need a crash course to eliminate that nonsense because we just cannot afford it.

RETURNING VETERANS

I would also like to simply say that I am concerned about the steep rise in unemployment for returning veterans returning from Iraq and Afghanistan. According to BLS, the unemployment rate for post-9/11 veterans jumped from 8.9 percent in January to 11.2 percent in February, a single-month increase of 26 percent. The overall unemployment rate for post–9/11 veterans is 32 percent higher than the unemployment rate for the general population.

How is the Labor Department enforcing Federal laws ensuring that military personnel returning from Iraq and Afghanistan are able to return to their jobs they left behind?

[The information follows:]

DOL's Veterans' Employment and Training Service (VETS) is the federal agency authorized to receive and investigate formal complaints filed by individuals who believe their rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA, 38 U.S.C. §§ 4301-4335) have been violated. USERRA requires prompt reemployment for members of the uniformed services when they return to civilian life, and prohibits discrimination against individuals based on their service. The agency executes its responsibility through a nationwide network of highly-skilled federal employees, most of whom are veterans themselves. VETS investigators are experts on USERRA and related regulations and have undergone extensive training in investigative techniques and procedures.

Located in all 50 states, the District of Columbia, and Puerto Rico, VETS investigators conduct outreach and provide technical assistance to service members, veterans, employers, and veterans' organizations at the national, state and local levels, as well as where service members are demobilized. Since the terrorist attacks of September 11, 2001, VETS has briefed over 536,000 individuals on USERRA. Briefings to mobilizing and demobilizing members of the National Guard and Reserves are given in collaboration with the Department of Defense's Employer Support of the Guard and Reserve. Together, the two agencies strive to ensure that every Guard and Reservist participates in a USERRA briefing upon mobilization and demobilization from active military service.

USERRA investigations are complaint driven. Upon receipt of an electronically filed or signed completed complaint form (the VETS 1010), VETS immediately opens a formal investigation. The assigned investigator collects and reviews pertinent documentary evidence and interviews available witnesses, under authority of subpoena if necessary. If the evidentiary record compiled in a USERRA investigation supports the complainant's allegations, the agency will attempt to obtain satisfactory resolution through negotiation or mediation. In keeping with the law's stated Purpose and Sense of Congress -- "*to minimize the disruption to the lives of persons performing service in the uniformed services as well as to their employers, their fellow employees, and their communities*" (38 U.S.C. § 4301) -- VETS encourages all parties to resolve disputes promptly and avoid litigation if possible. At any point during the investigative process, the claimant may elect to withdraw the complaint and pursue enforcement through private counsel.

If VETS is unable to resolve a USERRA claim involving a federal employer, we notify the claimant that his or her claim may be referred to the OSC for consideration of no-cost representation before the Merit Systems Protection Board (MSPB). Similarly, if no resolution is obtained in a non-federal case, VETS notifies the claimant that his or her claim may be referred to the Department of

Justice for consideration of no-cost representation in appropriate Federal courts. Historically, less than one-in-ten claimants find it necessary to request referral of their claims.

Service members who lodge USERRA complaints can – and do – benefit from other services that VETS offers as well. This is because VETS has a number of programs that help veterans gain access to a wide array of employment and training services that can help them upgrade their skills and link them to civilian careers. VETS' unique holistic approach allows it to identify and address the individual needs of our brave service members and veterans.

And what can the Labor Department be doing for unemployed veterans?

[The information follows:]

DOL focuses on providing employment programs to assist veterans in obtaining employment, and thereby reduce the unemployment rate for veterans.

The Department's Veterans' Employment and Training Service provides transition assistance through two programs: the Transition Assistance Program (TAP) employment workshops and the Recovery and Employment Assistance Lifelines (REALifelines) program.

TAP was established to meet the needs of separating service members during their period of transition into civilian life by offering job-search assistance and related services. VETS works closely with the Departments of Defense, Veterans Affairs, and Homeland Security in the presentation of this program. TAP employment workshops consist of comprehensive workshops at military installations worldwide. Workshop attendees learn about job searches, career decision-making, current occupational and labor market conditions, resume and cover letter preparation, and interviewing techniques. Participants also receive an evaluation of their employability relative to the job market, as well as information on the most current veterans' benefits. Since 1990, TAP employment workshops have provided job preparation assistance to over two million separating and retiring military members. During Fiscal Year (FY) 2008, VETS held 3,525 workshops in the United States for 120,875 participants, and 579 workshops for 9,796 participants at overseas locations. The Department's FY 2010 budget requests an additional $3.5 million to allow TAP to offer expanded services for spouses and family members of separating and retiring service members, including those with limited English proficiency.

VETS developed the REALifelines program in FY 2004 to provide one-on-one employment assistance to wounded and injured service members and veterans to help them transition into the civilian workforce. Through the end of FY 2008, the program has served over 7,000 injured and wounded service members.

In addition to these specialized programs, veterans receive priority of service within the wide array of DOL-funded training programs currently available through the One-Stop Career Center system.

Our FY 2010 budget request includes a number of key program increases to support our mission:

- State Grants (+$3.5 million): Our request anticipates an increased demand for Transition Assistance Program (TAP) Employment Workshops in FY 2010 as the military service branches work to achieve the DoD goal of an 85 percent TAP Employment Workshop participation rate. The funding increase will allow expanded services for spouses and family members, including those with limited English proficiency.

- Homeless Veterans Reintegration Program (+$9.0 million): These additional resources will be used to serve an additional 5,500 homeless veterans by expanding our competitive grant program. Grantees carry out the mission of assisting homeless veterans to re-enter the workforce. VETS also plans to resume its efforts to help incarcerated veterans and will coordinate its efforts with the Department of Veterans Affairs.

- Veterans' Workforce Investment Program (+$2.0 million): This program supports efforts to provide skills training to veterans, including those with severe employability barriers. The program is being refocused to provide services to veterans that will result in new skills and employment in Green Jobs (including jobs in the energy-efficient building, construction, and retrofits industries; the renewable electric power industry; the energy efficient and advanced drive train vehicle industry; and the bio-fuels industry.)

- NVTI (+$500,000): The National Veterans' Employment and Training Service Institute (NVTI) develops and delivers competency-based training to the State Disabled Veterans Outreach Program (DVOP) and Local Veterans Employment Representative (LVER) veteran service providers. These additional resources will support the broader Green Jobs and Green Vets initiatives by using NVTI training to give veteran service providers the tools and information they need to help veterans find green jobs.

Secretary SOLIS. Thank you, Chairman Obey.

This is of great concern to me as well. Having over the last 8 years represented a district in Los Angeles with one of the highest rates of veterans and homeless veterans, this is an issue that I do not think many of us quite understand how to get our arms around. But we do have incentives in our budget to provide assistance for homelessness for veterans but also for female veterans, because we are also seeing an increase there. And they face different problems, because many of them may have children. There is not enough space available at some of these transition homes, and there is a need for that.

So as we are uncovering and seeing our young people coming back from Iraq and Afghanistan, we are finding that they have multiple different types of challenges. But one that I am charged with overseeing is the fact that if a returning soldier, he or she, goes to a place of employment that they previously worked at and are denied that placement, we have an obligation to go back there and investigate and then file our complaint. That is something that I hope to beef up, because there are too many of those reports that are coming out.

And then, secondly, I am trying to work closely with DOD to look at their programs where returning soldiers are given appropriate information, not just a one-time kind of drop in the bucket, of different services or things that they can apply for but being a little bit more consistent with them and their spouses. Because the spouses are also an important element here. And I believe that the President's wife, Michelle Obama, also has a great initiative there to try to help with our veterans' spouses and the families.

ENHANCED ENFORCEMENT PROGRAM

Mr. OBEY. I just want to make a last point on my time.

In the early years I was on this subcommittee, I worked with Silvio Conte and to some extent with Bob Michel in trying to see to it that OSHA was more flexible in dealing with employers who were generally trying to meet their obligations to their workers. We worked to do a number of things that required retraining of inspectors so they quit focusing on the minutiae and started focusing on the real problems, and so I am all for the agency being reasonable. But there are also other kinds of employers who are not at all helpful.

Example, when my sister was dying, at first the doctors did not know what was wrong with her. Her lungs were filling up with fluid. They thought she was having an allergic reaction to something she was working with in the plant. And so they asked her husband if he could check on the plant floor, because they both worked at the same place. The doctor asked her husband if he could check to see what the chemical content was of the solvent that they were using on their machines. He tried to do that and was blocked from doing it by the employer, even after the doctor called and asked them to allow him to check that out.

So while there are certainly legitimate employers with whom we need to work, there are also people who put the dollar bottom line ahead of everything else. And that is why we need to have an OSHA that performs much better than it has in recent years, when

we discover that the Inspector General showed that the OSHA enhanced enforcement program was a spectacular failure because of OSHA's failure to go after employers who really needed going after.

And, with that, Mr. Tiahrt.

Mr. TIAHRT. Thank you, Mr. Chairman.

CREATING GREEN JOBS

The study that was conducted at King Juan Carlos University in Spain found out that the European model of creating green jobs cost 2.2 jobs on an average for every job created. In the study, they talk about how the government got locked into old technology in their pursuit of green jobs. And I see that already in our own government, where we are sort of locked into solar panels to generate electricity while the private sector is moving to photovoltaic panels; and they can generate more electricity. And they are going into parking lots, like in Phoenix, and getting landowners to allow them to create shade for their customers, while they put these panels overhead to create the shade and also generate electricity.

So with the innovation in the private sector and the tendency for our government to get locked into a technology that becomes stagnant, what level of job loss does the administration find acceptable to create green jobs?

Secretary SOLIS. Well, I look at this a bit differently. We have had tremendous job loss for the past—what—December 2007, long before this new administration was here. So this has been an ongoing issue for some time with high rates of unemployment that are not acceptable to anyone.

I think that green jobs is not a silver bullet by any means. I think that there is ample opportunity, however, for us to begin to invest R&D into research and new science and technology to help create our security independence away from fossil fuels and look at how we can use materials and resources that we have here at hand and be better navigators of those resources.

The study that you cite I understand was conducted by industry individuals who feel that there may be a job loss in their industry. I see this as an opportunity, as we heard a theme recurring here, is that we have many people who are being dislocated and displaced—engineers, bankers, people who are well educated and qualified to do many things. I hope that when we begin the discussion of looking at new, renewable jobs and jobs of potential growth that we look at all opportunities. But I do see green jobs as one of our priorities for this administration but certainly not the only one.

Mr. TIAHRT. Just to correct the record, the study was conducted by King Juan Carlos University and Dr. Alvarez. So it was done by the University and not the private sector.

Thank you, Mr. Chairman.

Mr. OBEY. Ms. DeLauro.

Ms. DELAURO. I have a very quick question, Madam Secretary.

DIACETYL

This is about an issue that I have worked on for a number of years, and it follows up with what Chairman Obey was talking about, the potential harm that is caused by the chemical diacetyl

to thousands of workers who are mainly working at popcorn manufacturing facilities. You have taken initial steps to address the issue, and you have convened a Small Business Regulatory Enforcement Fairness Panel to look at it. I understand there is a process in place, including a 60-day comment period. I want to ask for your assurances that this will be a priority for the Department and OSHA; and, if so, can we anticipate seeing a proposed rule on diacetyl in the Federal Register?

Secretary SOLIS. Congresswoman DeLauro, I am happy you brought this item up. It is one that I know I worked on here as a House Member with other members of the Labor and Education Committee, and it is something that we are taking very seriously.

Right now, we are finishing up a small business review process that has to be taken for diacetyl; and we will soon be able to move forward with a formal proposal.

Ms. DELAURO. Okay. Thank you. I would like to continue to work with you on that.

Thank you, Mr. Chairman.

Mr. OBEY. Mr. Cole.

Mr. COLE. Thank you, Mr. Chairman.

I know we are operating under an abbreviated time schedule here, so let me make two points, if I may, and then entertain, obviously, whatever response you would like.

OFFICE OF LABOR-MANAGEMENT STANDARDS

First, I would like to very much associate myself with Mr. Tiahrt's remarks about the concerns and the cuts in the Office of Labor-Management. You know, frankly, most of our money in the Department of Labor is appropriately spent on protecting workers in the workplace and mitigating disputes between employers, et cetera. But labor unions are not always a force for the good, and there certainly has been plenty of instances of abuse. And if we ever pass Card Check in this Congress, potentially you might need more oversight rather than less. So that does concern me greatly.

Second, while I appreciate the emphasis on green jobs, I want to say for the record in my State, in Oklahoma, frankly, the energy industry, the oil and gas industry has provided more opportunity for more people than any other industry in the history of the State. Upward mobility, the greatest concentration of technical talent, the highest salaries are paid there. We have the number one and two producers of natural gas in America headquartered in Oklahoma City, and even critics of carbon-based energy generally recognize natural gas as the least objectionable of the carbon-based energy sources. So if we are going to have an emphasis on green jobs, I would suggest natural gas is one that ought to get an emphasis.

And, honestly, nuclear energy ought to also get an emphasis. I do not see any way with renewables alone this country will be remotely energy independent in our lifetime. We are going to have a carbon-based energy sector. It is going to be extraordinarily important; and, frankly, we ought to follow the example of our friends in Europe, particularly the French, and look pretty seriously at our nuclear-based capabilities, where I think we have basically abandoned a lead that we had 20 or 30 years ago. They have actually done better than us in recycling and taking care of the waste prod-

ucts. So I would hope you look, when you think green, you do not exclude natural gas and you certainly do not exclude nuclear.

Secretary SOLIS. Thank you, Congressman Cole.

I would just concur that I think that natural gas is another source of energy that we should be utilizing more. I know that might be something that the Department of Energy will probably undertake, as well as the nuclear energy debate; and certainly we have to look at what resources we do have here. Hopefully, whatever takes place, it will be done in a manner where we can have the cleanest energy provided with the less egregious outcomes in our communities. So I am with you on that.

And with respect to OLMS, I would just say to you that they have had substantial increases in their budget for the last 4 or 5 years, more so than the other agencies; and what we are trying to do is level the playing field. We will be moving some of those investigators over to Wage and Hour, where we do need them, and in OSHA.

Now, there are appropriate skilled areas where there is a better fit. That does not mean we are going to hold back on looking at any fraud or misconduct facts if folks are not complying with the law. So we will be very diligent there, and I can promise you now that we are already keeping that pace now.

Mr. COLE. Thank you.

Mr. OBEY. Ms. Roybal-Allard.

Ms. ROYBAL-ALLARD. Just a quick statement.

MIGRANT AND SEASONAL FARM WORKERS

I have been asked, Madam Secretary, to thank you for recognizing the value and the contributions of migrant and seasonal farm workers to our society. This is the first time in 8 years that the job training program for these hardworking people has been included in the Department's budget. During the last 8 years, under the leadership of our chairman and his efforts, we have had to restore the funding for the over 45,000 eligible farm workers who have been trained and placed in steady, year-round employment. However, as you know, the funding for the program only permits us to reach a little less than 3 percent of the eligible population. So my hope is that we can continue to find ways to increase the funding for this very effective and successful program so that it can reach more farm workers.

Secretary SOLIS. Thank you, Congresswoman.

I would just add that we are trying to, with one of our notices that did go out, to the workforce investment system to provide additional information for funds for the national emergency grant program to be used for this particular population. So I am excited about that. But I know that we should have those discussions to further figure out how we can address the long-term issues here that I know both you and I are very concerned about.

Mr. OBEY. Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman.

TELEWORK AND TELECOMMUTING

One question. I know the Secretary of Transportation and the Secretary of HUD are working together on a Sustainable Cities,

Livable Cities Initiative; and one that I read in last year's report that the Department of Labor is looking at is the telework and telecommuting and those kinds of things. So if you could just comment on your opinion on telecommuting I think from traffic purposes and the whole greening of our country. This could be a component to it. So are you going to be involved in any of those discussions or initiatives?

Secretary SOLIS. Well, we are collaborating with Department of Energy and HUD and Department of DOT, and we know that it is very important to allow for flexibility in the workplace so that families—and this comes up often with respect to folks that need to work from home and having that flexibility. I think that that is a way to go. It saves costs overall, transportation congestion, but also probably more productivity on the part of the employee. So I think that those are mechanisms that, as you have outlined, that are very important for us to follow up on; and we will be working with our partners in the other agencies to see how far we can promote this program.

Mr. RYAN. Thank you.

Mr. OBEY. Mrs. Lowey.

Mrs. LOWEY. Thank you, Mr. Chair.

INTERNATIONAL LABOR AFFAIRS BUREAU

I referenced before the International Labor Affairs Bureau, and I know you care very much about it. I am very pleased that the budget sets the number at $92,000,000, which is an increase of more than $6,000,000 from fiscal year 2009. This is certainly a welcome increase, given that the previous President attempted to drastically reduce this account every year. At a time when we have taken on greater responsibility abroad, we have a duty, in my judgment, to do more to improve labor conditions in foreign countries, including reducing child labor, protect women's rights, maintain our education in the HIV/AIDS initiative.

My colleague whispered to me, and I repeated it before, that the worst abuses around the world are right here in agriculture. So, obviously, we have to address that; and I know you will.

Could you share with us how the Department plans to use the proposed increase to address these priorities?

Secretary SOLIS. Thank you, Congresswoman Lowey.

You know of my passion and concern for trying to provide information and data as to what the conditions are with trading partners in particular, and I think there has been an absence in this particular division for the last few years. It has not been a priority. While there has been funding incrementally provided for the exploitation of children and trafficking, those are good things that should continue; and I do not see us minimizing that. But I think now with the new President coming out with his proposals that he would like to introduce trade agreements again, it is very important that we do have the best data available; and I think that we have not had sufficient funding to allow the Department to be able to get that data, to work with NGOs, to work with our partners, to also help provide assistance to our trading partners so they can help hopefully elevate our standards. That helps American workers in the long run.

So I do have a vision, and I would like to be able to sit down when we can to tell you a little bit about more what my thoughts are.

But I was able to attend the Americas Summit with the President and met with many of my counterparts from countries representing Labor Secretary positions, and we had very good discussions. One of which I heard resoundingly is that they want to have more assistance from us; they want training from us as well. They could benefit from our OSHA staff going and conducting seminars and meetings with them but also importantly helping them to understand what our labor standards are. So this is something that is of great importance I know to the President as well as to myself.

Mrs. LOWEY. Thank you very much. I look forward to working with you.

STATE AID

Mr. OBEY. Madam Secretary, let me just make one point in ending the hearing. The new estimates have come out on the part of OMB, and they are indicating that we are going to experience an even larger deficit than we expected. One of the major reasons for that is because of the drop in revenue into the Federal Treasury.

And I would point out that the same thing is happening at the State level. In my own State, just in the last 3 months, their estimate of the size of the State deficit that they are going to incur has risen by $1,500,000,000.

The Washington Post this morning carried—and I just want to read a couple paragraphs—they carried an article this morning which says this:

Eleven weeks after Congress settled on a stimulus package that provided $135,000,000,000 to limit layoffs in State governments, many States are finding the funds are not enough and are moving to lay off thousands of public employees. And they tell stories about what is happening in the State of Washington, Massachusetts, Arizona, et cetera, et cetera. It says the layoffs are one early indication of how the stimulus funding could be coming up short against the economic downturn.

As the stimulus plan was being drawn up, there was agreement among the White House, congressional Democrats, and many economists that a key goal was to keep States from making big layoffs at a time when 700,000 Americans were losing their jobs every month. The House passed a stimulus bill with $87,000,000,000 in extra Medicaid funding for States, as well as $79,000,000,000 in stabilization money to plug gaps in State budgets for education and other areas.

But in the Senate the stabilization funding was cut by $40,000,000,000 to secure the necessary support to pass the bill. The article says, supporters of the final $787,000,000,000 bill, which included $25,000,000,000 less in State aid than the House plan, said it would help States avoid severe cuts, but tax revenues are coming in even lower than feared.

I would simply make the point that, as we discovered during the Carter and Reagan deficit era, when the economy was going to pot at an earlier time, we will never balance the budget or come anywhere close so long as this economy does not get moving again.

With all of the attention that is being paid to the negative impacts of deficits, I would urge the administration to remember and remind the country that, at least in the short haul, the economy needs to be stimulated by those short-term deficits; and if we do not have enough stimulation, we are not going to get out of this hole. Because if the unemployment continues to rise and if we continue to lay off more workers, those revenues are going to continue to drop, and that is going to leave us with an even bigger hole than we thought we were facing.

That can be avoided with the right policies, and I hope that the administration will recognize that the situation at the State level is significantly more serious than was thought at first, as is the situation at the Federal level, and it requires something more than simply hoping for the best.

With that, I appreciate your coming; and I wish you luck.

Secretary SOLIS. Thank you, Mr. Chairman.

Mr. OBEY. And I hope you eventually get some people around you on your team so that you do not feel like——

Secretary SOLIS. I am a one-woman show.

Mr. OBEY [continuing]. You are holding court alone. Thank you very much.

Secretary SOLIS. Thank you so much, Mr. Chairman, and members and ranking member. Thank you.

**[The following questions were submitted to be answered for the record:]**

**JOB CORPS FUNDING REQUEST**

Mr. Jackson: In these challenging economic conditions, it is critical that we not forget the millions of out-of-school, out-of-work youth who need successful job training programs like Job Corps that contribute to the health and vitality of our nation's workforce. It is my understanding that Job Corps faces an estimated operations budget shortfall of $127 million. However, the fiscal year 2010 funding request essentially proposes flat-level funding for Job Corps. How is the Department planning to address this shortfall in the FY 2010 budget proposal with a flat-level funding request so that there is no disruption in student services, staff layoffs or attrition?

Ms. Solis: The FY 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.

The FY 2010 request supports 44,950 slots—an increase of 495 over the 2009 targeted level. It includes funding for additional slots at the new Milwaukee Job Corps Center, scheduled to open in PY 2010. The FY 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.

**JOB CORPS AND GREEN JOBS**

Mr. Jackson: Madam Secretary, I'm very encouraged that you were the author of the Green Jobs Act of 2007. I hope, in addition to supporting new initiatives like the Green Jobs Act, you will also proactively support the efforts of existing programs like Job Corps that have already begun to respond to this emerging need of our economy. Job Corps centers across the nation have already begun to respond to green collar job growth in their communities. With a modest investment our Job Corps centers across the country could quickly retool their hundreds of construction, facilities, and automotive programs to incorporate the standards of the emerging green sector. These Job Corps centers could

also contribute to the Clean Energy Corps that President Obama envisions. Will you support an investment in the fiscal year 2010 budget to accelerate the steps individual Job Corps centers are already taking to retool the needs of our emerging green sector?

Ms. Solis: I whole-heartedly support the Job Corps program and its efforts to prepare young people for employment, and specifically for opportunities within the emerging green sector of our economy.

Job Corps is utilizing Recovery Act funds to incorporate green principles and standards in its Automotive, Construction, and Advanced Manufacturing trades, and over the course of the upcoming year, it plans to reexamine all trade areas to incorporate green skills training where appropriate. Working in close collaboration with industry, Job Corps will enhance current training curricula, expanding programs and developing new offerings based on industry standards and the current and future needs of the labor market. Job Corps' 18-month goal of preparing green graduates will necessitate ample resources and executive support – both of which I am firmly committed to. The 18 months is tied to the ARRA. By the end of 18 months we will have trained approximately 10,000 students in "green training".

Job Corps will be using Recovery Act funds to make important strategic capital investments that will improve the energy efficiency of its facilities and campuses. I am inspired by the Job Corps' efforts to create a culture of environmental awareness at each center – so that while students are receiving technical training, they are also learning the tenets of environmental stewardship and practices that will stay with them well beyond their Job Corps experience.

TUESDAY, JUNE 2, 2009.

# U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

## WITNESS

### HON. KATHLEEN SEBELIUS, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. OBEY. Madam Secretary, welcome. We are pleased to have you here for your first appearance before this subcommittee.

I note the presence of a Kansas cabal. And we welcome that too today.

Madam Secretary, when I was in the legislature, I served with a fellow by the name of Harvey Duhall, who is a retired dairy farmer, homely as a basset hound on a bad day. And he was probably the best human being I ever served with anywhere.

And one of the things he always said, was, "Do you know what? The problem with this country is that all too often the poor and the rich get the same amount of ice, but the poor get theirs in the wintertime."

It is my understanding that you have the outrageous view that that can change. It is also my understanding that you are coming in here today intending to do something very radical, which is to try to provide health care coverage for every American. I would just like to know where you get that crazy idea, because it seems to me that we have already seen hundreds of billions of dollars go out the door to help strengthen banks, insurance companies, and auto companies under both President Bush and President Obama. But now, evidently, you have the outrageous gall to come in here thinking that if we are going to have socialism for big people, we ought to provide at least a shadow of socialism for little people.

I don't happen to regard it as socialism, but as you know, some people like to refer to it that way and scare people with those naughty words. I just want to say that I hope that your secretaryship is marked by our finally achieving that long-sought goal of providing health access and affordable health care to every single American.

I know this hearing is supposed to be largely about your budget, but that is the great issue that hangs over all of our deliberations on this subcommittee this year. I for one hope that, as the administration puts together its plans and establishes its negotiating position, you along with the President will fight just as hard as he can to see to it that among the options available to American citizens will be a public plan.

I find it ironic that some of the people in this society, especially in the insurance industry, talk so vociferously about the need for consumer choice, I find it interesting that many of those same people would deny consumers the choice of having a government plan.

I fully recognize that we are not going to have anything like the Canadian single-payer plan. This is a different country than Canada. And I recognize that, in the end, we will be building primarily on a private insurance system. But I would certainly expect that we would have as an option a government plan for those who choose to have it and not imposed on anybody. I would hope that the administration would hang tough on that issue.

I know that I am told that the administration is probably going to be sending down to us additional requests for funding for pandemic flu, and simply ask you to convey to the White House that, since we are trying to finish the supplemental conference this week, they do so immediately so that we can give it full consideration in the conference.

In my view, President Bush was correct to ask for full funding for that program more than 5 years ago. This committee, for a variety of reasons, didn't quite measure up to that. I think we have got to get on with that business. And so I hope that the administration will send down to us, as quickly as possible, whatever their estimates are of what the true need would be.

I also have some concerns I would like to express to you with respect to certain aspects of your budget, especially LIHEAP, and what I regard to be a peculiar request that they had within NIH which I will save that for the question period.

Mr. Tiahrt.

Mr. TIAHRT. Thank you, Mr. Chairman.

And as a fellow Kansan, I want to provide a warm welcome for Secretary Sebelius. Congratulations on your confirmation. I know that after getting back to Washington and seeing the traffic, you have the same thought that I have: We are not in Kansas anymore.

As Secretary of Health and Human Services, you have the responsibility to ensure our Nation's health care and social services remain excellent and indeed improve. But like a physician, your philosophy should be, first, do no harm. This often is hard for the government; for meddling in access and choice, that government does in fact do harm.

I am interested in hearing how you will balance the desire to improve access to health care and human services while not interfering in the quality of the systems themselves. One of the biggest concerns with government interference in a health care delivery system that I have is that, and I am sure health care reform will be a large part of our discussion today, is that we will limit the innovation to choice and access to this process that we are going through to try to involve more government in the process.

The three areas of concern that I have with the administration's proposals are the utilization of comparative effectiveness to ration health care; the elimination of the conscience protection; and the overall concept of moving people from the private health insurance to public health insurance. I believe these three policies will negatively impact the quality in America's access to health care.

First, regarding comparative effectiveness, in the stimulus bill we included money that not only was for comparative effectiveness but also language directing your Department to use this research to make decisions about what treatments the government will and won't approve. The government will fund research to decide which

medicine or medical treatment works best for most people. Then and only then will they pay for that one option.

In other words, "comparative effectiveness" is just another way to say rationed health care. Who is going to be affected by this policy? Unfortunately, I think it is those who can least afford to lose will be the ones that experience the loss.

A fellow Kansan, Jennie Jobe from Johnson County, was in my office earlier this spring. She has an immunosuppressant disease. And under private insurance, she had medication that would allow her to fight off the common cold and the flu.

When she visited my office, she was suffering from the flu and was afraid to shake hands. She had left the life where she was completely able to function; she could play with her grandchildren, she could shop, she could be productive. Unfortunately when she switched to Medicare, the government would not fund her therapy or her medication, so she was forced to take a new medication in which provided her with headaches and backaches, and it did not protect her from diseases, such as a common cold.

When she came to my office, she was considering wearing a mask and was very worried about the H1N1 virus. And it was all because of the interference in the decision that was between her physician and herself.

Personalized medicine is a new frontier, and developing applications to meet these medical needs of individuals as individuals, as you know our own University of Kansas is developing the technologies that can not only detect and analyze an individual's unique physiological response to a disease, such as cancer, but also tailor the optimum treatment for that person. The outgrowth of the genomics research, personalized medicine has already seen success and is realized at the direction in which medicine should be moving.

In early February, the FDA announced that the creation of a new position to focus on ushering in new personalized medical methods came about. On one hand, the government promotes this personalized medical research, and on the other hand, it is stymieing the progress through comparative effectiveness policy. Comparative effectiveness will directly affect a doctor's ability to make the best decision for his patients.

The Federal Government is the largest customer in the health care industry. Once it no longer pays for certain medicines or treatments, it becomes financially unsound for manufacturers to be able to recoup their costs from research and development and thus limit their development of new products. Similarly, innovative research on gene therapy and other personalized medicine options will be threatened.

Second, I believe that the removal of the conscience protection will threaten our Nation's health care access. As Americans we believe that no one should be forced to act in a way that violates his or her morals or religious beliefs. There are many excellent health care professionals and health care facilities that do not believe abortion is a right or is right and do not provide that procedure. Now the administration wants to remove their right to refuse and provide a service that violates their moral principles and/or religion.

Besides the civil rights aspect of this policy, there will be a severe impact on access to health care. Catholic hospitals, clinics, and medical professionals are the bedrock of our health care delivery system in most parts of the Nation. In Kansas, it is 40 percent of our hospitals. As not-for-profit hospitals, they take care of all who come through their doors. They provide excellent care.

But if they are forced to close their doors or stop practicing, many Americans in Kansas will be left without a place for medical treatment. I am interested in hearing how the administration plans to ensure that our health care system doesn't come to a grinding halt if they stop reimbursing medical centers for freedom of choice.

Finally, in this area in which I know you are intimately familiar as former insurance commissioner of the State of Kansas, I would like to hear about your rationale for moving people from private health insurance to the public system. Not only will this exponentially increase the cost to the taxpayer, but it will also further rationed health care. The administration has expressed a desire for a public insurance plan that will directly compete with private health insurance plans.

Employers will see this as a cost avoidance and move their employees and their cost from their own pocketbook and bank account to the taxpayers. We have seen this already in SCHIP.

How will we pay for this as a Nation? Have you accounted for the vast enrollment beyond just today's uninsured?

Further, current public insurance accounts for about 40 percent of the health care coverage, while private insurance covers about 60 percent of it. We all know that the reimbursement rates are much lower than the actual cost when it comes to the public portion. In Kansas, they are experiencing from 25 percent to 70 percent below cost on reimbursement rates. And it is not one entity alone; it is hospitals, clinics and physicians.

They try to make ends meet by shifting costs from the private insurance payments to cover the shortfalls in the public funding insurance. Today in Kansas, one-third of the physicians will not take any new Medicare or Medicaid patients because of this. If HHS cannot find a way to meet the seniors' health care costs, then how will they be able to pay for the entire populace under government-run health care?

The only way this would be feasible would be a rationed health care system similar to what we find in other countries, like Canada, the United Kingdom, Norway, anywhere else on the face of the earth that has a similar program. And I believe this is completely unacceptable.

More importantly, I am concerned that it will be the downfall of the American health care quality and indeed in the world as we know it as a standard bearer in health care.

Secretary Sebelius, it is good to have you here today. I look forward to working with you to ensure that every American has the ability to pursue his or her dream, including access to the best health care and wellness programs in the world.

Thank you, Mr. Chairman.

Mr. OBEY. Mr. Lewis.

Mr. LEWIS. Mr. Chairman, thank you very much. I have no formal statement. I will wait for the Secretary's statement and hope I will have a chance to ask some questions.

Mr. OBEY. Okay. Madam Secretary, please proceed.

## SECRETARY'S STATEMENT

Secretary SEBELIUS. Thank you, Mr. Chairman.

It is good to be with the committee today, and I appreciate the greetings from my fellow Kansan and new ranking member of the subcommittee, Representative Tiahrt.

And it is nice to have Mr. Lewis also here today.

I appreciate the opportunity to come and discuss the President's 2010 budget for the Department of Health and Human Services. And this does mark my first appearance before this committee as Secretary. And I want to begin by thanking members of this committee for your hard work and your leadership. I know we do face tremendous challenges in our Nation today, and I hope we can work together to tackle those challenges.

One task we need to complete together is health reform. And as you consider the budget before you, you and your colleagues are working on a historic effort to reform our health care system. Like you, I know America simply cannot afford the status quo when it comes to health care. We have all heard from people throughout this country who don't know what they will do if they or their children fall ill. Too many families in America are one illness or accident away from financial ruin.

Businesses are suffering as well. Yesterday's bankruptcy of General Motors reminded us that the cost of health care makes it more difficult for American businesses to compete and succeed with their global competitors.

Today a report was released by the President's Council of Economic Advisors. It outlines how health care reform can help strengthen our economy and shows us the high cost of doing more of the same. The report found that if we continue on the path we are on today, by the year 2040, 72,000,000 Americans will be uninsured, and health care costs will account for over 34 percent of our gross domestic product. Without reform and action now, the Federal deficit will continue to rise, and Americans who receive insurance from their employers will see a larger portion of their salary go to health benefits instead of their take-home pay.

This is a problem we can avoid if we act now. The Economic Advisors' report found that real reform slows the growth rate of health care costs by about 1.5 percent, would help cut the Federal deficit, boost our economy, save jobs, and put more money in the pockets of American families. For a typical family of four, real income would be up about $2,600 by 2020 and $10,000 more in 2030, but only if we make health reform a reality.

The message is clear: health reform can give us a stronger economy and better health care system and boost families' bottom line. But if we do more of the same, we all will pay a heavy price. We need reform that protects what works in health care and fixes what is broken. The budget we are considering today invests in key priority areas and puts us on the path to health reform. It builds on the investments already made in the 21st century health system

that you all made in the American Recovery and Reinvestment Act. It sends a clear message that we can't afford to wait any longer if we want to get health care costs under control and improve our fiscal outlook.

Fraud costs our Nation billions of dollars every year, and the budget proposes that we further crack down on individuals who cheat the system. The Attorney General and I recently announced an interagency effort to fight and prevent Medicare fraud through improved data sharing, joint strike forces in key areas of the country, and increased operations. This budget includes increased funding to help HHS achieve our part of the bargain.

The budget also helps move us toward a central goal of health reform, improving, as Congressman Tiahrt has already mentioned, the quality of care. Now, thanks to Chairman Obey's leadership, the Recovery Act has already included critical new resources to fight health-care-associated infections, as well as new support for prevention and wellness programs that can keep Americans out of the hospital in the first place.

The 2010 budget builds on these investments. The budget includes critical support for patient-centered research that will give doctors and patients access to better information and treatments, as well as quality incentive payments to hospitals and physician groups who have better rates of readmission. It invests $354,000,000 to combat health disparities, improving the health of racial and ethnic minorities in low-income and disadvantaged populations.

And the budget recognizes that if we want to ensure that millions of Americans who lack insurance get quality affordable care, we need to increase the number of health providers in this country. We are responding to the challenge by including over $1,000,000,000 within the Health Resources and Services Administration to support a wide range of programs to strengthen our Nation's health care workforce.

The funding enhances the capacity of nursing schools; increases access to oral health care; targets minority and low-income students; and places an increased emphasis on ensuring that America's senior population gets the care and treatment it needs.

Finally, the 2010 budget will support our Department as we work to protect health and safety of our citizens. As the recent outbreak of the new H1N1 flu virus reminded us, HHS has a significant and critical role to play in preparing for and responding to the outbreaks that threaten the health of American people. The previous investments made in pandemic planning and preparation by this committee and this Congress allowed our Department to respond quickly and efficiently to the H1N1 virus when it first presented itself and to get Americans the information and resources they needed early in the outbreak.

But we still don't know what is coming later this fall and winter or what exactly will happen this summer in the southern hemisphere as the H1N1 virus mixes with seasonal flu virus. Putting safety of the American people first, this administration's supplemental request will help support the Federal response to the recent outbreak of the H1N1 flu.

These funds, in addition to the funds requested in the 2010 budget, will allow HHS to continue to respond to the current outbreak and remain prepared to protect the American people.

Mr. Chairman, President Obama has committed to creating a safer, healthier and more prosperous America, and this budget will help our Department achieve those goals. It invests in reform; will improve quality of care; and continues to provide essential services that so many families depend on.

I look forward to discussing the budget with you and your committee today, and I am happy to take your questions.

[The information follows:]

TESTIMONY
BEFORE THE SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES
UNITED STATES HOUSE OF REPRESENTATIVES

STATEMENT BY

**THE HONORABLE KATHLEEN SEBELIUS**

SECRETARY
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

**For Release on**
**Tuesday, June 2, 2009**
**at**
**2:00 pm**

**STATEMENT OF**

**KATHLEEN SEBELIUS,**

**SECRETARY**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**ON**

**FY 2010 BUDGET**

**BEFORE THE**

**SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES**
**COMMITTEE ON APPROPRIATIONS**
**U.S. HOUSE OF REPRESENTATIVES**

**JUNE 2, 2009**

Chairman Obey, Representative Tiahrt, and Members of the Committee, thank you for the invitation to discuss the President's FY 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 health care 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 health care resources. At HHS, we are dedicated to the continued improvement and accessibility of health care in the United States and committed to providing essential human services that families depend on, particularly in times of economic crisis.

The HHS FY 2010 Budget reflects a dedication to focus resources in the areas of health reform, improving the quality and accessibility of health care, 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 FY 2010 Budget for HHS totals $879 billion in outlays. The Budget proposes $78 billion in discretionary budget authority for FY 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 health care. American families and small businesses are being crushed by sky-rocketing health care 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, health care costs are consuming a rapidly growing share of Federal and State government budgets.

The United States spends over $2.2 trillion on health care 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 health care.

Despite this record spending, about 46 million Americans lack health care coverage. The President is committed to reform that assures quality, affordable health care for all Americans. Covering all Americans is not only a moral imperative, but it is also essential to a more effective and efficient health care 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 (CHIP), which has provided health care for millions of previously uninsured children.

The Administration is using Recovery Act dollars wisely to protect coverage for families and help strengthen our health care system. The funds this Committee 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% 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 health care 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 health care system that offers affordable, quality health care 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 health care 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 health care 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 health 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 health care for all Americans by supporting programs intended to enhance the

health care 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 health care system.

The Budget includes over $1 billion within the Health Resources and Services Administration (HRSA) to support a wide range of programs to strengthen and support our nation's health care workforce. This funding will enhance the capacity of nursing schools, increase access to oral health care 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 (AHRQ). This research will improve health care 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 health care system – and the utilization of electronic health records (EHR). The Office of the National Coordinator for Health Information Technology (ONC) will continue its current efforts as the Federal health IT leader and coordinator. During FY 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 & Medicaid Services (CMS) Program Management account increases by $235 million in FY 2010 to cover statutory and policy workloads in claims processing and in health care 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 health care system.

***Delivering Human Services to Vulnerable Populations***

HHS shares the President's belief in increasing access to critical services and health care 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 health care 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 FY 2009, an increase of approximately 70,000 over FY 2008. Approximately 115,000 infants and toddlers, nearly twice as many as in FY 2008, will have access to Early Head Start services in FY 2009 and

FY 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 (SAMHSA) 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 respond 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's supplemental request supports the Federal response to the recent outbreak of the H1N1 influenza. These funds, in addition to the FY 2010 Budget of $584 million, will allow HHS to develop, produce, and distribute antivirals, vaccines, personal protective equipment, and other medical counter-measures, as well as conduct 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 H1N1 and has created an H1N1 virus reference strain that manufacturers will need 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. CDC, ASPR, FDA 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%, or 11 million treatment

courses of the antivirals in the Strategic National Stockpile for distribution to States; issued Emergency Use Authorization (EUA) of diagnostic laboratory tests and to treat children under the age of 1 year with Tamiflu; issued regularly updated guidance for health care 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 over $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 health care 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 Centers for Disease Control and Prevention (CDC).

Rural Americans also often receive substandard care and the FY 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 eight years. In FY 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 health care 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 ten 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 Administration for Children and Families entitlement programs, and $1 billion for administration. Most of the increase in this funding will take place in FY 2009 and FY 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 health care, 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 two 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 health care. 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 Committee 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.

**SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**KATHLEEN SEBELIUS**

Kathleen Sebelius was sworn in as the 21st Secretary of the Department of Health and Human Services (HHS) on Tuesday, April 29, 2009. The Secretary governs one of the largest civilian departments in the federal government with more than 67,000 employees. HHS is the principal agency for protecting the health of all Americans by providing effective health and human services, especially for those who are least able to help themselves.

Secretary Sebelius has over 20 years of experience in state government, and has been a leader on health care issues for over a decade. She was first elected governor of Kansas in 2003 and was reelected in 2006. Throughout her tenure, Sebelius was lauded for her record of bipartisan accomplishment. She worked tirelessly to grow the state's economy and to create jobs, to ensure that every Kansas child received a quality education, and to improve access to quality and affordable health care. As Governor, Sebelius expanded Kansas' newborn screenings, put a renewed emphasis on childhood immunization and increased eligibility for children's health coverage. More than 59,000 additional children were enrolled in health coverage during her time in office. Sebelius also worked closely with Kansas first responders and law enforcement to prepare for natural disasters and other emergencies. In 2005, Time magazine named her one of the nation's top five governors.

Prior to her tenure as Governor, Secretary Sebelius spent 8 years serving as the Kansas State Insurance Commissioner. In that capacity, Sebelius turned her department into a steadfast advocate for Kansas consumers, and helped senior citizens save more than $7 million on prescription drugs. She also won praise for blocking the sale of Kansas Blue Cross/Blue Shield by an out-of-state, for-profit health care conglomerate, and for her role in drafting a proposed national bill of rights for patients. Previously, she was a member of the Kansas House of Representatives from 1986-1994.

Married to husband, Gary, a federal magistrate judge, for 34 years, they have two sons: Ned and John.

Mr. OBEY. Thank you very much.

Just a couple of things. First of all, with respect to health care reform, I do hope that as the process moves along, we will not give short shrift to long-term care. I think that has to be a key part of whatever we do.

Secondly, without belaboring it, I do take issue with the administration's request for low-income heating assistance. I understand that the amount that is being requested by the administration is significant in historical terms, but it still represents a reduction below last year, and I would think that that ought to be corrected.

Let me simply express one concern about your budget for NIH. I have been on this committee since 1974, and we have steadfastly, regardless of which party controlled the White House or the Congress, insisted that allocations to research on diseases be handled by scientists rather than politicians. And so we have always resisted efforts to direct a specific amount of funding at a specific disease.

As you know, and I understand this happened before you were appointed, that in the administration's initial request, they have crossed that line, and they have moved to request a specific amount of funding for cancer and autism to the exclusion of almost every other disease.

I don't think there is anybody on this panel who is in love with cancer or autism. I think all of us have a long record, regardless of party, in trying to combat both.

But I do think that it is important that we recognize that, once we start politically determining funding levels for one disease versus another, then the door opens and every group in society is going to be expecting to be in the front car on the train. Nobody is going to want to be in the caboose. The result will be political chaos in an area that ought to be determined by science.

So this committee will not follow the lead of the administration on that. I would urge that you talk to whoever made those decisions and suggest that there is a better way to skin a cat than that one.

The only other thing I would say, and then I would invite your comments if you want, on NIH, I would again ask that the administration as quickly as possible send us your full request for pandemic flu, because as you know, we had money in the supplemental that was ridiculed by some of our friends in the Senate. We have now again put money in—I mean, we put it in the stimulus initially.

We have now again put a significantly amount of money in the supplemental. But it is apparent I think to all of us that even that amount is not enough. So whatever the amount is the administration is going to request, I would hope that they would do it pronto.

I simply invite your comments before I pass you on to the next questioner.

Secretary SEBELIUS. Well, Mr. Chairman, I will certainly share your interest in avoiding disease-specific funding in the future with the administration.

I do know that the President personally feels very strongly about the opportunity to cure cancer in his lifetime and has talked about that for years based in large part on his personal experience. And I think that is a funding initiative that is reflected in this budget priority.

Having said that, they are also, both in the Recovery Act and again in the 2010 budget, as a significant investment in research. And the President also fully supports letting science guide the research. So I think that is a balancing act.

And I will share your concerns with him.

It is my understanding that the budget resolution, unlike the initial budget proposal, has retooled the LIHEAP funding in a way that I think is more suitable in terms of where you feel it is appropriate to go. I think the goal initially was to provide a little sort of truth in funding by putting the trigger in, in case the oil prices were as high as they had been in previous years.

But I understand your commitment to the program and assure you that we share that commitment. It is an essential program for really what are life-saving services for seniors around the country.

And finally, in terms of long-term care, there certainly is already an investment and interest in rebalancing a lot of our long-term care issues, funding more of a continuity-of-care system, and funding that part of the workforce. This speaks to the fact that for many Americans, care in their home, care with some assistance, before they would reach a nursing home, is much preferable and often provides a much higher quality of care.

So there are some underpinnings that are already in the budget, but I think it is very appropriate in the discussion of health reform overall that we address that issue, because right now, Medicare does not fund long-term care unless you are impoverished, and that has become somewhat of an industry to try and see that families can save some assets as one or other member of the couple faces that situation. So I think that has to be part of our discussion going forward. And I look forward to working with you and others on that issue.

Mr. OBEY. Thank you.

I would simply say, with respect to NIH, I think every member of this committee shares the President's concern about cancer and autism, but there are also legitimate and equally important concerns about Parkinson's, about Lou Gehrig's disease and diabetes, et cetera, you name it. And I think virtually all of us are more comfortable with the final decisions being made on the basis of what peer-reviewed process leads us to the best scientific judgments as opposed to doing a political balancing act.

Mr. Tiahrt.

## COMPARATIVE EFFECTIVENESS RESEARCH

Mr. TIAHRT. Thank you, Mr. Chairman.

I want to go back to the first one on comparative effectiveness. There was $400,000,000 that the stimulus bill passed on to your agency, and it is to determine the optimum procedure or a pharmaceutical for a given symptom.

As we experienced with Jennie Jobe when she came to my office, she lost access to the best solution for her symptoms because of Medicare.

How will you apply comparative effectiveness? Will you allow it to be used like it was for Jennie Jobe as rationed health care, or will you use it as an advisory tool for physicians in clinics and hospitals, so they can make the best decision how to apply the information they have?

Secretary SEBELIUS. Well, Congressman, let me start by saying, in my service as Kansas Insurance Commissioner for 8 years, I spent a lot of time and energy fighting the rationing of health care, which I saw each and every day, being conducted by private insurers who were making treatment choices and overruling doctors' medical decisions about drug applications and medical procedures.

So I share your goal that in transforming the health system, we not get to a system of rationed care; that medical protectives should make medical decisions—not government bureaucrats, not insurance companies, not others.

As you know, the language around comparative effectiveness research prohibits Medicare from using that research for cost-based decisions, for spending decisions. So it is established as a methodology to do exactly what you have just described: to identify not only best practices and effective outcomes, but to increase transparency, inform consumers and providers, and move us in a direction where we are using more cost-effective treatments, and also higher quality treatments which are in place in some parts of the country but too often not in place.

Mr. TIAHRT. Apparently, CMS hadn't gotten the memo about rationed health care because they did ration Jennie Jobe's health care.

Let me move on——

Secretary SEBELIUS. That may have been in a formulary that was created. I have no idea.

CROWD OUT OF PRIVATE HEALTH INSURANCE

Mr. TIAHRT. It is a danger I think that we are facing in America today. And we are seeing it play out in not only Medicare but also Medicaid.

In the public health insurance plan currently today 60 percent of health care is privately funded; 40 percent public funded. And every hospital clinic and every physician in America today covers the shortfall of public-funded health care by cost-shifting. They use the term cost-shifting. They budget cost-shifting. Because as you move towards public health insurance, how are you going to pay for it? How are you going to avoid not having the ability to cost-shift as you shrink that portion of privately-funded health insurance, because that is the direction that it is going to go?

And here is how it works. An employer has 10 employees. He pays $500 a month for each employee to have health care. That is $60,000 a year. If you give him the alternative to push them into Medicaid, like we did with SCHIP, he is going to say I have got a $60,000 break here. So he says to each one of his employees, you know, like you have here, we are going to change the benefit package; you are no longer going to get health care, but you do have

access to it through Medicaid. And he saves $60,000 a year, and it comes to the taxpayers to pick up that cost.

So how are you going to pay for the public health insurance program that your Department is moving forward and the administration is moving forward?

Secretary SEBELIUS. Well, Congressman, I think that the President starts with a principle that he does not support dismantling the system that we have for employer-based health coverage. He recognizes that 180-plus million Americans have coverage they like, have coverage that they want to keep, have a doctor they go to.

Mr. TIAHRT. It is not a point about them keeping the coverage. Excuse me for interrupting, because I am on limited time. It is not like the Governor's Office where you have control of all your time.

Today it is going to be an economic advantage for the employer. The individual won't have a choice. It will be the employer that makes that decision based on pushing cost to us taxpayers, which will be a cost advantage to him.

Secretary SEBELIUS. Well, I would suggest the biggest cost shift that is going on right now is the uninsured Americans who come through the doors of that hospital in Wichita and in Topeka and in Kansas City every day, and those costs are shifted directly onto private employers who are desperately trying to keep their employer coverage.

The system of providing a payment for every American, of having preventive care, of driving wellness care, reduces the kind of cost shift that we have right now, which falls most often on small business owners and small coverage. So as the health plan is being debated and constructed in Congress, I think that having a fair payment system, having shared responsibility and making sure that all Americans have access to more affordable and more effective health care treatment at the front end prevents the kind of cost-shifting that you have just described.

SINGLE-PAYER SYSTEM

Mr. TIAHRT. Health care reform does need to occur. I think we should have a good open debate about whether we use a different alternative rather than just a single-payer system that we are moving towards now. And I am glad that you are open to that debate, and I look forward—

Secretary SEBELIUS. I am. Congressman, I can assure you that I don't support and the President doesn't support a single-payer system. He wants to build on the system that we have, recognizing that 180,000,000 Americans have coverage they like, and they want to keep it. We are trying to determine how to get more effective and affordable coverage for everyone else.

Mr. TIAHRT. Thank you, Mr. Chairman.

Mr. OBEY. Ms. DeLauro.

Ms. DELAURO. Thank you very much, Mr. Chairman.

And welcome, Madam Secretary. What a delight to have you here today, knowing of your interest in health care and also your record as a Governor.

I want to say a particular thank you. We have had a chance to work together with regard to what was happening in rural America

and your focus in that area, but also in this job as how in fact, with your leadership and the President's leadership, we will be able to provide affordable health care for every American. It has been a long time in coming. And we didn't succeed in 1993, and the problems have only gotten worst. We cannot fail this time around. And I believe the President believes that, as do you.

I want to first associate myself with the comment on health care that the chairman pointed out. I am a very strong proponent of a public plan as part of the options that we provide to people today, that it helps us to level the playing field, and it does provide real choice there.

I would also would remark on the issue of this committee, and on a bipartisan basis, I think what we have tried to do is to not pick and choose the various diseases or illnesses that are focused at the NIH and our other research institutes so that, while, and I, too, have a personal interest in cancer as a survivor, but the, if you will, earmarking of autism and of cancer, I think we are best if we are not picking and choosing.

EARLY CHILDHOOD AND HEALTH CARE

I am going to go to another question, and hopefully in a second round I will come back to health care. But I wanted to just briefly talk about early childhood and Head Start if I might. And the recovery program did provide funding for Head Start as part of a safety net, but the dollars, as you know, don't increase the base funding for the program. The Recovery Act also provided resources for child care and development block grant, but again it isn't a part of, really, the 2010 budget which only included a slight increase for the block grant program. And what I wanted to do is to check in with you about your plans for working to ensure that the increased Recovery Act funding is sustained in 2011 and beyond with regard to early childhood and health care and how in fact you plan to work with the Secretary of Education, Secretary Duncan, to look at the coordination of services for children who are under 5.

Secretary SEBELIUS. Well, thank you, Congresswoman.

As you just said, the 2010 budget does include an increase in funding for Head Start and early Head Start that would start with a platform that was put in place by the enormous investment of the Recovery Act money. And I think that is so essential. I have had the opportunity to do a lot of work in early childhood education, and I take very seriously the notion that this is probably the best single investment we could make in America. The research on brain development is pretty clear that between birth and 3-years-old, particularly, is an enormous growth period.

Secretary Duncan and I have already had several preliminary conversations. In fact, I had the first one, when I was still governor of Kansas and he was already the Secretary, about how the work we were doing in Kansas could be expanded with some early education money. And I have circled back around now as the new Secretary to talk about ways that we can have a very collaborative and coordinated strategy.

I think it is important to have all the early childhood providers at the table to have a mutual goal about where this money is best directed, based on science- and evidence-based research, and also

to recognize that all children don't thrive in identical programs, that we need a variety of programs for parents and children to succeed. So I can assure you those conversations are very much under way, and it is a passion that both of us share.

Ms. DELAURO. The $300,000,000 Early Learning Challenge Grants, do you have any thought as to how that is going to be implemented with regard to States and how we are going to look at that?

Secretary SEBELIUS. Again, those conversations are just under way. But I think that what is important is to set up some kind of a platform for a program that is based on what we know works in the long run, what gets children ready to go to school.

We did an alarming study in Kansas a couple of years ago conducted by the Board of Education that found that about 50 percent of the 5-year-olds who hit kindergarten were not ready for kindergarten for a variety of reasons. And so early childhood education needs to target school readiness and close that learning gap so kids are ready to learn when they hit kindergarten.

Ms. DELAURO. Thank you.

Thank you, Mr. Chairman.

Mr. OBEY. Mr. Lewis.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Once again, welcome, Madam Secretary. It is a pleasure to be with you.

Secretary SEBELIUS. Thank you.

HEALTHCARE REFORM, H1N1 FLU FUNDING AND PROJECT BIOSHIELD

Mr. LEWIS. The last time we had a mutual review of the Nation's health care system and raised questions and discussed what the Federal Government might be doing about it was when Secretary of State Hillary Clinton was then associated with the President of the United States William Clinton, and he formed a commission that she headed. And they spent considerable time and energy reviewing where we should go with our health care system.

Once the product was developed itself I think many a message was sent to the Congress that we would be well served by reflecting upon, or that package hung out there long enough that essentially the people got a chance to understand what was in it, and they didn't want it very much. And they sent messages back to us that were very clear and rather direct. They said first that which the chairman suggested, and I believe your statement suggested, that people want first to be able to keep what they have. And then above and beyond that they want to ensure that they maintain choice as we go forward with such a package.

I do not know what a government single-payer system might lead us to. But a lot could be learned by also not just looking at the Hillary Clinton Commission, but some of that which John Maynard Keynes may have taught us about what socialized processes deliver in the final analysis. All of that will be a part of the discussion that is ahead of us. It will be a healthy one and an important one. The Chairman and I have spent some energy attempting to figure out what we do with a thing called pandemic flu.

I want to commend the Department for taking on H1N1 virus seriously and going forward with a program that will attempt to

make sure that we are ready and that we benefit from that which we have learned so far as a result of work by people like Julie Gerberding and the like. I note that within your budget there is a request that includes $354,000,000 for public health and social service emergency funds.

At the same time, I am concerned that there are plans to move bioshield money for flu vaccine production. Within that mix, it is awfully important that we make sure we are not stealing from Peter to pay Paul, that we have enough money to ensure that we are protecting the public and our country from difficulties with bioshield chemical, biological, radiological problems, et cetera. Could you tell me what your thinking is presently regarding that funding and if you agree that there are conflicts that could lead to funding difficulty?

Secretary SEBELIUS. Well, Congressman, I don't think that there is any question that the investment made over the past 5 years by this Congress and the previous administration in preparation and planning and beginning to work on the new vaccines that potentially are needed for a variety of deadly diseases have been critically important. And I know this committee and Chairman Obey and others have been in a real leadership role on pushing that ahead. I think that as a governor I was able to see some of the results of that because we were able to do planning and put a pandemic plan together, do cross-State preparation, involve private industry, and do a whole series of initiatives to prepare for an outbreak, which would not have been possible with only State funds.

So I have seen it both at the Federal level, but also experienced what those investments have done. I know that currently we are in the process of evaluating steps forward with H1N1, and at the same time recognizing that we need to keep the planning stages in place with BioShield for whatever eventuality might hit next. So I think that the budget and the administration's request for supplemental funding to deal specifically with H1N1 reflects a notion that safety and security are first. We know what is facing us right now with a whole series of uncertainties with H1N1. We know we have a new virus, and we know we have a need to take a look at the potential vaccine program. But we also know that there are a series of other outbreak potentials and terrorist acts that still are looming and we need to do both simultaneously. That is what is reflected in the budget before you and in the supplemental request.

NIH FUNDING

Mr. LEWIS. Mr. Chairman, could I just proceed with one more question?

Mr. OBEY. Sure.

Mr. LEWIS. Thank you, Mr. Chairman.

I can't help but be concerned about the fact that we have within the stimulus package increased NIH funding significantly, like a $10,000,000,000 adjustment in that baseline. As we go forward, I know that your Department is making a request, it is a pretty modest request, of 1.3 percent, I believe, in the projected year ahead of us. There is kind of a cliff out there that involves the $10,000,000,000, and it is bound to create pressures and a shift in priorities, et cetera. I would appreciate your letting the committee

know what your thinking is and how you are going to deal with that very real $10,000,000,000 problem.

Secretary SEBELIUS. Well, Congressman, I would love to tell you I know what the request will be in 2011. I am aware that there is a significant investment in the Recovery Act, which I think is very appropriate and will pay enormous dividends. And I can assure you that we are going to begin to work and look forward to working with this committee and the committees in the Senate side about the future, about a multi-year planning strategy. Because I think that everyone is aware that there has been a significant investment, it is basically out there. But the worst of all worlds is to, I think, key up a number of new initiatives and then take a huge step back. So, I do look forward to your ideas and suggestions and working with you as we look at the out years.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. OBEY. Mr. Jackson.

Mr. JACKSON. Thank you, Mr. Chairman. Let me first begin by welcoming the Secretary to our subcommittee and thanking her for her testimony.

I also want to associate myself with Chairman Obey and other members who have spoken on the question of specific earmarks for health-related diseases in this bill. Every member of this subcommittee has a personal story to tell, every member of the subcommittee has a case to be made for their constituents that drove us to seek an appointment to the subcommittee in the first place from cancer to mental health to meditation and other forms of health related practices that could improve the Nation's health. And there is a constant battle on this committee for the years that I have been on it to try and find the appropriate necessary resources to address each of our individual and collective concerns.

HEALTH DISPARITIES

One of my central projects since I have been on the subcommittee has been addressing issues of health disparities. When I first got appointed to the subcommittee, then-Chairman Porter of the subcommittee, while I was trying to advance what I thought would close profound gaps that exist in our society insisted on good science.

And he said, Congressman, as much as I want to be supportive it needs to be driven by good science. So I put language in an appropriations bill many years ago to address ethnic and racial health disparities. And the language charged the top scientists, doctors, and Nobel Laureates around the country at the Institutes of Medicine to come up with an approach, a scientific approach that would justify spending on this committee for addressing some of the profound gaps that exist in treatment. The scientists named the report, "Unequal Treatment." And for as long as I have been on the committee since the report was released, this committee has basically essentially attempted to follow the path, the roadmap laid out by these scientists in terms of the appropriations requests that we make to close these gaps.

Madam Secretary, as you know, many of us on the subcommittee have made it a point to prioritize reducing health disparities through a variety of programs at HHS. At the Office of Minority

Health and at the National Center of Minority Health and Health Disparities, we further focus on reducing health disparities by supporting many of these programs that contribute to diversity in the health care workforce. If you could, and I do understand that the budget lays out specifically another $354,000,000 for combatting these issues, could you lay out for us your thoughts, and over time we will get to even more specific, your thoughts on how the Department will approach the issues of health disparities?

Thank you, Mr. Chairman.

And thank you, Madam Secretary.

Secretary SEBELIUS. Well, thank you, Congressman.

And again, thank you for your leadership on that critical issue of health disparities. I know you have been working on it for a long time, and the work has paid off to some degree, but there is a lot more work to be done.

In my first week as Secretary, we released this year's report on health disparities, which continues to be pretty grim in terms of the appropriate treatment really by ethnicity is very disparate around the country. And I think that one effort that can be enhanced is just the transparency about what is going on. I don't think there is any question that the debate that is currently under way about health reform will have an impact on health disparities, because, unfortunately, what we know is that, by income and by minority group, the likelihood of individuals lacking insurance or being under insured is a predominant case.

And I think having an opportunity for a health home and an ongoing treatment protocol for every American is a step in the right direction. Certainly some of the steps to address also include workforce issues, not one that we necessarily automatically think as part of health disparities. There is some investment in the workforce money that looks particularly for minority students and combines that with underserved areas, because I think cultural competency is an issue with health care delivery. And whether or not folks feel comfortable about seeking out health information and follow it is often due to whether or not they feel a relationship with the health provider.

So, in addition to the funding that you have just cited for specific programs, I think there is another range of investments on workforce issues, on health reform, that will also help close the gap of disparities that we continue to see.

MANDATORY INSURANCE

Mr. JACKSON. Thank you, Madam Secretary.

Thank you, Mr. Chairman.

Mr. OBEY. Mr. Alexander.

Mr. ALEXANDER. Madam Secretary, welcome.

Secretary SEBELIUS. Thank you.

Mr. ALEXANDER. I have spent a great deal of my time last week traveling around the State of Louisiana. We had several health care summits, if you will. We had panelists made up of physicians, nurses, health care providers, nursing home owners and so forth.

They are afraid. They are scared about what lies ahead. I represent the ninth poorest congressional district in the Nation; I am told one of the unhealthiest in the Nation.

My question is, in Louisiana, we have had a successful SCHIP program. We call it LaCHIP program in Louisiana. I voted against the expansion of SCHIP simply because we have not met all the needs in Louisiana yet, although it has been an effective program compared to other studies.

I don't know if it is apathy or lack of knowledge about where people can sign up, but the question is, how now, as we look at the potential of compulsory insurance, what happens? How do we make it work? In Louisiana, we still have 100,000 children who are eligible for SCHIP or LaCHIP that are not signed up. So how do we encourage, how do we engage people to care and go sign up? And what happens if—do we turn them away at hospitals, emergency rooms because they don't have insurance of their own? What happens? How does it work?

Secretary SEBELIUS. Congressman, that is a great question. I think that one of my interests in the CHIP program is certainly taking some of the best practices in enrollment and trying to assist in spreading those throughout the country, because there are States that have done pretty creative work and had great success in enrollment and others that have not. And I think that one of the key building blocks for health reform is actually getting folks to enroll and engage in programs that they are currently eligible for and providing the coverage that Congress and the administration have seen as a high priority.

So outreach strategies, assisting with everything from presumptive enrollment to simplifying enrollment forms are important. Unfortunately, some States still, rather than relying on fairly easy technology, are relying on face-to-face visits, which often are complicated for families that are working and juggling opportunities. So I think there are a bunch of strategies that we can engage in in the Departments of Medicare and Medicaid to make it easier and more seamless for families to actually enroll their children in programs that they qualify for.

But I think as we move forward, having discussion and debate about everything from auto enrollment—which is, I know, one of the strategies that some Members of Congress are taking a look at—to presumptive enrollment, to how you make it easier for people who are eager to find affordable health coverage, to actually sign up and become engaged, is one of the discussions that are under way with the committees that are looking at this. Because the last thing we want is to make affordable health care have another huge barrier and that be some enrollment that becomes terribly complicated and sets up its own restrictions along the way.

We know what has worked in many areas. We know what has worked for employer care and for other care, and I think we can take those lessons learned and help spread that information as we move forward.

Mr. ALEXANDER. Thank you.

Mr. OBEY. Ms. Lee.

HEALTH DISPARITIES, SINGLE-PAYER SYSTEM AND SEX EDUCATION

Ms. LEE. Thank you very much, Mr. Chairman.

Hello, Madam Secretary; good to see you. And congratulations. I look forward to working with you, and I will just say how delighted I am that you are there in this very, very critical position.

I want to follow up on Congressman Jesse Jackson's point, first of all, with regard to health care disparities. As Chair of the Congressional Black Caucus, along with, of course, Congressman Mike Honda as Chair of the Asian Pacific American Caucus and Congresswoman Velázquez who chairs the Hispanic Caucus, we are working on a health care disparities bill, closing the disparities, and you know the problems. You have acknowledged it.

But I am wondering, in this overall health care debate now that is taking place, we don't hear much in the debate about this being a critical element of the health care reform package, whatever package may come out.

So I want to raise that with you, because I have raised this with the White House several times. And just know that in this debate, this has got to be front and center for many of us, because our communities, of course, are the ones who are, you know, the unfortunate, you know, beneficiaries, the terrible beneficiaries of these disparities.

Secondly, with regard to single payer, I know the realities of single payer as it relates to what ultimately will be the type of health care package that we come up with, but I hope that single payer is on the table for discussion. I don't think we need a health care reform debate without looking at all of the options that exist, and so single payer is an option that needs to be considered on the table as part of our efforts.

Thirdly, I just want to commend you and the President for your proposing to end the ineffective and discredited abstinence-only education programs. For many years now, Senator Lautenberg and myself have worked on legislation, H.R. 1551, the Responsible Education About Life Act, that allows for States—it is very simple—that allows for the States to use Federal money if they want to teach comprehensive sex education. It is abstinence and abstinence-plus. So I hope you will look at that. But I want to commend you and the President for that.

Finally, let me just say on behalf of Congresswoman Roybal-Allard, who comes from California—southern California; I am northern California—she was detained in her district until this morning. Unfortunately, she couldn't be back in time, but she wanted you to know she would be submitting questions for the record and to extend her welcome to you, Madam Secretary.

Secretary SEBELIUS. Thank you so much. I think that the health reform debate and discussion is firmly, here at the Capitol, under way in both the House and the Senate—three committees in the House and two committees in the Senate—and lots of you have been intimately involved. So whether it is single payer or health disparities, that information that you have the expertise about and the data that you know so well needs to be part of the discussion as the bills move forward. And I think that is not only very appropriate, but very important, that the options be looked at.

As you know, the President laid out some principles that he believed in with health care moving forward, and he felt very strongly that we needed to build on the current system and not dismantle

employer-based health coverage. But I know there are a number of strong advocates for the single-payer system, particularly here in the House, and I assume that will be part of the options that you look at as you move along.

Ms. LEE. Thank you. Let me just ask, make a point with regard to that though.

Yes, we are going to make sure that here in the House that is laid on the table and that is included as part of the debate, single payer and health care disparities. But I hope we hear from the administration the importance of not letting that slide, because sometimes, you know, we follow in many ways what the administration is laying out in terms of the general parameters.

Finally, the HIV–AIDS travel ban. I know HHS sent over a proposed rule, but it has taken a long time. Do you have an idea of when we are going to be able to finally lift the ban as it relates to HIV-positive people coming into the United States?

Secretary SEBELIUS. My understanding is that issue is very much on the radar screen, and it should be soon.

Ms. LEE. Thank you very much, Madam Secretary.

And thank you, Mr. Chairman.

Mr. OBEY. Mr. Cole.

NIH FUNDING AND HEALTH CARE REFORM

Mr. COLE. Thank you, Mr. Chairman.

And, Madam Secretary, it is great to have you here. I just want to quickly associate myself with probably the common bipartisan sentiment here about directing money towards specific diseases. If I was drawing on personal examples, I would talk about Alzheimer's and MS in my family. If I was looking at my district, I would talk about diabetes for the Native American population and what that does for the cost. So once we go down this slope, we would have a lot of arguments here that would be well-intentioned, but probably not productive for us; and I don't see how you open the door for two and not open it up for all.

Let me ask you specifically—I think I know the answer, but I want to make sure—is the President's position on health care now that it would be mandatory that everybody participate?

That is somewhat of a shift from the campaign. So has he made that decision yet?

Secretary SEBELIUS. He has not, Congressman. As you know, in the campaign he supported a mandate with regard to parents with children. He did not support an individual mandate. I think what he has said pretty consistently, though, is he is open to engaging in that conversation with Congress. He knows that a number of Members of Congress are very committed to an individual mandate, as have been some of the stakeholders at the table. But at this point, he has not made that part of his proposal.

Mr. COLE. That, as I am sure you know, is a concern simply because, while we use a lot of numbers about the uninsured population, there is always a subset, 25 percent to one-third or whatever, that really could afford insurance, but choose not to. So that is going to be a discussion we have.

The second question, because the single payer or government plan option is a big impediment for a lot of us, and I think it actu-

ally makes a bipartisan compromise much more difficult: Have you thought about anything modeled after something like Medicare Part D, which actually has worked pretty well? It came in at a lot less than estimated in terms of the cost. It has a high satisfaction rate. The premiums are comparatively low, lower than we estimated, CBO estimated at the time. It is an all-private system, but obviously has a government framework to operate in.

While it was a matter of a great deal of contention when we dealt with it, it has been interesting to me that almost nobody has wanted to go back and undo it. It has actually worked pretty well without a government plan as an option.

Secretary SEBELIUS. Well, Congressman, I certainly think that is one of the recent examples of a benefit package that was put on the table.

I would suggest, though, that it is not accurate to describe the public option, which would be part of the health exchange, as a single-payer plan. I don't think that is an accurate description.

What is envisioned is a health exchange where private plans side-by-side compete with public plans, and as they do now in many States in the country in State employee health plans, and as they do in many States in the country with the children's insurance program. Absent a public option, in many parts of the country you would not have choice and you would not have competition because one private insurer essentially has a monopoly over the marketplace.

So, again, in my insurance commissioner days, you can easily design an actuarially level playing field where it really is a competitive goal. And, frankly, I think that having a plan that has potentially miserable benefits and low provider rates is not likely to attract many Americans to choose that plan if they have a choice of another plan.

The notion of a public plan is to have a health exchange, where you provide choice and competition—to me, two great driving features—and give a number of Americans, who right now don't have a choice and there is nobody to compete with, some cost competition.

Mr. COLE. I would just suggest a lot of us share Mr. Tiahrt's concern that that is going to lead us toward a lot of private employers pulling out and effectively shifting.

I have got very limited time. Let me ask you one last question here.

You and the chairman in a dialogue, and I think appropriately so, expressed concerns about long-term care. It is obviously a huge problem for the country in terms of how you fund it. There are a lot of folks obviously that clearly start moving assets early.

Have you thought about or are considering any kind of expansion of health care savings accounts, again with the idea that over a lifetime you can build up a certain amount of capital and use that to defray long-term health care costs? I am not saying it is a solution for everybody, but the more people you pull out of the system that way or allow them to operate that way, the less public cost you might have.

Secretary SEBELIUS. I have not been engaged in that particular discussion. I was engaged over a number of years, and I know it

has been a proposal before Congress for years, that looked at everything from tax credits to incentives for individuals to do more purchasing of private long-term care policies. I think the balance always was that a number of the private long-term care policies did not include very robust consumer protections, and in fact many of them had cost escalators that had people paying in for a decade and then the policy became so expensive that they dropped it and ended up with nothing.

But we need to look at a variety of strategies, because as you well know, if you end up meeting the income guidelines, then you become eligible for long-term care benefits at basically the State level, and if you don't meet the income guidelines, Medicare does not provide those benefits. So we really do have a significant disparity right now.

Mr. COLE. Thank you, Mr. Chairman.

Mr. OBEY. Mr. Moran.

INTEGRATION OF SERVICES

Mr. MORAN. Thank you, Mr. Chairman.

Welcome aboard, Madam Secretary. I know you are going to make us all very proud.

The Department of which you are Secretary used to be called the Department of Health, Education and Welfare. When it was set up in the early 1950s in the Eisenhower administration, the idea was to address the whole panoply of needs of the individual. And they didn't use the term "holistic" in those days, but that is really what they meant.

We haven't achieved that objective. I think in large part the Congress is as much to fault as anyone, because as the chairman suggested, we identify particular needs, fund them, and as a result, we have this vast array of different programs: different people and programs to deal with education; others deal with health; others deal with human services; others deal with nutrition, et cetera, et cetera, all of the various needs of the individual. The problem is, it is the same individual.

If we really wanted to achieve the most savings, but even more importantly, perhaps most effectively, address the needs of that single person, we would start combining and finding overlapping jurisdictions and find ways that we could better integrate the services that we are trying to offer. Your budget alone, even after we take out education, there have got to be hundreds of programs, and some individuals are eligible for half of them.

One of the things that has been done around the country, for example, is to set up school-based health clinics. I know we had some opposition when I did that as mayor of Alexandria, Virginia, but once it was set up, we reduced the level of teenage pregnancy and, thus, abortions. We found any number of cases of cancer in adolescents who wouldn't have had a checkup and identified at an early stage, mental health problems, et cetera; and we achieved the kind of coordination-collaboration that I think best serves the individual.

Now, I am wondering how you feel about those kinds of efforts, of achieving more overlapping, more integration of all those hundreds—myriads of services that you are responsible for?

Secretary SEBELIUS. Congressman, you make a great point that all too often the same family may have people coming at them from 14 or 15 different angles, and only four or five hit the mark; and as we just talked about, enrollment strategies often fail. So I am a huge fan and believer in a systemic and collaborative approach.

In my brief tenure in this position, I know the President also shares those concerns and has implored Cabinet members to come together on strategies, leveraging assets and opportunities in departments. We have had some robust conversations already on childhood obesity and strategies of the Food and Drug Administration.

My first few days in Washington were focused on Cabinet-wide approaches to address H1N1, and it was a great illustration of how various members of the Cabinet and various departments needed to collaborate and cooperate, not just for that emergency, but on a regular basis.

So I look forward to not only figuring out within our own agency how to break down some of those silos and put people at the table on cross-cutting issues, but also to do that with colleagues in Cabinet agencies. Because often all of us are approaching the same problem, but through different lenses; taxpayer dollars will go much further, and programs will be much more beneficial if we can approach them holistically.

FINANCING HEALTH CARE REFORM

Mr. MORAN. Thank you very much, Madam Secretary.

Madam Secretary, the President requested over $600 billion as sort of a set-aside, seed money for the health reform proposal, although half of that was dependent upon generating revenue by reducing the tax deductibility of charitable contributions. It looks like the Senate has rejected that; so we are probably at about $300 billion in terms of revenue that would pay for health insurance overhaul, and yet the cost over 10 years is $1.2 trillion. I should have said the $600 billion was over a 10-year period. The cost is $1.2 trillion over a 10-year period, most people assume. So we are really short about $90 billion a year, $900 billion over the decade.

Are there other ideas that the administration may propose to Ways and Means and Finance particularly as to means of financing this gap, or are you anticipating any modification of the original goals?

Secretary SEBELIUS. Well, Congressman, that discussion is very much under way. I would suggest that the President hasn't retreated from his initial proposals, even on the revenue side, and I find that as Members engage in the work of trying to identify where money is available, the proposals are likely to be back on the table for starters.

Our agency has been asked, as have other agencies, to identify additional opportunities, and we are in the process of doing that right now within the Department of Health and Human Services. I also think that there are opportunities for various savings that haven't been scored; whether or not they will end up being scored remains to be seen, but prevention and wellness, at least in the outyears, may have significant payoffs.

We are now spending 75 percent of our health costs on chronic disease, and some efforts to better manage, better control, and improve outcomes with chronic disease management have significant payoffs down the road. So we are currently working on that.

There is also a great belief that the investment in health technology will pay huge dividends, not just in helping to drive appropriate protocol, but in lowering medical errors, again not quite in the system yet.

So there is some work to be done in terms of identifying, some of those outyear savings that most people agree are very much there, but just haven't been part of the discussion yet.

Mr. MORAN. Thank you, Secretary Sebelius.

Thank you, Mr. Chairman.

Mr. OBEY. Mrs. Lowey.

ENDING VIOLENCE AGAINST ABORTION PROVIDERS AND HEALTH CARE REFORM

Mrs. LOWEY. Thank you, Mr. Chairman.

I join my colleagues in welcoming you, Madam Secretary.

Madam Secretary, many of us were shocked and saddened by the horrific murder of Dr. George Tiller over the weekend. For years, the Bush administration went out of its way to protect doctors from being forced to provide services they found objectionable, yet did nothing to shield physicians providing legal and life-protecting medical care to women from ongoing harassment, threats and violence. This is unconscionable and must change. In my judgment, the Federal Government must send a message that acts of violence against health care providers will not be tolerated.

I was pleased to learn that Attorney General Holder has indicated that the U.S. Marshal Service will begin protecting certain abortion clinics and doctors, and this is a good first step. Today, the New York Times also called on Attorney General Holder to revitalize the National Task Force on Violence against health care providers that was originally established in the 1990s.

Now, I realize this task force would be under the jurisdiction of the Department of Justice, not HHS. I want to know, number one, would you support its revitalization and how does HHS intend to work with the Department of Justice to ensure that these acts of violence are eliminated? And do you agree that this type of violence could discourage medical schools from teaching doctors how to perform abortions, and how will HHS work with medical schools and provider organizations to ensure that this procedure is being taught?

Secretary SEBELIUS. Well, Congresswoman, I share your interest in making sure that health services are delivered within the law and that providers are protected. The Attorney General was quick to reach out and make it very clear that acts of violence would not be tolerated, that he would use the assets of the Justice Department to provide protection. He sent a very strong message about acts in the future that would be prosecuted.

I am not familiar with the task force that you have described, but would look forward to working with you, to take a look at it. If it is revived, I think the jurisdiction, as you note, is within the Department of Justice. But certainly having providers be able to

deliver health services to men and women across this country is essential.

Mrs. LOWEY. I thank you.

And following up on another issue, given your experience as the Kansas State Insurance Commissioner, you understand the threat to quality and affordable care posed to the insurance industry when multiple insurance companies merge or have record profits at the expense of health providers and consumers. In fact, from 2001 to 2004, health plans in New York State made more than $5 billion in profits while its hospitals lost $600 million. I think it is interesting that the Westchester County Association, which is run by many the businesses in Westchester County, points this out in many of their discussions and sessions with us.

So, first of all, do you agree that the relationship between private payers and the financial viability of the health care system needs to be examined? And if you could share with us your experiences battling the insurance industry in Kansas and how that impacted consumers, I would like to know if there are lessons from this experience that can be applied across the country and included in health care reform legislation.

Secretary SEBELIUS. Well, Congresswoman, I share your concern about oversight, and my colleagues who are serving as insurance commissioners across the country have jurisdiction to review everything from loss ratios to appropriate rate-setting. Some are aggressive and others, frankly, have very little choice because often there is a dominant carrier and a single provider, so the opportunity to have regulatory oversight is fairly limited.

When I was commissioner in Kansas we had a situation of a proposed takeover of the Blue Cross-Blue Shield Plan of Kansas by an out-of-state company, and I ended up ruling against that takeover ultimately because after reviewing all the testimony, after having a series of hearings, after having providers and hospitals come before us, it became clear that the only way to produce the profit statements to the shareholders, which the company had promised, was either to reduce benefits or to reduce payments to providers, all of which would not have been good for Kansas consumers.

So I do think there is an appropriate oversight role. It is certainly one that is in the proposal of the public plan. It is the President's goal and Congressional Members' goal that either regulatory oversight or competition within a marketplace work very well, and those things are part of the goal of the public plan option.

Mr. OBEY. Mrs. McCollum.

Mrs. MCCOLLUM. Thank you.

Madam Secretary, it is truly a pleasure to have you before the committee today. The Department of Health and Human Services has a full plate, and I am very grateful for your commitment and your team at HHS to work to reform health care and meet the needs for the services upon which millions of Americans depend. You have a big job, and I know you will do it well.

As you know, as Congresswoman Lowey pointed out, on Saturday an assassination took place in your home State of Kansas. A physician was murdered. It was an act of terrorism, and it was in his church. This act of an anti-abortionist vigilantism inspires fear and terror for not only health care providers, but for women who need

those services. The murdered doctor had previously been shot, and the clinic in which he had worked had previously been bombed.

Abortion in this Nation is a legal health care procedure, and I support a woman's right to make her own health care choices. The work of the courageous health care providers meet women's needs daily, and they should do so without fearing loss of life.

What America witnessed on Sunday was a Taliban-like tactic to prevent abortions by murdering a doctor. This is terrorism, and I hope this administration, as you have pointed out, will continue to extend protection to women's clinics all across this country. I know that Planned Parenthood in Minnesota—there was an article in the paper—has been targeted in the past, and they have received protection.

Thank you so much, and the women in the area that receive those services also thank you and thank Mr. Holder.

Madam Secretary, I support comprehensive sex education based on science. Comprehensive family planning and reproductive health care for all women and counseling to ensure women of all ages have the best information to make good choices about when they decide to have their children, that is how we reduce abortions and that is how we empower individuals to prevent the need for abortions.

So, I want to thank you so much for your commitment in the 2010 budget to provide women of all ages comprehensive information and reproductive health services. Thank you, and you can count on my support to do everything to get that passed.

HEALTH CARE FOR CHILDREN

But I do have a question. As we take on the challenges of health reform, I firmly believe that every American has the right to health care, and this should be especially true for every single one of our children. As we reform our health care system, we need to remember that no population stands to gain more from national health care reform than our children. Children insured by Medicaid and CHIP are covered under 50 different State programs and the D.C. to account for 51 different programs. A child's access to health care coverage and health care should not vary by location in this country.

So, the question is, how does the Federal Government ensure that its most important investment, the investment in the health of its children, be standardized in terms of uniform eligibility, national pediatric benefit set, and access to pediatric specialists for medically necessary care? How can I work with you to make this a reality, Madam Secretary?

Secretary SEBELIUS. Well, Congresswoman, I would love to have a chance to work with you on that critical issue.

As you know, there are some mandated benefits for young children in the Medicaid packages, which all States must follow. But beyond that, you have correctly identified that eligibility rates vary from State to State, particularly for the CHIP program, and vary regarding the very earliest prenatal care. So the likelihood of having reduced low-birth-weight babies and bringing people into the system varies.

This is a huge challenge, and I support—and I know that the President supports—the notion that the system start with the focus on children. I think that is why he was so enthusiastic during the course of the campaign about a mandate applying to families with children; he felt that we need to start universal coverage with children.

So I would look forward to working with you to make sure that all children have access to the benefits you have described.

Mr. OBEY. Mr. Kennedy.

HEALTH CARE REFORM AND OVERSIGHT

Mr. KENNEDY. Thank you, Mr. Chairman.

Welcome. Can I ask you, in terms of health insurance reform, the most basic tenet of health insurance reform is community rating. That means that insurance companies can no longer cherry-pick who they cover based upon who is healthy and who is sick and thereby make their money not by how well they provide the care and manage the care, but rather how good they are at choosing this person versus that person to be in their plan, therefore, excluding the sick people and only covering the healthy people.

Is the administration going to commit itself to community rating as an essential part of any health care reform plan?

Secretary SEBELIUS. I definitely think that the commitment that the President has made consistently is to eliminate the preexisting condition opportunities and to move to a system of affordable coverage for everyone. I haven't seen the specifics around community rating and how wide the bands would be, but certainly that is an essential element of the preexisting condition discussion.

You have accurately described the market as it often exists, where either a health condition eliminates you entirely or at least puts you in an unaffordable category. So either one, I think, would not be part of the health exchange moving forward.

Mr. KENNEDY. That is good to hear.

In terms of the whole issue of insurance oversight, we now know that insurance companies, it is roughly like 30 cents on the dollar for administration, versus Medicare and Medicaid, which is 3 cents on the dollar for administrative oversight. What is this plan going to do to go into and do a forensic audit of these insurance companies to ensure that they are not going to be able to pass along these enormous administrative costs they have embedded in the current administration of their plans that they pass on to the consumers?

This is part of something that I think you already know, being an insurance commissioner, is untenable for us. This is where our saving is going to be, is going after these 30 cents on the dollar that never make their way to health care at the bedside.

Secretary SEBELIUS. That is one of the essential elements of having some competition in the new marketplace. A health insurance exchange would combine private plan options with the public plan option, and they would compete for benefits and for costs; and I think that part of the competition is a way to get to regulatory oversight over the overhead costs.

Thirty cents on the dollar may be high for administrative costs, but I don't think there is any dispute that the figure is somewhere in the 15, 20, 25 range, depending on if you are talking about a

large employer plan or a smaller plan. Not only are those medical dollars not being spent, but the estimate is that most Americans who have private health insurance currently are paying another 10 to 15 cents on the dollar for the cost of those coming through emergency room doors without insurance.

So you get close to 50 cents on the dollar that is not buying a drop of medicine or a doctor's visit or a wellness visit or a treatment, and I think that is why we need competition and why we need choice.

Mr. KENNEDY. Would you not say when we have this new plan that we need to have teeth to enforcing regulatory oversight of the insurance companies, whatever happens?

I think of what happened recently with AIG, and I think if we are going to put out to bid billions and billions of dollars, essentially to manage our dollars in health care for provision of health benefits, what scares me is I see the battle on the Hill between Northrop Grumman and Raytheon for a particular weapons system. I can't imagine the lobbying that is going to go on up here between health care providers when it comes to health care contracts.

So, don't you think it is important that we have really strong oversight at the Department of Justice to make sure that when it comes to these bidding wars for various health contracts, that there is government oversight through the Department of Justice to make sure there are no shenanigans?

Secretary SEBELIUS. I think the appropriate jurisdiction for the Department of Justice is probably any antitrust issues that could come up.

I do think that a regulatory framework makes sense, but I also believe that competition goes a long way to help regulate cost, and that if you have a competitive marketplace, you don't need as heavy a hand in regulatory oversight. For this reason, I am often an enthusiastic supporter of a public option standing side-by-side with private plans, and of letting competition be the determinant of the price and benefit.

Mr. OBEY. Mr. Ryan.

UNPLANNED PREGNANCIES

Mr. RYAN. Thank you, Mr. Chairman.

Thank you, Madam Secretary, who is a Buckeye, I must remind everyone, originally from Ohio, and her father was the Governor of Ohio at one point in the early 1970s.

One issue that has come up a couple of times is the issue of unplanned pregnancies and abortions. The President—and I watched with great interest his speech at Notre Dame, and I thought he articulated not only a framework for our public discourse over the next few decades, but also a way of approaching these controversial issues that we truly want to find some common ground on. And I know Chairman Obey and members of this committee have made a large commitment toward reducing unplanned pregnancies and therefore reducing the need for abortions and supporting pregnant women.

As you know, Chairman Obey in the past has directed significant funds towards this purpose, and Congresswoman DeLauro and I

have been working for a number of years to introduce legislation in the past several Congresses that would help address this issue.

What is the Department doing, going to do, to try to implement President Obama 's initiative and partner with Congresswoman DeLauro and me to reduce the need for abortions?

Secretary SEBELIUS. Well, Congressman, I think it is an enormous challenge that we face and one that is something I have been working on in my home State of Kansas for a number of years. This issue brings together people who have varying views on abortion services and provides some common ground: if we can work to provide a host of services to reduce unintended pregnancies, we therefore reduce, by anybody's count, the number of abortions that are performed in this country. I think this is a goal that all of us could support.

We have a range of services in HHS that work toward that end. It includes comprehensive sex education, which has already been discussed. Affordable, available health care is an important piece of the puzzle. There are adoption incentives that work along the way. Early childhood education, support for women, and a range of programs for women and girls that provide an environment where they have options and choices are all essential to reducing the situations that produce unintended pregnancies.

I was alarmed by the recent CDC study that says we have an increase in teen pregnancies again, after having had a decrease for the last number of years. That is not good news. We know that 40 percent of births right now are to single parents. That is not the hallmark of good news.

So there is a lot of common ground and a lot of work to be done, and I think that a lot of the assets to do that work are in the Department of Health and Human Resources. And I look forward to working with you and Congresswoman DeLauro and others, because I think this is an issue where some real focused, collaborative attention can pay huge dividends in the long run.

STRESS REDUCTION

Mr. RYAN. I appreciate that. And I think Congresswoman DeLauro and I and other members of the committee would like to sit down with you and hash this out.

One other topic I would like to touch upon: I feel like when we have these discussions about health care, there is always an issue that we never really talk about, and that is the issue of stress. A lot of us are seeing it now in our congressional districts because of the economic situation we are dealing with. And the issue of stress leads to, I think—we know—increased illness, and these people who are losing their jobs and losing their health care, it has an effect.

I just want to ask, and we had this conversation a little bit with NIH, the brain research on being able to regulate yourself and regulate your emotions and reduce your level of stress is significant. So when NIH was here, I asked them specifically about doing more and more research on mindfulness, and Congressman Jackson brought up meditation and mindfulness-based stress reduction. They have been studying this for 30 years at the University of Massachusetts and different places across the country.

I just want to know if you are familiar with this, if it is a part of your approach moving forward here, the physiology of stress, the neuroscience behind it. This is a very inexpensive way to teach kids how to increase their level of attention, their attention span, their level of focus, how people who are dealing with the chronic pain you mentioned earlier and how you want that to be a significant savings, how dealing with chronic pain can be treated with this method as well.

So I just wanted to see if you are familiar with this and if there is any approach within the Department to not only increase the research, but increase the programming and the education of this.

Secretary SEBELIUS. I am certainly a bit familiar with it, but not nearly to the extent that you have just outlined. It is a prevention strategy that has the potential of paying huge dividends. I have seen it used as a violence prevention technique with kids in school, in lessons about various kinds of control methodologies.

And you see violence levels rise with, as you say, folks becoming unemployed, and the stress that is related to that. We will have a new leader in the mental health area soon, and certainly this issue overlaps with health reform and with work we are doing with early childhood. I would like an opportunity to continue this discussion. I am not sure what exactly is going on now with stress reduction, but I think it is a wonderful strategy.

Mr. RYAN. I have some information. I would like to get it to you. I don't want to book up your whole calendar, but I would like to sit down and talk to you in detail about this as well.

Mr. OBEY. Mr. Honda.

Mr. RYAN. I am done. I guess so.

Secretary SEBELIUS. But in an unstressful way.

### AIDS FUNDING AND MINORITY HEALTH DISPARITIES

Mr. HONDA. Thank you, Mr. Chairman.

And welcome, Madam Secretary. Let me again focus back on a couple of issues that have been mentioned before, and I mention it because it needs to be mentioned, and when these are not mentioned it doesn't exist. These are the two things: the minority AIDS initiative and the issue of health disparities.

On the minority AIDS initiative, I met with the National Minority AIDS Council a few months ago, and they expressed the initiative funding has not been reaching the grassroots organizations, but was being redirected to other priorities within HHS or being redirected to other priorities, to larger HIV/AIDS organizations that don't focus on minority communities and women, but on the white gay population; and that is not the intention of the MIA.

This year the funding was opened up for competition to for-profit organizations for the first time, and this put a lot of pressures on the community organizations and the local community organizations.

Understanding this, and understanding the possibility of this pressure on the organizations, what thoughts do you have about that process? Are you thinking of changing that, or is it your opinion that it is a fair process, that everybody is on an even playing ground?

And would you also commit to meet with the National Minority AIDS Council so they can also express themselves, for themselves, the way they see the issue? I think that those issues will come with them, and they will be able to express that more fully with you. I hope that you would be able to make some time for them.

The other area is the health disparities, the racial/ethnic health disparities, the Tri-Caucus. And when we say the Tri-Caucus, I want to emphasize also that there is a recognition that there is a stark disparity and that is evident in the tribal reservations, where very few people take time to visit. But it is stark, and I think it is time for this country to take a codel through those tribal areas and look at that and understand what is going on and what is not happening in those areas.

Coming back to the other areas of disparities, where we look at the needs that the communities have, we always talk about the great expenses that are in the area of health, and a lot of times it is because we are not paying attention to the gaps and the disparities in our communities. I think that there needs to be a conscious discussion and attention paid to the issue of disparities that exist in our communities for cultural, social and linguistic reasons; and I think a blueprint on that needs to be put together so that it will always be on people's minds as they discuss the critical issues of health and health care. I was hoping you might have some thoughts about that.

I know you mentioned disparities toward the end of your discussion, but it needs to be said up front very clearly, so that people understand that this is an area that needs to be paid full attention to as we move forward.

Secretary SEBELIUS. Well, Congressman, first of all, on the minority AIDS issue, I would welcome the chance to meet with the council. In preparation for these budget hearings, this change in procedure was brought to my attention, and I must confess I don't know enough about it to tell you if I am going to change it or not change it. But it certainly is on my radar screen, and I intend to go back and take a look at how it operated in the past and why the change was made, and make inquiries.

I think that not only does competition need to be on a level playing field, but that we make sure that we get resources into the hands of folks most likely to reach out to the population needing to be served. I think that is a very appropriate question to ask.

Even though it is not in the jurisdiction of this subcommittee, to your latter point about disparities, the 2010 budget does have a significant request for an increase for Indian Health Services and one that I would suggest is long overdue. We have a great new leader who has been confirmed by the Senate, Yvette Roubideaux, a doctor and Native American who is coming in to lead the Indian Health Services and who has worked in this area for a long time. I think there is a recognition that we haven't lived up to our commitment for appropriate health services to that community for generations. In the whole overview of health disparity, the Native American community has been very much off the radar screen. I think the President recognized as much in his budget request, which calls for a 13 percent increase for the Indian Health Service.

This community is one that I will personally commit to paying a lot of attention to.

As a governor, I worked closely with the tribes in Kansas. The first day I was on the job, I went to the tribal leaders' meeting and told them that I want to stay involved and committed, and I will continue to do that.

Mr. OBEY. The gentleman's time has expired.

What I would like to do is to run a 2-minute round so everybody gets a chance to ask one additional question.

Mr. Tiahrt.

HEALTH CARE REFORM AND PRIVATE INSURANCE OPTIONS

Mr. TIAHRT. Thank you, Mr. Chairman. I will try to confine all my questions here to 2 minutes.

I think we are on a path to single-payer rationed health care, starting with competitive effectiveness, the concept of having a subsidized public insurance company compete with the private sector. I think we will get further down that path. You have heard on this committee that many would prefer a single-payer system.

I would like to see your organization consider some free market competitive methods of approaching the problem. In many States, including Kansas, we require everybody who drives to have car insurance. The result was that we have a fundamental insurance package for automobiles, for car insurance.

We could do the same thing for a basic health care policy that included a certain number of visits to physicians, including hospital days. We can have an annual physical, which I think would be very good, including counseling for a healthy lifestyle, which would probably avoid a lot of costs in the future. We could have an annual dental visit on it, which many people need as well. We could provide tax incentives for everybody to purchase a basic health care policy, and if they couldn't afford it, a voucher—for example, those under the poverty level—where they could go out and shop for it.

It would have a provision that I think would address the need that Mr. Kennedy brought up, a very compassionate man, who knows there are some people who get denied coverage. In the example of auto insurance, we have a high-risk pool where each provider takes a turn at drawing a name from a pool which would cover people who have preexisting conditions.

It is an alternative that would provide competition. It would be lower cost. And if you look, right now health care is about 20 percent of our gross domestic product. If we did privatize or take the privatized portion and move it into the public sector, it would cost at least $1.5 trillion a year. That is almost a 50 percent increase in what our current Federal budget is. I don't think we can afford that in today's economy. So for us to provide an insurance plan that would be competitive would be a good alternative.

Would you consider developing a basic health care policy that could be considered as part of the debate?

Secretary SEBELIUS. Well, Congressman, those policies exist across the country, and in most cases they are not attractive to other employers or employees going to an individual market, which is really the description that you are giving, is not what insurance is about. It is about sharing risk.

People right now are interested in getting in a pool where they are pooling their own health situations with others and driving the market. This has been suggested, I would say, strongly, in the last 8 years. It was the administration's primary suggestion for solving the health crisis—having all Americans move towards individual coverage. Dismantling the employer coverage that we currently have is not something that I support, and I know it is not something that the President supports.

Mr. TIAHRT. Perhaps you misunderstood me. It is not a pool of one, it is a pool of 300 million. It would be a policy that would be applicable to everyone. So I think that is something that I would like you to consider.

Secretary SEBELIUS. If you are talking about a health exchange that you could join as an employer or an individual, that is exactly what is being contemplated, with a benefit package that would be affordable.

Mr. TIAHRT. I will be glad to look at it.

Thank you, Mr. Chairman.

Mr. OBEY. Ms. DeLauro.

Ms. DELAURO. Thank you, Mr. Chairman.

Madam Secretary, just let me make a comment, and I will get the piece of legislation to you. I think my colleague Mr. Kennedy would be interested in this. It is called the Informed Consumer Choices in Health Care Act. Senator Rockefeller endorsed it in the Senate, and Congresswoman Schwartz and myself have introduced it here.

It would provide consumers with a coverage facts label, similar to the nutrition label, which would streamline—it would make it consistent as to what was being offered so people could understand what is being offered.

Secondly, it creates a Federal Office of Health Insurance Oversight to deal with oversight and regulation. Obviously, the States have a major portion of that, but at the Federal level it would be helping to monitor that effort. I would love to get your thoughts, taking a look at conceptually whether or not this is something that can fit in with the health care debate.

## FOOD SAFETY

Let me move quickly to food safety. I know you have had just a little bit of time to settle into the Department, and you do cochair the Food Safety Working Group. I was wondering what you see as clearly the most important goals and objectives. How do you believe we ought to measure its success?

A final comment there is, you know where I stand on the issue of food safety functions and taking them out of the FDA to an agency that has its own commissioner and its own agency. Is this an idea you would be open to considering?

Secretary SEBELIUS. I am enthusiastic about the collaborative work between the Department of Agriculture and HHS on food safety, and certainly appreciate your passion and leadership on this issue over the years.

We have a new commissioner of the Food and Drug Administration, Peggy Hamburg, who has now been confirmed. The deputy is in place.

Redoing the inspections and food safety system is essential. It has got to be a public-private partnership. Whether or not it is a stand-alone agency or in the Food and Drug Administration, I think is almost secondary to what the system needs to examine. I am eager to restore the FDA to its gold standard, which it certainly is a long way from right now.

Ms. DELAURO. Thank you.

Mr. OBEY. Mr. Lewis.

STATE AND COMMUNITY INVOLVEMENT

Mr. LEWIS. Thank you, Mr. Chairman.

Madam Secretary, historically our health insurance programs and systems have been driven by the individual States. New York State law used to dominate this whole arena. Commissioners across the States play a significant role. You had that experience yourself.

You have indicated, by way of your statement for the record, that you intend to begin by building on the system that we have. Doing that, do you see the Federal Government's role being one of cooperatively working with the individual States, trying to react and support their challenges and their solution or do you foresee a more centralized Federal Government system?

Secretary SEBELIUS. I met with my former colleagues the other day; the insurance commissioners were here dealing with this very issue and coming to lobby some of you, I am sure.

I am a strong supporter of the consumer protection role that States play in the health insurance area; I was engaged in that myself, and I saw firsthand the individuals covered by ERISA plans who really had nobody to turn to if those benefits were denied or if the claim wasn't paid or if the company suddenly ceased offering insurance. So I am a strong believer that there is an important consumer protection role, and also an important oversight role the States will continue to play in the future.

Markets are often regional or local, and I think having somebody in that role who understands that and not a cookie-cutter approach that is nationwide makes very good sense. Nothing I have seen being discussed runs counter to that at this point.

Mr. LEWIS. Thank you.

Mr. OBEY. Mr. Jackson.

Mr. JACKSON. Thank you, Mr. Chairman.

Madam Secretary, I have been a longstanding supporter of community health centers because in my district health centers provide access to affordable, high-quality, culturally competent care to medically underserved individuals who might otherwise go without. I know that President Obama is well acquainted with the central role health centers play in health care in Illinois and nationwide. Indeed, the President recently stated, "Health centers, primary care and prevention are at the heart of my plan for an affordable, accessible health care system."

My first question: Do you agree that we must continue growth of this important program as we undertake comprehensive health reform?

Secretary SEBELIUS. Yes, I do.

HIV/AIDS, HEALTH DISPARITIES

Mr. JACKSON. Secondly, the epidemic of HIV and AIDS continues to rage in the African American community. According to the CDC, even though blacks account for about 13 percent of the population, they account for about half, 49 percent, of people who get HIV and AIDS.

I am pleased to note that while CDC's budget continues to prioritize prevention, testing and treatment activities among African Americans, I am concerned that the program entitled "The Heightened National Response to the HIV-AIDS Crisis in the African American Community" has been slow to mobilize to conduct the HIV and AIDS testing activities called for in the initiative.

Madam Secretary, can you please review this situation and see what needs to be done to facilitate this important testing activity?

Secretary SEBELIUS. Yes, I will.

Mr. JACKSON. Thank you.

Thank you, Mr. Chairman.

Mr. OBEY. Mr. Cole.

FINANCING FOR HEALTH CARE REFORM

Mr. COLE. Thank you, Mr. Chairman.

We all agree, whatever our stance is, it is an enormously expensive undertaking for health care if we have a government program. It is expensive for families individually. So I have got two questions.

One, is the administration considering taxing current health care benefits to pay for the expansion of health care? And, second, is the administration considering allowing those who are not in employer-based plans, that are paying for health care currently, or insurance, with after-tax dollars to do it with pretax dollars, to have the same deductibility that people that are covered governmentally or by private companies have?

Secretary SEBELIUS. Congressman, as you know, during at least the course of the campaign, the issue of taxing employer-based health coverage was discussed in a fairly robust fashion. The President opposed then and continues to oppose taxing employer-based health benefits, as he feels that it would dismantle the current system that 180–plus million rely on.

Having said that, he also proposed and continues to support tax credits, particularly for small employers, but for a variety of individual employers who are currently struggling in the marketplace. And he has said he is open to further discussions about the whole taxing issue.

I think there is no question that looking toward the future, there are a variety of ideas on the table in both the House and the Senate. But at this point he feels that providing a tax to all employer benefits would dismantle the market that so many rely on.

Mr. COLE. Thank you. Thank you, Mr. Chairman.

Mr. OBEY. Ms. Lee.

RECOVERY ACT FUNDING: MINORITY OUTREACH, MENTAL HEALTH SERVICES

Ms. LEE. Thank you very much, Madam Secretary. A couple of things with regard to the Recovery Act funding. One is as you know it is very difficult oftentimes for communities of color to access Federal funds for grants. And so I appreciate the diligence and the urgency that HHS has placed in putting these funds forward that we provided in the economic recovery package. But I wanted to see if you had any specific outreach efforts for the African American, Latino, Asian-Pacific American and Native American communities to be able to compete with these funds, and if so, how you are coordinating that?

And also ensuring that minority serving institutions such as Hispanic serving institutions and historically black colleges have the benefit of being able to understand and compete for these funds so that they can certainly access them. And then secondly, I wanted to ask you about mental health services as a part of the economic recovery funding. I know we provided funding for a variety of health care strategies and initiatives, but how does mental health fit into that. And finally, thanks to Congressman Kennedy and others, his father, Senator Kennedy, we do have mental health parity now as the law of the land. And so have we considered that in the allocation of the funding under the Economic Recovery Act?

Secretary SEBELIUS. In the Recovery Act, there is a new stream of funding that is targeted for capacity building of community and not-for-profit organizations that, while not exclusively targeted to minority groups, certainly would be an applicable source of funding to build capacity of the neighborhood resource groups that are often so vital to deliver services. Back to Congressman Jackson's notion, there is also an expansion, as you know, of community health centers, and of the workforce in community health centers, through minority student loan assistance designed to increase the number of health providers.

So there are a series of strategies under that umbrella to target services to appropriate populations. This 2010 budget request also includes an increase request for mental health services, particularly for children. It has a grant proposal to serve 11,000 more children and provide services, to 35,000 additional parents and siblings, something that I know Congressman Kennedy and others have worked on diligently. Expanding those health services is an important feature of this budget request.

Ms. LEE. Thank you.

Mr. OBEY. Mr. Kennedy.

EARLY EDUCATION; MENTAL HEALTH SERVICES

Mr. KENNEDY. Thank you. Madam Secretary, thank you for mentioning that. I think if we could elaborate on the expansion of services for young people mental health needs, could you explain your work with your counterpart, Arne Duncan, about early education and how we could better use the monies that are being appropriated for Head Start early education programs from his point of view and his Department so that the dollars are really used where they are needed the most as opposed to across the board. Because

frankly we need to target the dollars, target them towards children who come from families where there is domestic violence, where there is depression, where a parent is in jail, where there is addiction. We know those are the dollars that are going to go to make the biggest difference as opposed to trying to blanket the whole country with dollars for every child. We would love to do that for every child, but frankly, in the metrics of things, those aren't going to be as successful as if we really target the dollars to where they make the most sense.

If you could respond to that as one point. And then the second point is in terms of the prominence of mental health in the administration and where it will figure in to health care reform. Obviously there has been no appointment yet to the SAMHSA director. But could you comment on the notion of a medical home as a central part of any health care reform, meaning coordination of an integration of services, and mental health being a key part of any medical home that is being adopted under the President's plan for purposes of reimbursement and particularly the ASPR program which reimburses doctors in the white coat community through the ICD codes for their work doing brief screening intervention and treatment for mental health services.

Secretary SEBELIUS. Congressman, I know you have done extraordinary work in this area, and I would look forward to learning more about the identification that you have been able to make of what are the most cost effective strategies and the best practices, because they exist. But I can tell you that there is no question, as we look at overall health costs, that focusing on mental health as a strategy is going to be extraordinarily effective. Depression is often an underlying related link to a number of chronic diseases that we just talked about as being one of the cost drivers and vice versa.

If you suffer from depression, you often are more likely to have some of the conditions which create chronic disease. So there is a partnership there that has to be addressed as we look at ways to reduce not only the 75 percent of health dollars we are spending on chronic disease, but also to produce healthier lifestyles in the long run. The earlier identification of precursors to mental health issues is done in young children. So having a strong link in the early childhood Head Start community with those warning signals of violence potential and high stress households and, as you say, substance abuse households and focus on those children as an early prevention strategy also pays huge dividends down the road.

We have had those discussions with potential SAMHSA directors and are looking for somebody who really understands that this can't be an isolated strategy, a stand-alone or a second or third chapter; it has got to be at the forefront of our dealing with health reform.

Mr. KENNEDY. Thank you very much.

Mr. OBEY. Ms. McCollum.

OVERSIGHT AND MEDICARE REIMBURSEMENT DISPARITIES

Ms. MCCOLLUM. Thank you. And thank you for your comments about Indian health care services. I was just with Ojibwe, the band in Leech Lake, Minnesota and Malax, Minnesota. They are very ex-

cited that there was an increase. They are very happy for the other tribes who have seen their health care facilities being listed in the upgrades. They are anxiously awaiting their opportunity as well, so I know that we will be working with you with that.

And I was with some Pueblos in New Mexico too. In fact, I will get some information to you. I personally was in a hospital that I thought should have been shut down. I was very concerned about the patients who were there, and the patients who were there were concerned about the type of health care they were going to get. One Pueblo had great health care, one moderate and another one was awful. I want to also let you know I am going to be submitting a question for the record on health care technology.

I am concerned about some of the contracts, and I know the chairman was trying to get copies of all the contracts that had been submitted by the administration for providing many health care services, but I am very concerned about a health IT contract that was submitted under a previous administration. I am very supportive of health care but I don't want the fox watching the hen house, and that might be happening. But I would like to just very quickly point out to you that I am very concerned about low cost high quality states like Minnesota. We are doing everything the Medicare program could ask to have done. We are delivering services in a cost effective manner yet we are being hammered. We are losing physicians because of the reimbursement formula.

So I applaud you for making high quality health care long-term sustainability of medical and health care reform a priority. But I urge you, as we move forward, to bring a comprehensive health care reform, I urge you, I can't urge you enough, to carefully craft provisions to avoid having disproportionate impacts on Medicare beneficiaries like States like Minnesota that are doing everything that is asked for them, but at times being paid half, half the amount for States with doctors and facilities that are delivering abysmal outcomes compared to what we are doing.

Secretary SEBELIUS. It probably won't come as a great surprise to you that I just had this conversation with Senator Klobuchar an hour or 2 ago before I came over here, so I am very well aware of that situation. And the last thing we want to do is discourage high quality lower cost services from being delivered. In fact, we want to highlight them, not only as best practices but to drive other systems toward delivering that same kind of care. So whether it is Mayo or others who are at the front of the line, I can assure you we are taking a careful look at how we can make sure that doesn't happen in the future.

Ms. MCCOLLUM. Mr. Chairman, I have some bedtime reading for you on the IT issue.

Mr. OBEY. I will think about it. Mr. Honda.

Mr. HONDA. Thank you, Mr. Chairman. Quick things. You have two great experiences in your background; one is being governor, the other is commissioner of insurance. As us, with the governor's background in your current position, have you thought about having your Department do an internal audit in terms of them asking themselves where are the gaps that we think are there? And perhaps there might be an exercise that can be done administratively where they can do the internal kinds of questioning so that they

can perhaps just by themselves come up with some identifications of gaps in services and disparities. It can be everything from CDC to medical school and things like that.

Second, as commissioner of insurance—I know that there is 50 states and territories. I also know that when I ask the question about antitrust and its role in health costs and other costs in this country, the issue of reimbursements from the Federal Government to the cost of medical services and doctors being able to afford protecting themselves through insurance premiums. What impact would there be if there were antitrust—if we brought the insurance companies under the Federal antitrust laws as the other corporations are.

I could get my answer in writing if you want, but it is still on my mind, these kinds of things. And I am not an expert on these areas but it certainly seems like the insurance companies are players in a lot of these arguments we have about premiums, rising health costs and things like that.

Secretary SEBELIUS. Congressman, I am not quite sure what the system is that you are describing for the future, but I can tell you that oftentimes there is a prohibition that currently exists with companies collaborating in terms of price fixing, having discussions prior to submitting rate proposals on what prices should be. But there are varying degrees of oversight that currently take place in terms of rule submissions and loss ratios. So as we move forward in health insurance and health reform, one of the issues is, can you deliver an insurance package to more Americans at a more affordable rate? And again, I am a believer that not only appropriate oversight is important, but competition is very important. And I have seen that work effectively in marketplace strategies over and over, which, again, is why I think that having some public options side by side with the private plans is the way to keep a competitive marketplace and give consumers and employers the kind of choice they need.

Mr. HONDA. Thank you.

Mr. OBEY. Mr. Tiahrt, did you have one last question before we shut it down?

Mr. TIAHRT. No, thank you.

Mr. OBEY. Madam Secretary, let me simply add my voice to the remarks of Congresswoman McCollum on reimbursement rates. These reimbursement disparities are outrageous in my view. I just hope that people putting this bill together in the end will understand that they would make a big mistake if they would take for granted the support of people from States like Wisconsin and Minnesota if this outrageous disparity in reimbursements is not corrected to a significant degree. Our States feel like we have been taken for suckers for years, and those outrageous disparities are just going to have to shrink significantly if we are going to get a product that everybody can support. With that, I thank you for coming. I am happy to see you where you are. We look forward to working with you and will see you again. The committee is adjourned until 2:00 tomorrow afternoon. Thanks.

RYAN WHITE HIV/AIDS PROGRAM

Mr. Jackson: How do you think we are going to provide the necessary healthcare and medications to all these people by only growing the program by 2.2 percent?

Secretary Sebelius: The Budget proposed for HRSA prioritizes funding for HIV/AIDS medications and supports a comprehensive approach to HIV/AIDS care for the poor and uninsured. Access and adherence to comprehensive antiretroviral medications is a cornerstone of HIV/AIDS treatment and care. Within the overall budget there are targeted increases which will help ensure individuals receive needed care such as: +$10 million (+5%) in for competitive grants to community organizations to provide care and treatment to over 5,000 patients; +$4 million (+12%) to AIDS Education Training Centers to fund a new grant opportunity to provide in-depth, long term training to practicing clinicians; and +$2 million (+15%) to support the oral health needs of approximately 1,400 individuals.

CDC HIV PREVENTION

Mr. Jackson: Can you describe what you and the CDC are doing to reduce the number of new infections and is the amount proposed in the budget adequate to meet the actual needs?

Secretary Sebelius: To reduce the number of new HIV infections, the FY 2010 Budget includes $745 million, +$53 million above FY 2009, to support CDC's domestic HIV/AIDS surveillance and testing, prevention research, capacity building and technical assistance, prevention interventions, and program evaluation and policy development. Specifically, CDC will increase the reach of HIV testing with an emphasis on gay and bisexual men of all races/ethnicities, African Americans, and Hispanics by awarding approximately $27 million to State and local health departments to test 600,000 persons and identify 6,000 new HIV infections per year.

CHRONIC DISEASE PREVENTION PROGRAMS

Mr. Jackson: Will chronic disease prevention be a top priority of this Administration?

Secretary Sebelius: Yes, the FY 2010 Budget supports a variety of chronic disease prevention programs to help ensure a productive, healthy life for all people. The 2010 Budget includes $2.8 billion for CDC key prevention activities, an increase of $72 million above the FY 2009 Omnibus. To reduce the burden of chronic diseases, CDC works to prevent the onset of chronic diseases; to identify early the presence of chronic diseases and associated complications; to reduce progression of the basic chronic condition or associated complications; to improve the care and management of chronic diseases; and to promote healthy behavior choices. The Recovery Act also includes $650 million for HHS innovative prevention activities to decrease the prevalence of chronic

diseases and improve the quality of life of Americans. In addition, the health care reform effort will have a substantial impact on improving disease prevention.

Mr. Jackson: Within the context of discretionary programs in the Labor/HHS appropriations bill, how will this Administration promote chronic disease prevention?

Secretary Sebelius: The FY 2010 Budget supports a range of chronic disease prevention programs throughout HHS. For instance, the FY 2010 President's Budget supports the Preventive Health and Health Services Block Grant in CDC, which gives all States a flexible funding source for prevention programs. For example, the FY 2010 Budget provides additional resources for the Racial and Ethnic Approach to Community Health (REACH) program to fund 12-15 additional communities. The Budget also continues investments in other CDC programs targeted to chronic disease prevention. In addition, HHS is leading a Departmental effort to determine how to most effectively use the $650 million the Recovery Act appropriated to deliver specific, measurable health outcomes that address chronic disease rates. Furthermore, the HRSA budget also supports and funds chronic disease prevention programs including the Patient Navigator Outreach and Chronic Disease Prevention Demonstration Program (PNDP) which provides grants to organizations such as health centers, hospitals, and non-profit groups for the development and operation of patient navigator services to improve health care outcomes for individuals with cancer and/or other chronic diseases, with a specific emphasis on health disparity populations.

Mr. Jackson: What are your thoughts on our current spending on chronic disease prevention -- given that many of the Centers for Disease Control and Prevention's (CDC) chronic disease prevention programs are not funded at levels to support programming in all 50 states? Over the next few years, will this Administration send us budgets that build up these programs to enhance our prevention efforts in all states?

Secretary Sebelius: CDC is committed to researching, developing, and putting into practice evidence based strategies for chronic disease prevention. Through tools such as the Community Guide, that publishes guidance on interventions that work, CDC will continue to focus on policies and programs that work to reduce the burden of chronic disease in the United States.

ABSTINENCE ONLY PROGRAMS

Mr. Jackson: As Secretary, how will you ensure that HHS focuses on programs that are truly comprehensive and address scientific methods of disease prevention for America's youth?

Secretary Sebelius: The FY 2010 President's Budget proposes a new Teen Pregnancy Prevention initiative, which would support a broad range of programs that seek to reduce behaviors associated with both teen pregnancy and HIV/STI infection. Many of the programs that demonstrate strong impacts on reducing teen pregnancy and sexual risk behavior are broader multi-component and youth development programs.

Youth development programs take a comprehensive approach by providing sexual health information in addition to offering opportunities to participate in service learning and other in-school or extra-curricular activities that promote life skills and connections, which may provide the best protection against high-risk sexual behavior. Along with ensuring that models funded are evidence-based, we would plan to develop new procedures to ensure the accuracy of the educational materials used by grantees. While the process has yet to be determined, we will review educational materials for accuracy before they are used and will use public health/medical expertise to do this.

In addition to the newly proposed Teen Pregnancy Prevention Initiative, since 2000, HHS' Healthy People program has specific objectives and goals to increase the proportion of females at risk for unintended pregnancy (and their partners) who use contraception (objective 9-3), increase the proportion of sexually active, unmarried adolescents aged 15 to 17 years who use contraception that both effectively prevents pregnancy and provides barrier protection against disease (objective 9-10) and who receive formal instruction on reproductive health issues (objective 9-11). HHS programs directly or indirectly provide funding to state and local entities to prevent teen pregnancies or HIV/STDs. A variety of programs in the Department have a primary goal of preventing teen pregnancy and HIV/ STD infection. For example, CDC's School Based HIV Prevention and Safe Motherhood programs provide funding to states and local education agencies to implement HIV education. Some of these funds may be used for training and implementation of comprehensive sex education. HHS block grants also support teen pregnancy and HIV/STD prevention services in various states. Finally, HHS funds family planning services to adults and adolescents through a variety of programs including, but not limited to: Title X Family Planning Clinics, Medicaid, the Children's Health Insurance Program (CHIP), and HRSA health centers.

PUBLIC HEALTH WORKFORCE

Mr. Jackson: How do you believe that the cuts in state and local health departments last year will affect public health department's ability to provide services and promote health?

Secretary Sebelius: Effective health action requires an adequately staffed, highly skilled, diverse and interdisciplinary workforce prepared to address health challenges of the 21st Century. States report that ensuring an adequately sized and trained public health workforce has become difficult because of the economic situation facing many State and local governments.

Mr. Jackson: Are there any programs in your budget designed to bolster the public health workforce and restore any of the lost jobs?

Secretary Sebelius: The FY 2010 Budget includes $36 million for CDC's Public Health Workforce and Career Development to support the development of a competent and sustainable public health workforce that is prepared to meet current and emerging health promotion and protection priorities.

In addition, the FY 2010 Budget supports three HRSA programs that aim to increase the public health workforce. First, HRSA's Public Health Traineeship Program funds grants to schools of public health to provide financial support to students pursuing graduate or specialized training in public health. The President's Budget will support approximately 2,700 graduate and postgraduate students. Second, HRSA's Preventive Medicine Residency Program awards grants to support the planning and development of new residency training programs, the maintenance or improvement of existing residency training programs; and to provide financial assistance to residency trainees enrolled in the programs which prepare physicians to become board certified in preventive medicine. The President's Budget will support approximately 44 preventive medicine residents. Finally, HRSA's Dental Public Health Residency Program grants promote the postgraduate education of dentists in public health. Grant funds support efforts to plan and develop new training programs and maintain or improve existing residency training programs and provide financial assistance to residency trainees enrolled in such programs. The President's Budget will support five dental public health grants.

Mr. Jackson: How do you think the federal government can help recruit and train the next generation of public health professionals?

Secretary Sebelius: I agree that the public health workforce is critical in so many areas. The FY 2010 Budget invests in recruitment and training of the next generation of the public health workforce and invests in degree-oriented public health fellowship programs. Programs such as CDC's Epidemiologic Intelligence Service are important to creating the next generation of growth. I look forward to working with you on ideas to keep the pipeline into public health strong.

Mr. Jackson: What are your thoughts on offering scholarships and loan repayment to individuals committed to serving in governmental public health?

Secretary Sebelius: The FY 2010 supports programs in CDC and HRSA to recruit and train individuals committed to serving in governmental public health to ensure that there is an adequate public health workforce.

Mr. Jackson: There is not currently a regular enumeration of the public health workforce to track trends in employment. Will it be a priority of this Administration to collect this data or contract out with an academic institution or organization to collect it?

Secretary Sebelius: Having good, current data on the health workforce shortages is essential to developing meaningful workforce policy. It is particularly important as Congress and the Administration consider health reform and its implications.

Mr. Jackson: In the midst of a pandemic, bioterror incident or other public health emergency, our public health workforce could easily be overwhelmed. What is your opinion of the current capability of our public health workforce to respond to a public health emergency?

Secretary Sebelius: The capacity of the public health workforce to respond to a public health emergency has increased dramatically with the over $5 billion worth of funds sent to State and local public health departments from CDC for bioterrorism, pandemic flu, and public health emergency preparedness. In addition, the FY 2010 Budget includes a $14.5 million increase in the Public Health Emergency Preparedness Cooperative Agreement program managed by CDC. This funding goes to help State and local public health departments strengthen preparedness.

MICROBICIDES TO PREVENT HIV/AIDS

Mr. Jackson: Please outline your vision for microbicide research and development going forward.

Secretary Sebelius: The development of microbicides is a key component of our HIV/AIDS prevention research priorities. The National Institutes of Health leads the U.S. government's efforts, and 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 HIV acquisition and transmission and its prevention. NIH also supports behavioral and social science research on the acceptability and use of microbicides among different populations. The U.S. government effort also utilizes the specific resources and expertise of individual government agencies, academic and industry scientists around the world, professional organizations, national and international foundations and community representatives. Microbicides research must be based on the fundamental understanding of how men and women become infected with HIV and other sexually transmitted diseases. This includes understanding the biological, behavioral, cultural, and social circumstances that may increase risk or prevent acquisition of these infections.

Our goal is to strengthen and maintain an integrated approach to research that leverages U.S. Government and external resources to identify and conduct the important studies required to bring microbicide products through the clinical pipeline to approval by the FDA and ultimately to distribution and acceptance by individuals and communities around the world. Just as the current strategies for the treatment of HIV involve a combination of therapies; our efforts in HIV prevention will also involve a combination of approaches. This will require the development of multiple microbicide products with multiple mechanisms of action to ensure effectiveness and acceptability in individuals and communities where they are critically needed. The research components include microbicide development, clinical evaluation, acceptability, and adherence research.

Mr. Jackson: How would you propose better coordinating these efforts with other key US government entities, like the Agency for International Development and the PEPFAR program, so that the development and deployment of microbicides is prioritized across the US Government, and that HHS's role is clear?

Secretary Sebelius: Mechanisms are in place to coordinate microbicide activities across the U.S. government. The Office of AIDS Research (OAR) in the Office of the Director in the National Institutes of Health is mandated to plan, coordinate, and budget microbicide activities across the NIH. OAR has implemented a number of activities to accomplish that mandate and has used its authorities to make microbicides research one of its highest scientific priorities. The OAR develops an annual Trans-NIH Strategic Plan that includes the scientific agenda, priorities, and opportunities for microbicides research. The Trans-NIH Microbicides Research Coordinating Committee (MRCC) convened by OAR with membership drawn from NIH Institutes and Centers assists OAR in the development of the microbicide plan and fosters information-sharing and trans-NIH coordination, and identifies scientific opportunities and research gaps that may require further investigation. The planning process also includes representatives from CDC, FDA, USAID, as well as representatives from academia, industry, foundations, and the community. All NIH expenditures for microbicide research are coded to the objectives of the plan and tracked by OAR.

The OAR established and convenes a Trans-Governmental Microbicides Coordinating Committee that includes representatives from NIH, FDA, CDC, USAID, and PEPFAR. This coordinating committee serves as a forum for updates on microbicide related activities and an opportunity to exchange ideas, identify scientific opportunities and research gaps that may require further investigation, limit duplicative efforts, and discuss efficient resource utilization.

OAR established a Microbicides Research Working Group (MRWG), an independent panel of non-government experts who meet periodically to provide guidance to OAR, NIH and other government and non-governmental entities that support microbicide research and development in this high-priority area. CDC, FDA, USAID, and PEPFAR are invited to meetings of this working group and to submit topics for consideration.

Mr. Jackson: Would you support an enhanced cross-agency strategic planning effort to avoid duplication of effort and identification of the most promising microbicide candidates for funding?

Secretary Sebelius: The Department of Health and Human Services remains deeply committed to supporting a coordinated effort to discover and develop safe, effective, and acceptable topical microbicides, and to support HIV/AIDS prevention efforts worldwide. As discussed above, significant cross-agency planning and coordination is well established for microbicide research – perhaps more than for any other area of AIDS research.

Each agency of the U.S. government involved in microbicide research has its own mandate, specific responsibility in the process to develop these products, and different methods to evaluate and fund research proposals. The funding of NIH research depends on a rigorous system of peer review. Scientists, physicians, and other experienced individuals in biomedical fields from around the world evaluate the merit of proposed

research and its potential to advance science. Other US government agencies have their own methods to determine funding of research. The participation of relevant government agencies in the NIH planning process can help prevent duplicative efforts in microbicides research and development and enhance resource sharing.

## SUBSTANCE ABUSE TESTING

Mr. Jackson: What is the current status of the regulations regarding substance abuse testing?

Secretary Sebelius: As you are aware, the Department of Health and Human Services (HHS) establishes scientific and technical guidelines for forensic workplace drug testing that are required to be used in testing civilians in Executive Branch Federal agencies and in the industries regulated by the Department of Transportation and the Nuclear Regulatory Commission. These guidelines include standards and ongoing quality assurance programs for the HHS certification of laboratories engaged in drug testing for Federal and federally regulated industries. In November 2008, HHS published revisions to the guidelines in the Federal Register in order to expand and strengthen the existing standards for the drugs tested and methods required that use the best available technology for ensuring the full reliability and accuracy of laboratory-based urine drug tests, and also include collection sites and Medical Review Officer issues. Earlier this month (June 2009), a public meeting of the HHS/SAMHSA chartered Drug Testing Advisory Board was held to address the revisions to the guidelines and establish the timelines for activities, decisions and related documents needed when these revisions become effective in May 2010. HHS is continuing to examine scientific and legal information related to the testing of oral fluid, hair, and sweat, and the use of point of collection devices. Following this examination, HHS anticipates publishing further revisions to the guidelines that will address the use of these alternative forms of testing, with opportunity for public comment.

## OFFICE OF REFUGEE RESETTLEMENT
## U.S. DOMESTIC REFUGEE RESETTLEMENT PROGRAM AND THE ECONOMIC CRISIS

Mr. Jackson: How is ORR planning to respond to the consequences of the economic crisis refugees and other vulnerable populations while they work toward integration and self-sufficiency?

Secretary Sebelius: 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 eight 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 FY 2010 budget request includes $337 million for refugee transitional and medical services, $55 million more than the amount appropriated in FY 2009. ORR will closely monitor arrivals and benefit access, and provide updated cost estimates to Congress as necessary.

Mr. Jackson: How will ORR ensure that the US domestic refugee resettlement program is prepared to serve refugees adequately?

Secretary Sebelius: ORR will continue to work closely with all its partners to assist refugees in attaining economic self-sufficiency while providing needed cash and medical assistance and social services. As noted above, ORR will closely monitor arrivals and benefit access, and provide updated cost estimated to Congress as necessary.

Mr. Jackson: What components of the domestic refugee resettlement program are in greatest need of reform or increased support?

Secretary Sebelius: The domestic refugee resettlement program has successfully assisted refugees in attaining self-sufficiency for more than thirty years. Over that time the needs of refugees have changed and we continue to modify the program to address the changing needs. At the same time, the Administration is keenly interested in examining ways to improve refugee resettlement programs, especially in light of the current economic crisis.

## CHRONIC UNDERFUNDING OF THE U.S. REFUGEE RESETTLEMENT PROGRAM

Mr. Jackson: If ORR is funded at President's request in fiscal year 2010, do you believe those funds will be sufficient to address such acute problems as refugees' homelessness?

Secretary Sebelius: 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.

Mr. Jackson: Can you explain why ORR has had carry over funds and why they have not been used to address urgent needs, increase funding for successful programs such as the Voluntary Agency Matching Grant, or initiate new programs that would facilitate refugees' path to self-sufficiency?

Secretary Sebelius: Recently, ORR has carried over Transitional and Medical Services (TAMS) funds at the end of a fiscal year due to numbers of refugee arrivals that

fall short of the refugee ceiling established by the State Department, on which ORR budget estimates are based. Because TAMS expenditures are directly linked to the number of arrivals, a lower-than-projected number of arrivals lead to carryover funds. It should be noted, however, that the number of refugees is on the rise, and, for the first time since 2001, the number of arrivals in FY 2009 is approaching the refugee ceiling. Carryover funds are used to support the on-going costs of the refugee program.

Mr. Jackson: Do you have plans to produce a report that would analyze refugees' needs in the United States and gaps in ORR's services to refugees? Can you provide such an analysis to this Committee?

Secretary Sebelius: ORR produces an Annual Report to Congress, as required by Section 413 of the Refugee Act of 1980, which describes the various populations served by ORR, the programs that serve them and aspects of their economic adjustment post-arrival in the U.S. ORR has no plans to produce a report beyond the required Annual Report to Congress.

EMERGENCY HOUSING ASSISTANCE

Mr. Jackson: What steps will you take to address the housing needs of resettled refugees and other vulnerable populations served by the Office of Refugee Resettlement to prevent evictions and homelessness for these populations?

Secretary Sebelius: 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.

Mr. Jackson: How are you planning to address the housing needs of refugees that have been in the United States for more than eight months, are not longer receiving cash assistance and have not achieve self-sufficiency?

Secretary Sebelius: 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.

Mr. Jackson: The cash assistance refugees receive is determined by welfare rates in the states they reside in. In almost all cases, 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?

Secretary Sebelius: 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.

Mr. Jackson: 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?

Secretary Sebelius: Refugees can access a variety of homelessness prevention and assistance programs through the U.S. Department of Housing and Urban Development 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.

REFUGEE WOMEN

Mr. Jackson: Are households headed by refugee women eligible to receive any assistance targeted to their special needs?

Secretary Sebelius: Refugee households headed by single women with minor children are eligible for benefits through the TANF program. ORR also has a number of discretionary grant programs that can provide special assistance to refugee women, including the Supplemental Services grant program.

Mr. Jackson: Should the Office of Refugee Resettlement be funded at the level that the President has requested, do you believe ORR will be equipped to offer adequate support to resettled women heads of households and other vulnerable refugees?

Secretary Sebelius: 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 eight 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 FY 2010 budget request includes $337 million for refugee transitional and medical services, $55 million more than the amount appropriated in FY 2009. ORR will closely monitor arrivals and benefit access, and provide updated cost estimates to Congress as necessary.

INTEGRATION AND SUPPORT TO PROFESSIONAL REFUGEES

Mr. Jackson: Has ORR made any estimate of the economic impact on the United States of refugee skill underutilization?

Secretary Sebelius: The ORR Annual Report to Congress contains some information on refugees' education and employment histories before arrival in the U.S., as well as education and employment outcomes post-arrival, but does not estimate the economic impact of refugee skill underutilization.

Mr. Jackson: Which of ORR's programs target skilled refugees? Given the Obama administration's proposed budget request of provides $741 million for ORR, will the office be able to expand any of its assistance to refugee professionals?

Secretary Sebelius: 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.

Mr. Jackson: 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?

Secretary Sebelius: 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.

Mr. Jackson: 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?

Secretary Sebelius: 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.

PSYCHO-SOCIAL NEEDS OF REFUGEES AND OTHER VULNERABLE POPULATIONS

Mr. Jackson: How much of ORR's funding will be used to address the psycho-social needs of resettled refugees?

Secretary Sebelius: Refugees are able to access mental health services via both refugee medical assistance and, if eligible, Medicaid. In addition, some ORR social services discretionary grants allow providers to create programs that address mental health and trauma recovery needs of refugees. ORR also has an inter-agency agreement with SAMHSA which focuses on refugee mental health issues.

ASSISTING REFUGEES TO ACHIEVE SELF-SUFFICIENCY

Mr. Jackson: 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?

Secretary Sebelius: Under the FY 2010 budget request, the Matching Grant program will be funded at the same level as FY 2009.

Mr. Jackson: The structure of the US 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?

Secretary Sebelius: 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 Supplemental Security Income (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.

CHRONIC DISEASE

Ms. Roybal-Allard: Chronic diseases account for seven out of every ten deaths in the U.S. and 75 percent of health care spending. I firmly believe that in order to reduce long-term health care costs, prevention must be a central tenet of our health care agenda, and the President has repeatedly stated his commitment to prevention. However, the proposed 1.7% increase in the FY10 budget for the Centers for Disease Control and Prevention's (CDC) chronic disease prevention programs is regrettably not enough to support programming in all 50 states.

Will chronic disease prevention be a top priority of this Administration, and within the context of discretionary programs in the Labor/HHS appropriations bill, how will this Administration promote chronic disease prevention?

Secretary Sebelius: Yes, the FY 2010 Budget supports a range of chronic disease prevention programs throughout HHS. For instance, the FY 2010 President's Budget provides additional resources for the Racial and Ethnic Approach to Community Health (REACH) program to fund 12-15 additional communities. CDC's REACH program has produced significant improvements in reducing health disparities in communities across our nation. REACH U.S. communities will continue developing, implementing, and evaluating a broad range of community-based strategies. The Budget also continues investments in other CDC programs targeted to chronic disease prevention. In addition, HHS is leading a Departmental effort to determine how to most effectively use the $650 million the Recovery Act appropriated to deliver specific, measurable health outcomes that address chronic disease rates. Furthermore, the HRSA budget also supports and funds chronic disease prevention programs including the Patient Navigator Outreach and Chronic Disease Prevention Demonstration Program (PNDP) which provides grants to organizations such as health centers, hospitals, and non-profit groups for the development and operation of patient navigator services to improve health care outcomes for individuals with cancer and/or other chronic diseases, with a specific emphasis on health disparity populations.

Furthermore, the Department's disease prevention and health promotion strategy, Healthy People, will continue to provide a framework to guide and support a range of prevention efforts and serve to promote chronic disease prevention. Work is ongoing to develop the next set of national prevention objectives, Healthy People 2020, which will underscore the importance of an integrate approach to improving health and will focus on risk factors and social determinants of health. To reach beyond the traditional health arena, we are collaborating with our colleagues in other Federal Departments as well as stakeholders outside of the Federal government. A fully public, voluntary panel of 13 subject matter experts, the Secretary's Advisory Committee on National Disease Prevention and Health Promotion Objectives for 2020, is guiding the development of this national prevention strategy.

Ms. Roybal-Allard: Over the next few years, will this Administration send us budgets that build up these programs to enhance our prevention efforts in all states?

Secretary Sebelius: CDC is committed to researching, developing, and putting into practice evidence-based strategies for Chronic Disease Prevention. Through tools such as the Community Guide, that publishes guidance on interventions that work, CDC will continue to focus on policies and programs that work to reduce the burden of chronic disease in the United States.

COMMUNITY-BASED PREVENTION

Ms. Roybal-Allard: Much of the discussion relating to prevention focuses on clinical preventive services, like immunizations and screening, which are extremely important. To maximize improvements in health status, though, we need a sustained investment in clinical and community level interventions. A report from Trust for America's Health finds 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 five years. Will it be a priority of this Administration to promote and fund community-based prevention programs?

Secretary Sebelius: The FY 2010 Budget supports community-based prevention programs. For instance, the Budget includes funds for these programs in CDC, such as the Racial and Ethnic Approaches to Community Health (REACH) and the Healthy Communities program to implement evidence-based strategies for chronic disease prevention and health promotion. Specifically, the FY 2010 Budget provides $40 million, an increase of $4 million above FY 2009, to fund a broader array of communities working to reduce and eliminate racial and ethnic health disparities.

For more than 40 years, Health Centers funded by HRSA have delivered comprehensive, high-quality, cost-effective primary healthcare to patients regardless of their ability to pay. During that time Health Centers have become the essential primary care provider for America's most vulnerable populations: people living in poverty, uninsured, and homeless; minorities; migrant and seasonal farmworkers; public housing residents; geographically isolated; and people with limited English proficiency. Health Centers advance the preventive and primary medical/healthcare home model of coordinated, comprehensive and patient-centered care, coordinating a wide range of medical, dental, behavioral, and social services. Today, more than 1,100 Health Centers operate over 7,500 service delivery sites.

Ms. Roybal-Allard: Can you provide any detail on how HHS intends to spend the $650 million from the stimulus for evidence-based clinical and community prevention? When will a formal plan be announced?

Secretary Sebelius: HHS is leading a Departmental effort to determine how to most effectively use these funds to deliver specific, measurable health outcomes that address chronic disease rates. The goal of this activity is to reduce risk factors and prevent or delay chronic disease, promote wellness, and better manage chronic conditions. HHS

will support communities and States to implement evidence-based interventions that can serve as effective models to help lay the groundwork for health reform.

Ms. Roybal-Allard: What is your assessment of CDC's Healthy Communities program? Do you think it should be expanded to more communities across the U.S.?

Secretary Sebelius: The FY 2010 Budget includes $23 million for the Healthy Communities Program to support local communities in implementing evidence-based interventions in community-based settings, such as schools, workplaces, community organizations, and health care settings. Because of a new grant structure in FY 2008, this program is able to accelerate the spread and adoption of effective community strategies in communities across our nation. CDC anticipates that the cumulative impact of the Healthy Communities Program will reach nearly 300 communities by FY 2010. An assessment of this program in 2006 indicated the need for local communities to continue to receive training, tools, and technical assistance to develop and implement effective community-based strategies that address obesity and chronic diseases. In FY 2008, CDC began funding ACHIEVE Communities through the Healthy Communities Program. ACHIEVE brings together local leaders and stakeholders to build healthier communities by promoting policy and environmental change strategies with a focus on: obesity, diabetes, heart disease, healthy eating, physical activity, and preventing tobacco use. ACHIEVE communities are able to capitalize on the experience and expertise of national organizations in strengthening community leadership, building capacity, and activating change.

Ms. Roybal-Allard: How do you intend to work with your partners across the federal government (i.e., the Secretary of Transportation, the Secretary of Agriculture) to fund and implement population based prevention programs and changes to the built environments necessary to promote healthy lifestyles?

Secretary Sebelius: We will continue to support programs addressing population based prevention and the built environment, working collaboratively with other partners. In the past seven years, efforts in the CDC's National Center for Environmental Health (NCEH) have laid a foundation in research, surveillance, capacity building, and partnership development for a robust Healthy Community Design Initiative. The primary purpose of this proposal is to create a cadre of workers within state and local health departments who, through training, coalition building, health impact evaluation, and effectiveness research, is equipped to improve health outcomes by affecting community design plans and policy. These efforts will be focused on transportation systems, parks and greenspace, food systems, and other features affecting the built environment that impact chronic disease, injury, and climate change drivers.

Ms. Roybal-Allard: Is the Administration considering other investments outside of the discretionary appropriations process to enhance our nation's investment in public health programs and community level prevention? Would the Administration be supportive of a dedicated trust fund for prevention funded outside of the discretionary appropriations bills?

Secretary Sebelius: We continue to evaluate all options to support the Nation's public health programs, and the FY 2010 Budget supports community-level prevention programs to improve the Nation's health. Investing in prevention and wellness is one of the eight principles that the Administration has set in working with Congress on health reform. For instance, CDC funds many Community Based programs including the Racial and Ethnic Approaches to Community Health and the Healthy Communities program to implement evidence-based strategies for chronic disease prevention and health promotion.

## INFLUENZA ANTIVIRAL TREATMENT VS. PROPHYLAXIS

Ms. Roybal-Allard: Since 2005, it has been U.S. policy to develop a pandemic flu vaccine and stockpile enough antivirals to treat 25 percent of the population, which was the WHO standard and the practice of many industrialized nations at the time. Today, we are months away from the point at which we have a vaccine for the specific H1N1 strain we are facing right now in enough quantity for the general population. At the same time, science has marched onward, and we now know more about using antivirals to prevent the flu, based on studies that have found that there are considerable benefits related to using antivirals for prophylaxis in addition to treatment. We also have reports from both HHS and the Institute of Medicine, issued in 2008, which discuss the importance of deploying antivirals for prophylaxis for the estimated 9.7 million healthcare workers and emergency personnel who will be on the frontlines of treating people infected with a pandemic flu. To do so, however, we would need to significantly bolster our level of stockpiles. As of September 2008, states have purchased 23 million courses of antivirals, despite a goal of having state stockpiles for 31 million courses. Do you expect all 31 million courses to be purchased, and if so, when?

Secretary Sebelius: Currently, State stockpiles have 24.5 million treatment courses. Indications are that States will purchase up to an additional 4 million more treatment by the end of September 2009.

Ms. Roybal-Allard: Is the previous Administration's concept of shared responsibility (with a 75 percent state matching requirement) working, or should stockpiling be more of a federal responsibility?

Secretary Sebelius: Overall, the State program for purchasing antivirals is successful. Currently, State stockpiles have 24.5 million treatment courses of antivirals and many have plans to purchase additional courses. In addition, the Federal stockpile includes 44 million treatment courses for distribution to States.

Ms. Roybal-Allard: Do you plan to divert some of the current stockpile that is intended for treatment toward prophylaxis for critical health care workers and emergency personnel? If so, how do you plan to make the antiviral stockpile "whole" again?

Secretary Sebelius: Consistent with the National Strategy on Pandemic Influenza, HHS has a Federal stockpile of 44 million courses of antivirals for treatment in the event

of a pandemic. HHS will continue to examine the best science available as it makes future pandemic influenza procurement decisions.

Ms. Roybal-Allard: Will pandemic funding in the 2010 regular order bill be used to increase the antiviral stockpile for prophylaxis for health care workers and emergency personnel, and if so, how many courses of treatment will that yield?

Secretary Sebelius: The FY 2010 President's Budget includes $584 million for the NIH, FDA, CDC, and the Office of the Secretary to enhance our pandemic preparedness through building of vaccine production capacity, development of next generation antivirals and ventilators, and expansion of international and domestic surveillance and detection capabilities. HHS currently has 50 million courses of antivirals in the Strategic National Stockpile that are intended for treatment.

Ms. Roybal-Allard: When do you expect to have these important protective medications in hand and deployed to our doctors, nurses, police, firefighters, and other first responders who will literally be on the front lines of this essential fight?

Secretary Sebelius: In the early days of the first wave of the 2009 H1N1 Pandemic in the US, 11 million courses of antivirals, 25 percent of the Federal stockpile, were deployed from the Strategic National Stockpile (SNS) on a pro rata basis into State antiviral stockpiles. According to State pandemic preparedness plans, these antivirals will be distributed as needed.

## DRUG RESISTANT TUBERCULOSIS

Ms. Roybal-Allard: HHS is to be commended for its ongoing efforts to respond to drug-resistant strains of tuberculosis, including the partnership between National Institutes of Health and Centers for Disease Control and Prevention on the development of the Federal TB Task Force Action Plan on Extensively Drug Resistant Tuberculosis (XDR-TB). XDR-TB, because of its severity and difficulty to treat, is of enormous concern to Border States like California, which has a disproportionately high burden of TB. What is the current status of the implementation of the Task Force report?

Secretary Sebelius: HHS has begun addressing the recommendations in this plan. Specific examples include: provision of technical assistance to enhance global lab capacity to detect drug resistance and to improve national TB programs in the areas of treatment and infection control; development and testing of new drugs, vaccines and diagnostic tests; and development of training and educational programs and materials.

Ms. Roybal-Allard: As the new Secretary of HHS, what plans do you have to address the early detection and treatment of XDR-TB, especially among the uninsured and underinsured in this country for whom the cost of treatment is often prohibitive?

Secretary Sebelius: CDC recently convened a group of external consultants to address ways to accelerate and improve the diagnosis of drug-resistant TB. We are currently reviewing the recommendations made in their report. Because treatment of TB

is required to prevent transmission, State and local health departments generally provide treatment regardless of insurance status or ability to pay. CDC is not aware of TB patients who have not received treatment because they are uninsured or underinsured.

## HEAD START

Ms. Roybal-Allard: Head Start, as you know, is the nation's premier early childhood services program for low income children and families. In order to bolster this safety net while more families are slipping into poverty during our current economic crisis, the House Appropriations Committee has placed significant amounts of ARRA funding with the Office of Head Start. But as you know, these dollars do not increase the base funding for the program, and the President's FY 2010 budget only requests $7.23 billion for Head Start, a mere 1.7% increase over FY 2009 funding. How will HHS focus on the unmet community need for Head Start services without a significant increase in the base funding for the program?

Secretary Sebelius: In FY 2009, Head Start received $2.1 billion in funding from the American Recovery and Reinvestment Act. Head Start funding also received increased appropriations of $235 million this year, resulting in a total FY 2009 funding increase of $2.335 billion. Much of these funds will be used to expand the Head Start and Early Head Start programs and in FY 2010, HHS will be working with our grantees to continue implementation of this very large expansion. With Recovery Act funds, Head Start expects to enroll an additional 16,600 pre-school age children and Early Head Start an additional 55,000 infant and toddlers reaching a total of approximately 978,000. The additional Head Start funding requested for FY 2010 will maintain this enrollment. The Early Head Start increase will nearly double the size of the current EHS program while the increase in Head Start funding also will allow both American Indian/Alaska Native grantees and Migrant and Seasonal grantees to serve an additional 1,200-1,300 children each.

Ms. Roybal-Allard: Is the requested funding level sufficient to provide for the full $10 million in special expansion funding provided for MSHS in the 2007 Head Start Head Start for School Readiness Act (PL 110-134) ?

Secretary Sebelius: In FY 2009 Migrant and Seasonal Head Start programs were allocated $10 million for purposes of expanding enrollment. That $10 million will continue to be available to the Migrant and Seasonal Head Start programs in FY 2010, assuring the continuation of the FY 2009 expansion.

Ms. Roybal-Allard: When do you expect to see a new appointee at the helm of the Office of Head Start?

Secretary Sebelius: The Department continues to work to place qualified, talented individuals in key positions to help support its mission. As part of that effort, we are working diligently to fill the critically important position of Director of the Office of Head Start, and hope to have an appointee in place this summer.

BIOTERRORISM FUNDING

Ms. Roybal-Allard: In light of the current circumstances surrounding the potential for global pandemic with the H1N1 influenza virus, it appears wise and prudent that Congress has provided over $6 billion to increase stockpiling of antiviral drugs and gear-up cell-based vaccine manufacturing capabilities in order to address this alarming threat. But in your role as Secretary of Health and Human Services, you also have responsibility for preparations to address the threat of bioterrorism.

What is the Department doing, and are we doing enough, to position the United States to be prepared for the other potential bacterial and viral threats that we may see either as emerging infectious diseases or as terrorist weapons against the country, specifically anthrax, smallpox and botulinum toxin as well as chemical nerve agents?

Secretary Sebelius: The Biomedical Advanced Research and Development Authority (BARDA) within the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) leads the mission to develop and procure medical countermeasures that will prevent and mitigate the adverse health consequences associated with chemical, biological, radiological, and nuclear (CBRN), pandemic influenza and emergent infectious disease agents. BARDA also manages the Public Health Emergency Medical Countermeasures Enterprise, which is responsible for defining and prioritizing requirements, focusing research and development, and setting deployment strategies for medical countermeasures. To date, BARDA has invested over $2.2 billion in the development and procurement of medical countermeasures against CBRN threat agents. It has delivered over 25 million doses of anthrax vaccine, 22,000 doses of anthrax antitoxin, and 86,000 doses of botulinum antitoxin to the Strategic National Stockpile (SNS). BARDA also has a development/procurement program for a third-generation smallpox vaccine that will be delivered to the SNS in 2009/2010. BARDA is also working with the National Institutes of Health and the Department of Defense to develop next generation anthrax vaccine, radiological/nuclear countermeasures, broad-spectrum antimicrobials, and chemical nerve agent countermeasures. In addition, the Centers for Disease Control and Prevention (CDC) have invested over $518 million to license and procure a second generation smallpox vaccine (ACAM2000) for the SNS. The CDC SNS also has large quantities of medicines (e.g. antibiotics) and medical supplies (e.g. masks, syringes) to protect the American public from health emergencies (including CBRN threats).

Ms. Roybal-Allard: Recently, former Senators Bob Graham and Jim Talent released their World at Risk Report. Do you agree that a bioterrorist event from a biological weapon remains at or near the top of our nation's most serious threats?

Secretary Sebelius: HHS agrees that chemical, biological, radiological, and nuclear agents remain at or near the top of our Nation's most serious threats.

Ms. Roybal-Allard: Which biological threats are most likely and what countermeasures do we have stockpiled or in development to protect the American people?

Secretary Sebelius: The events of September and October, 2001 made it clear that our Nation is not immune from terrorists. The Department of Homeland Security has issued thirteen Material Threat Determinations (MTD) and Population Threat Assessments which have been used by HHS to develop medical countermeasures programs. The Biomedical Advanced Research and Development Authority (BARDA) leads HHS' mission to develop and procure medical countermeasures against chemical, biological, radiological, and nuclear threats. BARDA currently funds countermeasure development programs in response to all thirteen MTDs. Procurements for the Strategic National Stockpile by BARDA and the Centers for Disease Control and Prevention include anthrax vaccines, antibiotics, and therapeutics, botulism antitoxins, smallpox vaccine, chempacks, and two types of radiological drugs.

Ms. Roybal-Allard: Additional funding to support pandemic flu is anticipated in the short-term and I agree with that approach. Are additional funds necessary to adequately address the bioterrorism threat?

Secretary Sebelius: The FY 2010 President's Budget includes $4.6 billion to address bioterrorism threats. This funding includes $1.8 billion in NIH, $1.5 billion in CDC, and $891 million in the Office of the Assistant Secretary for Preparedness and Response. In addition, the budget proposes the transfer of Project BioShield from DHS to HHS, which established the use of the $5.6 billion Special Reserve Fund in FY 2004 for late-stage development and procurement of medical countermeasures.

Ms. Roybal-Allard: Are more intensive efforts necessary to educate members of Congress regarding the importance of our preparedness for potential biological and chemical threats?

Secretary Sebelius: Yes, continued discussions with Congress and other stakeholders are essential to ensure that the Nation is protected from potential threats. There are a number of documents that describe ASPR's plans and activities to date including the Project BioShield annual reports, the semi-annual Pandemic Influenza Reports to Congress, the PHEMCE Strategy, the PHEMCE Implementation Plan, the draft BARDA Strategic Plan, and other information on ASPR's website (http://www.hhs.gov/aspr/index.html). Also, ASPR holds an annual conference for stakeholders and other meetings where ongoing and planned efforts are discussed.

## CDC HIV PREVENTION

Ms. Roybal-Allard: Last year, the CDC announced that the number of new HIV infections in the United States is over 56,000 each year, which translates into a new infection every 9 ½ minutes. This number is 40 percent higher than previous estimates, and disproportionately affects minority populations. At the same time, CDC's budget for

HIV prevention has been either cut or flat funded in the last couple of years, and President Obama's proposal to increase funding to CDC's HIV prevention programs by $53 million is still far from what the CDC needs to actually decrease the number of new infections in our country. Can you describe what you and the CDC are doing to reduce the number of new infections in this country?

Secretary Sebelius: To reduce the number of new HIV infections, the FY 2010 Budget includes $745 million, +$53 million above FY 2009, to support CDC's domestic HIV/AIDS surveillance and testing, prevention research, capacity building and technical assistance, prevention interventions, and program evaluation and policy development. Specifically, CDC will increase the reach of HIV testing with an emphasis on gay and bisexual men of all races/ethnicities, African Americans, and Hispanics by awarding approximately $27 million to State and local health departments to test 600,000 persons and identify 6,000 new HIV infections per year.

Ms. Roybal-Allard: Is the amount proposed in the budget adequate to meet the actual needs?

Secretary Sebelius: The FY 2010 Budget includes $745 million, +$53 million above FY 2009, to support CDC's domestic HIV/AIDS surveillance and testing, prevention research, capacity building and technical assistance, prevention interventions, and program evaluation and policy development. Specifically, CDC will use increased funds to expand HIV testing to allow State and local health departments to test 600,000 persons and identify 6,000 new HIV infections per year. Furthermore, with increased funds, CDC will expand HIV referral and prevention services; will integrate HIV prevention services with services to prevent sexually transmitted diseases, viral hepatitis, and TB; will build State and organizational capacity; and will support HIV surveillance.

Ms. Roybal-Allard: What specific outreach does CDC have planned to address the significant growth of new infections in communities of color?

Secretary Sebelius: With the increased $53 million that the FY 2010 Budget requests for domestic HIV/AIDS, CDC will enhance its to reduce the number of new infections with special attention to those populations most affected by the disease, including communities of color. Approximately three quarters of CDC's funding for HIV prevention and surveillance serves racial and ethnic minority populations. In FY 2010, CDC will use increased funds to expand the HIV Testing Initiative with an emphasis on communities of color and to enhance prevention efforts for racial and ethnic minority populations.

## U.S. DOMESTIC REFUGEE RESETTLEMENT PROGRAM AND THE ECONOMIC CRISIS

Ms. Roybal-Allard: 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. 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 for rent and other basic household needs.

How is ORR planning to respond to the consequences of the economic crisis refugees and other vulnerable populations while they work toward integration and self-sufficiency?

Secretary Sebelius: 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 eight 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 FY 2010 budget request includes $337 million for refugee transitional and medical services, $55 million more than the amount appropriated in FY 2009. ORR will closely monitor arrivals and benefit access, and provide updated cost estimates to Congress as necessary.

Ms. Roybal-Allard: How will ORR ensure that the US domestic refugee resettlement program is prepared to serve refugees adequately?

Secretary Sebelius: ORR will continue to work closely with all its partners to assist refugees in attaining economic self-sufficiency while providing needed cash and medical assistance and social services. As noted above, ORR will closely monitor arrivals and benefit access, and provide updated cost estimated to Congress as necessary.

Ms. Roybal-Allard: What components of the domestic refugee resettlement program are in greatest need of reform or increased support?

Secretary Sebelius: The domestic refugee resettlement program has successfully assisted refugees in attaining self-sufficiency for more than thirty years. Over that time the needs of refugees have changed and we continue to modify the program to address the changing needs. At the same time, the Administration is keenly interested in examining ways to improve refugee resettlement programs, especially in light of the current economic crisis.

Ms. Roybal-Allard: If ORR is funded at President's request in fiscal year 2010, do you believe those funds will be sufficient to address such acute problems as refugees' homelessness?

Secretary Sebelius: 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.

Ms. Roybal-Allard: Can you explain why ORR has had carry over funds and why they have not been used to address urgent needs, increase funding for successful programs such as the Voluntary Agency Matching Grant, or initiate new programs that would facilitate refugees' path to self-sufficiency?

Secretary Sebelius: Recently, ORR has carried over Transitional and Medical Services funds at the end of a fiscal year due to numbers of refugee arrivals that fall short of the refugee ceiling established by the State Department, on which ORR budget estimates are based. Because TAMS expenditures are directly linked to the number of arrivals, a lower-than-projected number of arrivals lead to carryover funds. It should be noted, however, that the number of refugees is on the rise, and, for the first time since 2001, the number of arrivals in FY 2009 is approaching the refugee ceiling. Carryover funds are used to support the on-going costs of the refugee program.

COMPREHENSIVE SEX EDUCATION FUNDING

Ms. Lee: I want to thank you and the President for finally proposing an end to the ineffective and discredited abstinence only education programs. I believe that we have been wasting taxpayers money on these programs for far too long in the face of a severe lack of evidence that they work.

I have always said that instead of abstinence only, we should be funding abstinence plus. Meaning that teaching about abstinence has to be ***the start*** of any conversation about preventing unintended pregnancies or the stopping the spread of HIV and other sexually transmitted infections, ***and not the end*** of that conversation.

I'm pleased that in his budget request, the President has proposed that we fund proven evidence based teen pregnancy prevention programs. I believe that legislation that I have introduced along with Senator Lautenberg in the Senate, would help to accomplish this goal.

Our bill, HR 1551 the Responsible Education About Life Act, would provide funding to states to support the teaching of comprehensive sex education, that includes information about abstinence, contraceptives, condoms, and teaching positive life skills to empower young people to take care of themselves.

I'd encourage you and the Administration to look at our bill as you work with Congress to establish the President's proposed teen pregnancy prevention initiative, and I would ask for your support for the bill.

Secretary Sebelius: We are pleased that you have reacted positively to the new Teen Pregnancy Prevention proposal included in the President's budget. The Department is strongly committed to funding evidence-based programs that seek to reduce behaviors associated with both teen pregnancy and HIV/STIs, and we believe the approach taken in this initiative will achieve this goal. Many of the 20 experimentally evaluated evidence-based models referenced in the Department's Congressional Justification have a similar focus to that which you highlighted: encouraging teens to wait to have sex, providing information on contraception and comprehensive sex education, and teaching positive life skills.

We commend you for introducing the Responsible Education About Life (REAL) Act, and have reviewed the proposed legislation. We look forward to working with you.

HEALTH REFORM AND HIDDEN COSTS OF PRIVATE INSURERS

Ms. Lee: As a strong proponent for a single payer health care model that guarantees high quality universal health care, I applaud the President for taking on the issue of health reform this year. And I'm pleased that he is trying to ensure that his first budget provides the space to enact meaningful changes to our healthcare system.

For too long our health care system has rewarded the industry that runs it at the expense of the people it is intended to serve. We've got to change that.

I'm concerned however that we aren't focusing enough attention on the importance of consumer choice and in guaranteeing the ability of our constituents to choose a high quality publicly run health insurance plan, like Medicare.

I think people tend to forget that the health insurance industry is fundamentally based on a profit seeking model. They pay out multimillion dollar salaries and bonuses to their executives, just like AIG and Goldman Sachs. For example last year the 5 highest paid CEO's in the industry raked in a combine $64 million in salary and compensation. And that's just for 5 people!

In addition there's a whole host of dividend payouts, advertising, marketing, and administrative costs associated with private health plans that you just don't have in a publicly managed plan.

So there's a profit margin that is automatically tacked onto every private health insurance plan to cover all these costs that our constituents are getting charged for already.

On top of that, if a private health insurer finds that it's not making enough money to cover these costs in a particular region, or for a particular specialty, or if a particular patient is too costly, they can simply end coverage, and you've lost your access to health care.

So I just want to be clear that when we talk about health reform that we don't shy away from talking about what the true costs of a private health insurance plan is.

Conversely that we are clear about what the benefits of a publicly run health plan can provide:

- A guarantee of coverage regardless of pre-existing condition
- A choice of doctors and hospitals, and
- A built in incentive for private insurers to lower costs to compete.

Can HHS articulate a list of all the administrative and bureaucratic costs that private insurers carry that would be cut out of a public plan, and can you provide us with a general estimate of those costs for private insurers?

Secretary Sebelius: The major costs associated with private insurance that do not exist for public insurance are product design, medical underwriting, marketing, and profit. A report by McKinsey Global Institute estimates that approximately $64 billion per year in excess costs is spent by private plans on medical underwriting and marketing. If health reform is successful, the costs of medical underwriting should be eliminated from the premiums. Both public and private plans must administer enrollment and process claims. Administrative costs in the private health insurance industry are variously quantified and may or may not include profit. These estimates range from 8 percent to 25 percent while Medicare's administrative costs as quantified in the annual Trustees report are 1.4 percent.

Ms. Lee: Has HHS put together any estimates for how much we can save our constituents if private health insurance plans actually had to compete with a public health insurance option?

Secretary Sebelius: This will be the subject of CBO scoring.

Ms. Lee: Won't having a public option plan drive down the costs of health care beyond the industry's recent pledge to reduce the rate of growth of their profit margin?

Secretary Sebelius: While we are unable to quantify the exact cost-containment that will result from public plan/ private plan competition until specific bills are scored, it is our expectation that the operation of a public plan will provide strong incentives to private plans to increase efficiency and reduce premium costs and that scorable savings will be associated with the operation of the public plan.

Ms. Lee: What are you doing to get the message out about the importance of having a public health insurance option be included as part of health reform?

Secretary Sebelius: Both the President and the Secretary have engaged in substantial outreach and visits throughout the country talking about the need for health reform, the effort to provide a robust private marketplace that encourages employers to maintain insurance, and the importance of a public plan in making the private system work. Health reform was the topic of the President's radio address this week. Health reform efforts from HHS will multiply in the coming weeks to match the level and pace of legislative activity.

STATUS OF HIV TRAVEL BAN

Ms. Lee: Secretary Sebelius, I wanted to ask you about the status of a proposed rule that is currently under review at OMB.

Last year, as part of the passage of the global AIDS reauthorization bill we included language, which I originally authored in the House, to remove the statutory ban on travel and immigration for people living with HIV/AIDS.

We all agreed on a bipartisan basis along with the previous administration, that banning HIV positive people from traveling or immigrating to the United States was discriminatory and wrong, and provided no public health benefit whatsoever.

While we removed the statutory ban, the regulations implementing it remained in place, and that functionally they can't be removed until new regulations are formulated and published.

Its my understanding that HHS has put together a proposed rule and that it was submitted to OMB for review on April 10, 2009, just last month.

The official title is: Medical Examination of Aliens: Removal of HIV Infection as a Communicable Disease of Public Health Significance and the RIN is: 0920-AA26.

Can you provide us with an update on this specific rule? Has OMB been talking with all of you at HHS about it, and are there any specific issues with this rule that you can talk to us about?

Secretary Sebelius: This rule is still under review. The Administration is with OMB and others to get it published as soon as possible.

Ms. Lee: Has HHS determined, what if any budget related issues will this rule create? For example do we need to provide additional funding to implement a proposed rule change during the 2010 Fiscal Year?

Secretary Sebelius: The rule is a notice of proposed rule making and we are still working to address all issues related to this rule. At this time the FY 2010 President's Budget includes sufficient resources to administer regulations to prevent the introduction, transmission, and spread of communicable diseases into the United States.

Ms. Lee: How long does it normally take to go through the process of reviewing a rule like this? Do you think that we can get this rule published before the end of the summer?

I'm very concerned about any further delay on this and I'd like to at least see a proposed rule out before we reach the one year anniversary of the passage of the global AIDS bill, which is coming up in July.

Secretary Sebelius: The timeline to review a rule varies based on the issues presented in the rule. Regarding this rule, we are working to get this rule published as soon as possible.

PARTICIPATION OF MINORITIES IN ACCESSING ARRA FUNDS

Thank you for your testimony regarding the status of Recovery Act funding.

I appreciate the urgency and diligence that HHS is putting into using the funds we provided in the economic recovery package.

I'm particularly concerned however that as we dole out these funds that we are especially mindful about the need to ensure that they can benefit all segments of our diverse population.

As you know its often been difficult for minorities to access federal grants for funding.

Ms. Lee: Can you describe how you plan to ensure that you have diversity in terms of who benefits from funding provided in the recovery package?

Secretary Sebelius: The American Recovery and Reinvestment Act funds HHS programs of which many focus on providing services to underserved and minority populations. For example:

- Health Centers: Approximately $2 billion is being awarded to over 1,100 health centers operating about 7,500 service delivery sites in every U.S. State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. These health centers serve over 17 million medically underserved people annually with a wide range of health needs. About two-thirds of health center patients are ethnic and racial minorities. In

2007, 28 percent of health center patients were African-American and 34 percent were Hispanic/Latino - almost twice the proportion of African-Americans and over two and a half times the proportion of Hispanics/Latinos reported in the overall U.S. population.

- Head Start/Early Head Start: $2.1 billion will support Head Start and Early Head Start programs which provide comprehensive child development services to economically disadvantaged children and families. At least 90 percent of the families served by Head Start have incomes below the poverty line. Over 72 percent of the children enrolled are ethnic and racial minorities. In 2008, 30 percent of children enrolled were African-American and 36 percent were Hispanic/Latino.

- Health Professions Training: Increasing the diversity of the health professions workforce is a key goal for most of these Public Health Service Act Title VII and VIII programs, as many provide funding preferences or specifically require participation by disadvantaged and minority students. Just over half of the students that benefit from health professions programs (51%) are underrepresented minorities and/or disadvantaged individuals.

Ms. Lee: Can you provide the committee with your specific outreach plans to ensure that African American, Latino, Asian Pacific Islander, Native American and other racial groups are represented among grant recipients?

Secretary Sebelius: Assuring that all American communities have access to funds appropriated under the American Recovery and Reinvestment Act (ARRA) of 2009 has been an important focus of the Department of Health and Human Services. We have and will continue to work to inform individuals, minority organizations, minority serving institutions, as well as our local, state, tribal, and regional partners about available ARRA funding through multiple means. Examples include:

- Presentations and briefings on ARRA funds at conferences and meetings of minority organizations, including the National Caucus of Black State Legislators, National Hispanic Medical Association, and the Native American Health Research Advisory Council.

- Communications with local, state, tribal, regional and national partners to share information about ARRA funds and ensure organizations serving communities with significant low income and minority populations are prepared to apply for available funds.

- Ongoing technical assistance, including national conference calls, regularly updated Frequently Asked Questions and other supporting documents, and application templates.

- Active messaging to minority organizations and minority serving institutions on ARRA provisions.

- Listening sessions to hear from individuals and organizations on Comparative Effectiveness Research (CER), obtain data and information for a report to Congress on CER, inform HHS' spending plan for ARRA funds focused on CER, inform HHS' efforts regarding prevention, and educate the public on the ARRA funds. These listening sessions included individuals who represented leading minority organizations, minority serving organizations, and racial and ethnic minority communities.

- Planned technical assistance sessions for potential CER applicants focused on minority researchers and minority serving institutions.

- A focused newsletter to over 11,000 individuals, researchers, minority organizations, and minority serving institutions to inform them of upcoming ARRA funding opportunities.

- HRSA has leveraged its existing relationships with Health Center grantees as well as its state, regional and national cooperative agreements and partners to reach out to all existing health centers as well as potential new health center providers, including communities with significant low income and minority populations, to ensure that they are aware of and prepared to apply for ARRA funds and implement successful projects. This outreach included significant technical assistance in the forms of national conference calls (with replays available), direct contact information for program and grants staff, regularly updated Frequently Asked Questions and other supporting documents, and application templates.

Ms. Lee: How are you coordinating these efforts across each Agency within HHS?

Secretary Sebelius: In April 2009, the HHS Health Disparities Council, comprised of senior officials representing HHS STAFFDIVs and OPDIVs, met to discuss and coordinate strategies regarding ARRA funds as it pertains to minority communities. Each agency reported on its progress to-date and efforts to encourage the participation of minority researchers and to fund minority serving institutions. Council representatives will continue to collaborate in developing priorities and implement strategies to improve data availability and quality of data for racial and ethnic populations. The Department's key Recovery Act coordination bodies also play a role. The Implementation Team reviews spending plans that define program scope and award recipients. The Technical Council addresses operational issues of program implementation including outreach to minorities.

Ms. Lee: What are you doing to ensure that minority serving medical institutions (like Meharry Medical College) know about these funding opportunities and are able to compete for these funds?

Secretary Sebelius: The Deputy Assistant Secretary for Minority Health has met with leaders of minority serving institutions (including Meharry Medical College) to encourage those institutions to consider applying for appropriate funding opportunities supported by ARRA. For example, at NIH, such funding opportunity announcements specifically state, "Individuals from underrepresented racial and ethnic groups as well as individuals with disabilities are always encouraged to apply for NIH support." This communication complements other outreach efforts

by the NIH to organizations and institutions that primarily serve underrepresented racial and ethnic groups. Additionally, the NIH has created a Web page devoted to "Grant Funding Opportunities Supported by the American Recovery & Reinvestment Act of 2009 (ARRA)" (http://grants.nih.gov/recovery/), to further public access to information about these new funding opportunities. The NIH also communicates about funding opportunities, including those supported by ARRA, through the NIH Guide for Grants and Contracts, the official publication for NIH medical and behavioral research, grant policies, guidelines, and funding opportunities. Potential applicants can access the Guide on-line (http://grants.nih.gov/grants/guide/) and can receive weekly updates to the Guide by joining the NIH Guide LISTSERV (http://grants.nih.gov/grants/guide/listserv.htm).

UTILIZING REMAINING ARRA FUNDS FOR PREVENTION

Ms. Lee: Thank you for the update on how HHS is distributing the funding we provided in the Recovery Act.

As part of HHS's allocation we also provided $1 billion to fund prevention initiatives with a portion going to the CDC and the states, and the remaining amount, about $650 million remaining largely at your discretion.

Have you made any plans about how you are going to allocate the $650 million we provided in the Recovery Act?

Secretary Sebelius: HHS is leading an interdepartmental effort to determine how to most effectively use these funds to deliver specific, measurable health outcomes that address chronic disease rates. HHS will support communities and States to implement evidence-based interventions that can serve as effective models to help lay the groundwork for health reform.

Ms. Lee: What sorts of priorities do you envision trying to meet as you start to plan how these funds will be used?

Secretary Sebelius: Our goal for these funds is to reduce risk factors and prevent or delay chronic disease, promote wellness, and better manage chronic conditions.

HIV/AIDS FUNDING FOR THE CDC

Ms. Lee: In April, the President and CDC announced a new communications campaign to re-focus the public's attention on HIV/AIDS. The price tag for the five-year effort is $45 million. It was a very positive sign to those on the frontlines of the epidemic.

A few weeks later, the President released the FY10 budget which included increases in HIV/AIDS prevention, treatment and care and the Ryan White program among others.

However, last year at the request of the House Oversight and Government Reform Committee, the CDC prepared a professional judgment budget outlining the funding necessary for the agency to improve HIV prevention efforts and reduce HIV transmission in the United States. That budget called for an additional $877 million in funding over the next five years.

Would you clarify how the administration will address HIV/AIDS funding when the CDC has indicated substantially more funding is needed to gain control of the epidemic?

Secretary Sebelius: The FY 2010 Budget includes $745 million, +$53 million above FY 2009, to support CDC's domestic HIV/AIDS surveillance and testing, prevention research, capacity building and technical assistance, prevention interventions, and program evaluation and policy development. Specifically, CDC will use increased funds to expand HIV testing to allow State and local health departments to test 600,000 persons and identify 6,000 new HIV infections per year. Furthermore, with increased funds, CDC will expand HIV referral and prevention services; will integrate HIV prevention services with services to prevent sexually transmitted diseases, viral hepatitis, and TB; will build State and organizational capacity; and will support HIV surveillance.

INSTITUTE OF MEDICINE REPORT ON THE CRITICAL ROLE OF TITLE X FUNDING

Ms. Lee: In a report released just 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, "The ability of individuals to determine their family size and the timing and spacing of their children has resulted in significant improvements in health and in social and economic well-being. The Title X federal family planning program provides these critical services to those who have the most difficulty obtaining them."

The Institute's study also cites that "funding for the program has not kept pace with: inflation; increased costs of contraceptives, supplies, and diagnostics; great numbers of people seeking services; increased costs of salaries and benefits; growing infrastructure expenses; or rising insurance costs."

Do you agree with that assessment, and 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 health care services?

Secretary Sebelius: The patients served with Title X funding includes clients with 100% the Federal poverty level and 91 % less than or equal to 200% Federal poverty level. The additional funding in FY 2010 will expand current services and continue to ensure access to a broad range of family planning and related preventive health services for millions of low-income or uninsured individuals. In addition, approximately 10 percent of the FY 2010 increase will be used to support training of family planning clinic personnel, research and data collection for service delivery improvement, and support for program administration and monitoring.

TUBERCULOSIS

Mr. Honda: Tuberculosis continues to be a significant threat in the United States, particularly in the Asian American Pacific Islander community which, according to the Centers for Disease Control and Prevention suffers from a tuberculosis rate of 25.8 per 100,000, an increase of 3,295 cases in 2006 to 3,423 cases in 2007. My county, Santa Clara, has seen steady increases in the number of Multiple Drug Resistant and a few extreme drug resistant cases in the past several years. Will your office be working to create culturally and linguistically appropriate health information campaigns to target particularly vulnerable communities?

Secretary Sebelius: Yes, CDC provides funding through cooperative agreements to State and local health departments to support information and educational efforts. In addition, CDC develops culturally and linguistically appropriate educational materials to assist State and local health departments and funds regional training centers around the country that also develop educational and information materials.

Mr. Honda: In addition to every state, the CDC directly funds 10 cities because of their increased incidence of TB. I understand that the CDC is in the process of revising the funding formula and I would like to know if the CDC will be reconsidering funding cities and maybe expand the ten city list to include high-risk regions like my home county.

Secretary Sebelius: CDC is in the process of reassessing the funding formula for the next project cycle, FY 2010 to FY 2014, and convened a workgroup of external experts that included multiple TB program representatives to provide recommendations for funding for TB prevention and control and laboratory efforts. The workgroup has provided HHS with multiple options for directly funding cities for TB prevention and control. HHS is reviewing these options and will share these decisions with you once they have been finalized.

HEALTH IT SYSTEMS

Mr. Honda: El Camino Hospital in my district has had an electronic health record system since the late 1970's and have worked through a lot of the details of how to structure a system on their own. I understand that HHS is in the process of setting up the regulations that will govern health IT systems. Who is on the Health IT Standards + Policy Committee (HIT companies, hospitals, provider groups, consumer groups, etc.)?

Secretary Sebelius: The following is a list of the members of the Health IT Policy Committee and the Health IT Standards Committee:

**HIT Policy Committee:**
**Chair**
David Blumenthal, HHS/Office of the National Coordinator for Health Information Technology

**Members**
David Bates, Brigham and Women's Hospital
Christine Bechtel, National Partnership for Women & Families
Neil Calman, The Institute for Family Health
Richard Chapman, Kindred Healthcare
Adam Clark, Lance Armstrong Foundation
Arthur Davidson, Denver Public Health Department
Connie White Delaney, University of Minnesota/School of Nursing
Paul Egerman, Businessman/Entrepreneur
Judith Faulkner, Epic Systems Corporation
Gayle Harrell, Former Florida State Legislator
Charles Kennedy, WellPoint, Inc.
Michael Klag, Johns Hopkins University, Bloomberg School of Public Health
David Lansky, Pacific Business Group on Health
Deven McGraw, Center for Democracy & Technology
Frank Nemec, Gastroenterology Associates, Inc.
Marc Probst, Intermountain Healthcare
Latanya Sweeney, Carnegie Mellon University
Scott White, 1199 SEIU Training and Employment Fund

**HIT Standards Committee:**
**Chair**
Jonathan Perlin, Hospital Corporation of America
**Vice Chair**
John Halamka, Harvard Medical School

**Members**
Dixie Baker, Science Applications International Corporation
Anne Castro, BlueCross BlueShield of South Carolina
Christopher Chute, Mayo Clinic College of Medicine
Janet Corrigan, National Quality Forum
John Derr, Golden Living, LLC
Linda Dillman, Wal-Mart Stores, Inc.
James Ferguson, Kaiser Permanente
Steven Findlay, Consumers Union
Douglas Fridsma, Arizona State University
C. Martin Harris, Cleveland Clinic Foundation
Stanley M. Huff, Intermountain Healthcare
Kevin Hutchinson, Prematics, Inc.
Elizabeth O. Johnson, Tenet Healthcare Corporation
John Klimek, National Council for Prescription Drug Programs
David McCallie, Jr., Cerner Corporation
Judy Murphy, Aurora Health Care
J. Marc Overhage, Regenstrief Institute
Gina Perez, Delaware Health Information Network
Wes Rishel, Gartner, Inc.

Sharon Terry, Genetic Alliance
James Walker, Geisinger Health System

Mr. Honda: Are you looking at models developed in local hospitals and by regional providers over the years for examples from which to draw best practices? For example, how much is the provider community being folded into the process and how can they provide comment based on their years of experience with EHRs?

Secretary Sebelius: The membership of the HIT Policy and Standards Committees reflects a broad range of stakeholders, including providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information.

Several members are affiliated with organizations that are recognized leaders in adoption and use of HIT and EHRs. Also, many of the staff in the Office of the National Coordinator for Health Information (ONC) and Committee members come from advanced HIT organizations and through their research and leadership positions within the industry have substantial knowledge of the efforts of other advanced HIT organizations.

In addition to these advisory Committees, HHS is actively looking for opportunities to learn from front line physicians to advise our HITECH Act implementation plans. ONC recently convened a technical expert workgroup that included providers experienced with EHRs to advise ONC on the implementation of the HITECH grant programs.

## HEALTH DISPARITIES

Mr. Honda: I and others on this committee are dedicated to ending racial and ethnic health disparities and while I am glad to hear the president refer on occasion to the issue, I would like to bring to your attention the fact that the OMH developed a blueprint to end health disparities during a year long listening session across the country with thousands of community groups and activists. Many of the goals echo what is found in the Tri-Caucus (CBC, CHC, CAPAC) health disparities elimination act. Why haven't we seen more of that detailed blueprint and concrete recommendations in the policy recommendations to congress?

Secretary Sebelius: Thank you for your longstanding commitment to ending racial and ethnic disparities in health. The Department of Health and Human Services (HHS) also is committed to ending racial and ethnic health disparities and will soon complete the complex process that was initiated some time ago.

Following the Regional Conversations, the Office of Minority Health (OMH) worked to ensure that the voices of community and other stakeholders drove the development of ten individual Regional Blueprints and the first national health disparities

plan. We listened carefully and through a deliberative process have identified priority strategies, a series of related actions, and performance measures that account for the unique population and health disparities issues by region and that also form the basis for a cohesive national plan. A critical component of this *bottom-up approach* has entailed maintaining the individual priorities of each Regional Blueprint while connecting priorities across regions in the national health disparities plan.

A longer-term goal is to assure that regional and national actions can be evaluated to assess progress. Toward this end we also have established a Federal Team comprised of representatives from all HHS agencies and several Executive Branch Departments as a means for ensuring Federal engagement in the development, implementation, and evaluation of the strategies and actions contained in the ten Regional Blueprints and national health disparities plan.

Mr. Honda: The Tri-Caucus staff has been working to organize a meeting between you and the Tri-Caucus Chairs and Health Task Force Chairs; will you commit to meeting with us as the health reform process moves forward?

Secretary Sebelius: I met with the Congressional Black Caucus on June 16th and the Congressional Hispanic Caucus on June 17th and will meet with Congressional Asian Pacific American Caucus as soon as schedules permit.

HEALTHCARE SYSTEM

Mr. Honda: President Obama has committed to ending cancer in addition to reforming our healthcare system; among AAPIs the top killer is liver cancer as a result of chronic hepatitis b infection. African Americans die at rates twice as high as white Americans from complications due to chronic hepatitis c infection. Within the CDC the President has only allocated the Division of Viral Hepatitis a $57,000 increase. Although I have advocated on the Committee for an increase in the Division, I am hoping that you can work with the CDC to see that the Division has more resources available to it in the future in order to target culturally and linguistically appropriate education and outreach efforts to vulnerable populations like new immigrants and pregnant women.

The American Recovery and Reinvestment Act provided $1 billion for a Prevention and Wellness fund. This funding was originally intended for the CDC to support a broad range of proven national and state-based education and outreach programs to prevent disease and reduce the healthcare costs associated with treating many costly conditions and chronic diseases – including sleep disorders. What plans does your Department have for the use of these funds?

Secretary Sebelius: CDC plans to spend the $300 million appropriated to it in the Prevention and Wellness fund by reaching more children and adults through immunizations. CDC and CMS are providing funds to States to implement healthcare-associated infections reduction strategies. Regarding the $650 million appropriated for prevention and wellness strategies, HHS is leading a Departmental effort to determine

how to most effectively use these funds to deliver specific, measurable health outcomes that address chronic disease rates. The goal of this activity is to reduce risk factors and prevent or delay chronic disease, promote wellness, and better manage chronic conditions. HHS will support communities and States to implement evidence-based interventions that can serve as effective models to help lay the groundwork for health reform.

## PANDEMIC INFLUENZA

Mr. Honda: First, I want to thank you for all of your hard work to prepare our nation for a pandemic influenza outbreak and to keep the American people informed, especially over the very hectic days since the H1N1 virus was identified on April 21st. We have reports from both HHS and the Institute of Medicine, issued in 2008, which discuss the importance of deploying antivirals for prophylaxis for the estimated 9.7 million healthcare workers and emergency personnel who will be on the frontlines of treating people infected with a pandemic flu.

Of the $1.5 to $2 billion that will likely be included in the final emergency supplemental bill for pandemic influenza preparations, do you have an estimate of the amount that will be dedicated to stockpiling antivirals for prophylaxis for health care workers and emergency personnel?

Secretary Sebelius: These funds, in addition to the FY 2010 request and the remaining balances, will allow HHS to develop and distribute antivirals and vaccines, and personal protective equipment as well as conduct public health surveillance to track the outbreak.

## COLLABORATION IN MEDICAL RESEARCH

Mr. Rehberg: As you know, collaboration between the public and private sectors is essential for medical progress. This has been highlighted in NIH reports describing the complementary roles of NIH and the private sector and medical advances. New discoveries in fields like genomics are bringing us to the threshold of even more exciting breakthroughs -- this makes it all the more important to continue supporting the collaboration between public and private researchers at NIH, academic institutions, and biopharmaceutical research companies, for example. As HHS Secretary, how do you plan to encourage and expand on research collaboration to help us achieve these breakthroughs?

Secretary Sebelius: Various types of interactions between industry and NIH occur now on a regular basis and are expected to continue to increase in scope and impact. Technology transfer mechanisms, such as Cooperative Research and Development Activities (CRADAs), Clinical Trial Agreements (CTAs) and Research Collaboration Agreements, facilitate scientific collaborations with industry. In particular, the CRADA allows the industrial collaborator to access resulting inventions made by NIH scientists in exchange for the collaborator's intellectual property contributions and other contributions to the research. Also part of technology transfer is the licensing of inventions made by NIH scientists for commercialization and dissemination ultimately as a means to improve public health. University recipients of NIH funding likewise collaborate with industry to move technologies down the developmental pipeline to benefit public health. For example, the Small Business Technology Transfer (STTR) program provides funding to small businesses that establish formal collaborations with universities to increase private sector commercialization of technology developed through Federal R&D.

Public-Private Partnerships (PPPs) are an increasingly productive means of engaging a wide variety of outside partners, including industry, foundations, patient and professional groups, other government agencies, and others, to gain the synergy of multi-disciplinary and multi-sector research efforts. Examples of such partnerships include Genetic Association Information Network (GAIN, genome-wide association studies of common diseases, involving pharmaceutical and biotechnology companies, academia, and NIH) and the Biomarkers Consortium (a PPP dedicated to the discovery, development and qualification of biomarkers and involving NIH, FDA, CMS, The Foundation for NIH, PhRMA, BIO, many companies, academic institutions, patient groups and professional societies). PPPs allow the NIH to leverage private sector expertise; patient populations, samples, and datasets; platforms and reagents; analytical capabilities and more. Through technology transfer and PPPs, the government investment in science is multiplied through synergy with partners.

## CANCER RESEARCH

Mr. Rehberg: NIH and NCI are on the front lines of our fight against cancer. How are we supporting them in making President Obama's call for a cure for cancer in our lifetime a reality?

Secretary Sebelius: As the President has recognized, there is a tremendous need to enhance the speed with which we are working toward the prevention and control of cancer. A recent University of Texas M.D. Anderson Cancer Center study estimated that over the next 20 years, the number of new U.S. cancer cases will increase by 45 percent; cases among minorities will double, and cancer in our senior population will increase by 67 percent. Unless our investment in science has a significant impact on these incidence numbers, the impact on healthcare will be enormous. Cancer treatment accounted for about $72.0 billion in 2004. The additional economic burden of cancer due to morbidity and premature mortality is estimated to be $120.4 billion per year, resulting in an estimated total economic burden of cancer in 2004 of $192.4 billion.

As the leader of the National Cancer Program and part of the National Institutes of Health (NIH), the National Cancer Institute (NCI) has built a national network that includes regional and community cancer centers, physicians who are cancer specialists, cooperative groups of clinical researchers, and volunteer and community outreach groups.

We have asked the NCI to work with the other Institutes and Centers at NIH to develop an NIH cancer research strategic plan in support of President Obama's commitment to double cancer research funding over the next eight 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.

We also recognize that investment in cancer research not only provides new approaches to prevent, detect, and treat cancer for the more than 1.6 million people diagnosed each year, it also provides pivotal insights into understanding the genetic basis and biology of almost every other disease. Important breakthroughs in the treatment of diabetes, heart disease, HIV-AIDS, and Alzheimer's have come from the understanding of basic cellular biology gained from cancer research. Several therapeutic agents developed for cancer have proven useful in other diseases including taxol-based eluting intravascular stents to prevent endothelial proliferation and inflammation in treating coronary atherosclerotic heart disease, as well as anti-angiogenic factors as a treatment of macular degeneration.

The promise of changing the course of cancer in this country lies in our knowledge that cancer is a disease of altered genes. By developing an understanding of the complete catalogue of these defects, we will drive the diagnosis, the ability to determine prognosis, and the delivery of highly targeted therapeutic solutions of the future. The power to do all of this appears imminent since the technologies exist today to sequence whole genomes and to examine cell function.

With the significant funding increases proposed by the President, we can realize 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 changing the course of disease. NCI and the NIH are cornerstones in delivering the promise of personalized cancer care through their efforts to significantly

shortening the path between making an innovative discovery in the laboratory to having an effective impact on a patient in the clinic. 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.

PERSONALIZED MEDICINE

Mr. Rehberg: The field of personalized medicine -- using genetics and other health information to target the best care to the individual patient -- is an example of how medical innovation is an important part of the solution for better patient care, and for a sustainable health care system. I strongly support the steps NIH is taking to advance personalized medicine, such as supporting the cancer Bioinformatics Grid, the BIG Health Consortium. Would you agree that advances in this field hold promise for better health and better health care value?

Secretary Sebelius: There is no question that personalized medicine is an integral component of improved health care and health care value. "Personalizing" care means knowing what works, knowing why it works, knowing who it works for, and applying that knowledge for patients. For example, by using new diagnostic tools to help identify the most effective treatment options for a patient, personalized medicine promises to help avoid ineffective treatments and the associated costs.

In addition, new knowledge about associations between molecular factors and health conditions should help identify disease early and point toward effective prevention. Preventing disease becomes cost-effective by preempting disease before it develops, thus avoiding unnecessary treatments or costly future procedures.

.A critical component of personalized medicine is the development of interoperable health information technology with the goal of establishing patient electronic medical records. These new capabilities will further enhance the physician's ability to determine the most effective treatment for each individual patient. In addition, eventually, such data might be used to obtain an overview of each individual's long term health profile allowing individuals to take specific, proven steps to enhance their health throughout the lifecycle.

Thus, personalized health care should be an explicit component of health care reform as the goals of personalized medicine-personalized health information, based on individual biology, yielding increasingly precise and predictive health care-hold tremendous promise for both better health and better health care value.

Mr. Rehberg: How can we ensure that NIH's comparative effectiveness research is informed by molecular knowledge and utilizes these research infrastructures?

Secretary Sebelius: Comparative effectiveness research (CER) is an important partner in bringing about personalized medicine. At the same time that CER is being used to identify which interventions and strategies work best on average, it can also identify different responses by different groups of patients. In some cases, different existing therapies may be identified as most effective for specific sub-populations. In other cases, CER may also help to identify significant sub-populations for whom effective treatments do not yet exist.

One approach that NIH is taking is to ramp up studies of the genetic changes that are associated with common diseases, including myocardial infarction, stroke, diabetes, hypertension, chronic pulmonary disease, anemia, inflammatory bowel disease, macular degeneration, glaucoma, osteoporosis, autism, and multiple sclerosis. Taking advantage of the large data bases from NIH funded clinical trials and observational studies - some of which have been ongoing for decades - researchers will be able to predict individual patient outcomes based on a patient's specific genetic variations.

MEDICAL ADVANCES AND COMPARATIVE EFFECTIVENESS RESEARCH

Mr. Rehberg: Madame Secretary, one question that comes up in the comparative effectiveness discussion is it's effect on maintaining medical advances. Many of us have worked hard to support medical advances--new treatments that save lives and improve quality of life, that help keep people at work and able to be productive rather than disabled, and that move toward personalizing care so that it's more effective, as we've begun to do with breast cancer. That's why so many of us are strong supporters of the National Institutes of Health. The value of this support is evident in the sharply improved results for cardiovascular disease and cancer in recent years.

In this context, could you tell me how you expect comparative effectiveness research to affect the rate of medical advances and patients' access to them--will it slow them down or speed them up? On this point, I'm particularly interested in questions around evaluating advances when they're new. As NIH has told us, it often takes a long time to get a new treatment from bench to bedside. And it's often the case that we don't learn the full value of a new treatment until years after it's been introduced--there are many examples in which an advance initially thought to be modest evolved into major progress against disease. This is often the case, for example, with cancer treatments.

Secretary Sebelius: Comparative effectiveness research will speed up the rate of medical advances and patients' access to them. An example is NIH-funded clinical trials for cancer treatments, where newly discovered drugs that target and selectively kill certain types of cancer cells may be compared to conventional chemotherapy or radiation therapy, which non-selectively kills any rapidly dividing cell. Both the new drug's efficacy - whether it works to kill cancer cells – and its relative effectiveness compared to standard treatments can be simultaneously assessed in one clinical trial.

Randomized clinical trials must have a "control" to compare to the experimental treatment being tested. For NIH-funded trials, whenever possible the preferable control is an intervention that is effective and is already in wide use; in contrast, industry-supported trials typically use only placebo controls. So, comparative effectiveness often plays a role in the discovery stage of NIH clinical research, well before a treatment becomes widely used.

Mr. Rehberg: How do you construct a system of comparative effectiveness evaluation that avoids slowing down the medical progress that has been leading to better outcomes, and that avoids suppressing a new treatment before its full value is known?

Secretary Sebelius: The tools of personalized medicine will allow physicians and other health care providers to go beyond the "one size fits all" treatment model and make the most effective clinical decisions for patients based on genetic information. You indicated some new treatments have been prematurely discarded because they either present adverse reactions in some patients or are not beneficial to the patients who participated in the early clinical trials. Researchers can now study how variations in genes affect the way a person responds to medicines ("pharmacogenomics"). Already researchers can predict whether medicines such as the anti-clotting drug Warfarin might be effective, ineffective, or even toxic in certain individuals. NIH is initiating large-scale pilots to integrate pharmacogenomics with electronic health records in real-world settings. Linking genetic variations with drug responses will lead to improved patient care, reduced errors, and safe and effective use of medications.

Comparative effectiveness should ideally include patient sub-populations and draw on the emerging research linking some genetic changes with disease. Comparative effectiveness evaluation will center on ensuring that both of these parameters figure into trial design, conduct and dissemination of results.

HEALTHCARE REFORM

Mr. Alexander: In regards to the current health care reform debate, if insurance was compulsory, how exactly would this be implemented, and how do you plan make the public actually enroll in health insurance?

Secretary Sebelius: People could enroll in a number of different ways that would make enrollment a seamless process in the conduct of other activities. For example, people can enroll when they fill out employment forms for tax withholding or retirement plans. Booklets could be available at libraries and post offices and divisions of motor vehicles. They could enroll when they file their tax returns or enroll a child in school. And of course, people can enroll on line. Finally, when people show up for medical care, they can be enrolled in a health care plan. Enabling enrollment and outreach can be accomplished efficiently.

ALABAMA MEDICAID

Mr. Bonner: As a former governor, you bring to this job valuable experience with the challenges of administering Medicaid programs on the state level. Alabama, my home state, has struggled with CMS for more than a decade to try to resolve the question of how state agencies define "cost," and how states can use that definition, along with statutory measures such as intergovernmental transfers (IGTs) and certified public expenditures (CPEs), to help fund their Medicaid programs.

Given the challenging economic times we find ourselves in and the difficulties most states will continue to have with funding for safety net programs like Medicaid, I'm sure we agree it is important for states to have access to every federal dollar they are able to draw down.

Can you address how CMS will work with states to make sure they are able to use all the various means at their disposal, including IGTs and CPEs?

Secretary Sebelius: I assure you this Department will work with the State of Alabama to address any outstanding issues. CMS has worked at length to resolve the intergovernmental transfers (IGTs) and certified public expenditure (CPE) issues in the State of Alabama. Specifically, in 2005, CMS worked with the State providing technical assistance on how IGTs can still be utilized in compliance with Federal rules. At that time, the State expressed an interest in moving to a CPE financing process and CMS outlined the basic requirements for use of CPE financing including the use of cost reports for cost determination purposes and final reconciliation to actual cost. Between 2005 and 2008, CMS worked extensively with the State to develop cost documentation methodologies in accordance with CMS requirements.

Currently, CMS continues to review materials exchanged between the Agency and the State to resolve outstanding compliance concerns. CMS and the Administration will continue to work with the State, in accordance with the proper administrative processes, to resolve these outstanding compliance concerns.

Mr. Bonner: Specifically, will you address how CMS officials and staff will work with states to find innovative solutions and ways to overcome institutional inertia with regard to IGTs and CPEs for Medicaid funding?

Secretary Sebelius: As you know, this Administration wants to ensure the financial integrity of the Medicaid program. CMS is committed to working collaboratively with states on issues pertaining to the financing and administration of their Medicaid programs. CMS has worked successfully with a number of states to resolve issues of Medicaid financing to ensure public expenditures are appropriate. As a former Governor, I understand the importance of the federal-state partnership and assure you that this Administration and CMS will continue to work to resolve ongoing intergovernmental transfers (IGTs) and certified public expenditures (CPEs) methodology issue.

AREA WAGE INDEX

Mr. Bonner: As you are aware from your service as governor of Kansas, CMS' area wage index (AWI) can pose significant problems for hospitals in multi-state labor markets. Wage indices can vary significantly from city to city, especially where adjacent cities lie in bordering states. In areas like the Gulf Coast, where multiple states – and multiple statistical areas – are part of the same labor markets, hospitals finding themselves in low wage index cities face a very real disadvantage when competing with higher wage index cities.

Obviously, wage index disparities are not unique to Alabama or to the Gulf Coast. Over time, Congressional prerogative and bureaucratic expediency have combined to make a hash of an already confused patchwork of high and low wage indices.

Has HHS studied the budgetary impact of inequalities in the area wage index, including the effect such inequalities may have on nursing shortages? Has the department looked into alternatives to the current metrics which may provide for more consistent wage indices within labor markets, rather than exclusively within states?

Secretary Sebelius: The Social Security Act requires the Secretary to adjust the inpatient prospective payment system (IPPS) payments to reflect area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. This adjustment factor is the wage index. As required by statute, the data used to construct the wage index comes directly from hospitals; however, hospitals may seek geographic reclassification to a higher wage area if they meet certain criteria.

Section 106(b)(2) of the Tax Relief and Health Care Act (TRHCA) of 2006 required the Secretary to consider proposals (including several proposals from MedPAC) and to ultimately propose recommendations to revise the wage index adjustment. With the assistance of a contractor (Acumen LLC), CMS conducted a detailed impact analysis comparing MedPAC's wage and hospital compensation indexes with the CMS wage index. This impact analysis was summarized in the FY 2009 Medicare IPPS final rule and is published on the following web site: http://www.acumenllc.com/reports/cms.

Acumen is also assisting CMS in developing a proposal or proposals that addresses the specific wage index issues enumerated in section 106(b)(2) of the TRHCA. This final step involves two parts: the first part is to analyze the strengths and weaknesses of the data sources used to construct the MedPAC and CMS indexes. This report is accessible at the above Web address. The second part will focus on the methodology of wage index construction and covers issues related to the definition of wage areas and methods of adjusting for differences among neighboring wage areas, as well as reasons for differential impacts of shifting to a new index.

WEDNESDAY, JUNE 3, 2009.

# U.S. DEPARTMENT OF EDUCATION

## WITNESS

## HON. ARNE DUNCAN, SECRETARY, U.S. DEPARTMENT OF EDUCATION

### CHAIRMAN'S OPENING REMARKS

Mr. OBEY. Good afternoon, Mr. Secretary. I will give you a minute to get organized.

Well, Mr. Secretary, welcome. This job would be a great job if we didn't have to vote, but I am told that, within a couple of minutes, we are going to get some roll calls on the House floor which will discombobulate this hearing. But we will try to do the best we can.

Mr. Secretary, I am not quite sure where to start. Let me, first of all, state that we want to be on the same team. We want to work with you. We want you and this President to succeed, and we enjoyed the opportunity to work with you on the initial stimulus or recovery package, as people are now calling it. But Will Rogers said once that when two people agree on everything, one of them is unnecessary. And I find myself in that position this afternoon, as I indicated to you to some extent yesterday, and let me paint you a picture of what is happening in my district.

### UNEMPLOYMENT IN THE CHAIRMAN'S DISTRICT

A year ago, Taylor County was riding at 7 percent unemployment; today, it is 14.5. Rusk County a year ago, 7.3; today, 17 percent. Polk County, 5.9 percent a year ago; 12.5 today. Oneida, 6.7 a year ago; 12 percent today. Marathon, 4.1 percent a year ago; 9.4 today. Lincoln, 5.3 percent a year ago; 12.6 today. Langlade, 5.8 a year ago; 12.1 today. Iron, 8.7 a year ago; 14 percent today. Clark, 5.7 a year ago; 11.3 today. Chippewa, 5 percent a year ago; 11 percent today. Burnett, 7.1 a year ago; 13.2 today.

Now, I cite those numbers to try to make a point, which I will eventually get to.

### RECOVERY ACT FUNDS AND BUDGET STABILIZATION

As you know, we tried to—in the stimulus package, we tried to take into account that this was happening and that is why we provided large amounts of money to States to try to stabilize their budgets. That is why we provided a good deal of additional funding in direct financing to local school districts by formula. And if you take a look at what is happening around the country, according to the Center on Budget and Policy Priorities, some 47 States are facing fiscal stress. According to one analysis from the University of Washington, State education budget shortfalls could result in the loss of nearly 600,000 jobs in K–12 education alone.

Mr. Secretary, you have established certain principles to guide the expenditure of Recovery Act funds: one, to preserve and create jobs; two, to improve student achievement through innovation and reform. And you have been quoted as saying that schools face a perfect storm for reform. That may be, but I think that they also face a devastating storm in terms of just general economic conditions. I am concerned that there are so many communities that are so cash strapped that they are using Recovery Act funds simply to mitigate State and local revenue shortfalls in order to prevent layoffs; and, for those districts, all they may be able to do is to pay for existing teachers, keep the lights on, and pay for other essentials.

TIMING OF PROPOSED INITIATIVES AND ECONOMIC TURMOIL

If the first focus of States and school districts is to plug these devastating budget gaps and avoid deep layoffs, then I think it is legitimate to question whether it is realistic to also expect them to implement dramatic new reforms until the economic situation stabilizes. I don't want to set them up for failure in the public's eyes because they can't do two things at the same time because of the extreme economic collapse that we have seen in the country, and so I would hope that you would take that to heart in the way that you administer the funds under your control.

Secondly, I have been on this committee for almost 40 years, and I think I have got a track record of giving a damn about what happens to these programs. But I am not so much interested in programs as I am performance. And I am certainly supportive of reform, if that process occurs in the context that makes it possible for people to think about reform.

I voted for No Child Left Behind because I thought the previous President had a right to have his first domestic priority supported. Unfortunately, I overestimated his willingness to live up to the financial commitments attendant to that deal.

PROPOSED EDUCATION BUDGET INITIATIVES

But I am concerned, frankly, about the direction some of your budget decisions would take us. You request $800 million for new early childhood education, $300 million more for new reading initiatives, next, $100 million to expand the Innovation Fund and to scale up best practices from $650 million in the Recovery Act to $750 million in your budget. You propose a large increase for the Teacher Incentive Fund which supports the design and implementation of performance-based teaching compensation systems, more than quadrupling from $97 million to $487 million, and to $717 million with Recovery Act funds, even though the Department has yet to complete any rigorous evaluation of the effort which began 4 years ago.

ESEA TITLE I DECREASE PROPOSED

I want to support the Administration and its education priorities but not at the expense of reliable and predictable Federal support for thousands of school districts across the country that depend on that funding. And I confess I find troubling the $1.5 billion, or 10

percent, cut in basic Title I grants that you provide for in your budget in order to finance these new initiatives.

In essence, your budget would force school districts to backfill this deep reduction with Recovery Act funds. It will put additional strings on Title I by requiring districts to commit other Recovery Act funds to start new preschool programs as a condition of receiving Title I early childhood grants, and I am not at all convinced that that is not unfair and untimely, given the economic situation.

PROPOSAL TO MAKE PELL GRANTS MANDATORY

I also want to express reservations about your higher education budget. I am a huge fan of Pell grants. I have been a champion of Pell grants every year I have been in this committee. But I confess I am dubious about the wisdom of this committee, in the midst of trying to convince people that we are responsible financially and fiscally, I am not convinced that this is the time to create another, in essence, entitlement by putting another program on automatic pilot. In fact, I am concerned that the recommendation that you have with respect to Pell might in fact have a perverse reverse effect by, in essence, actually putting a ceiling on the amount of future increases in the maximum award under Pell.

So, as I say, we are all friends here and we want to work together, but I have got to be honest and lay out my misgivings about some of the directions that I see you and the Administration going in, and I hope that we can work them out.

Mr. Tiahrt.

Mr. TIAHRT. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. Congratulations on your new role here.

You have a very interesting history. I think you have accomplished quite a bit in the State of Illinois and in Chicago, and I think those accomplishments would not be classified particularly as supporting a Democratic point of view or a Republican point of view. I think you took a refreshing approach in a lot of new areas.

I understand you have a background in basketball. Each year, Congress plays the business community in September and we are going to try to recruit you for that game.

EDUCATING THE NATION'S WORKFORCE

We hear a lot about a changing economy and changing world and a need to prepare our children to participate in the 21st century and in the job market that is going to be coming about during that time. In the last Administration, we worked a lot on accountability and how to best ensure that school districts help every child reach his or her potential. This is still an issue, and there are many debates surrounding No Child Left Behind and the emergency alternatives such as charter schools and the like, and we will probably discuss that later. I look forward to hearing your views on accountability and how to fix No Child Left Behind without discarding, quote, principles that I think we all agree upon.

As for the issue of preparing our workforce and children for the future, I would argue that the future is here. It is today. Michael Wesche of Kansas State University has done a lot of research about today's technology revolution and its impact on society, the market-

place, and education. He correctly points out that we need to be adapting faster and more efficiently in order to keep up.

I do have concerns, however, with his views and others and the insistence that the education systems of old are outdated and should be overhauled. Yes, new technologies need to be incorporated into classrooms from a young age so that children can learn how to use these tools and be safe while they use them. And, yes, schools should work to capture the attention of a child. But these aren't new issues or new views. There have been age-old education problems from which slide rules have transformed into calculators and one-room schools into the separation of grades and ability levels. Our school systems should be challenged to continually meet those needs and continually improve.

There is reason to be concerned, however, that we push to move out of the traditional classroom and permit children to not pay attention to lessons they do not feel are relevant to their future careers. Besides basic knowledge of the world around us, one of the most important aspects of education is teaching us how to learn and how to analyze new information and to put it into use, how to focus on issues that might not be to our liking or in which we may not have a natural aptitude, how to meet deadlines, how to work with others, how to still learn, and so on.

Most of what I learned in school was not applicable to my job as a systems engineer or as a proposal manager and certainly not as a Member of Congress. But the fundamentals are age-old and should not be thrown out with the bathwater.

I am interested in hearing your thoughts on this issue and how we balance the desire for more technology and personal education and make sure our children are prepared to meet the timeless challenges of learning in a real word.

EDUCATION, JOB TRAINING AND RETRAINING

Education and retraining are keys to ensuring that American workers are the most competitive around the world. Modern economies are driven by knowledge and skills. Just as America's public education system changed the notion that schooling is for the upper class, we now need to change the notion that education ends at 18 or 22. Job retraining and school enhancement are in addition to schooling. They are part of the larger continuum, a lifelong pursuit of education.

Most importantly, for the short and long term, we need to help Americans access not only higher education but also continuing education. Job training and retraining is necessary to keep up in today's environment.

I also have a couple of concerns about overall spending and specifically the impacts that the chairman made about Pell grants and the mandatory program, rather than discretionary. But in this changing world we need innovative ideas and should have a vigorous debate on how to best educate our children.

I look forward to working with you and to ensure that every child achieves his or her dream.

Thank you, Mr. Chairman.

Mr. OBEY. Mr. Secretary, please proceed.

## OPENING STATEMENT OF SECRETARY ARNE DUNCAN

Secretary DUNCAN. Thank you so much, Mr. Chairman. I just appreciate your support and decades of leadership on this issue and your passion. I look forward to working with you to dramatically improve the quality of education for children around the country, and I appreciate the tremendous leadership you have shown for a long, long time on these issues.

### FY 2010 EDUCATION BUDGET PRIORITIES

Thank you for the invitation today to talk about President Obama's fiscal year 2010 budget request. 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 our 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 the assurance that the Federal Government will be there to help them. Together, all of these policies will help our children reach the President's goal that, by 2020, the United States once again will have the largest proportion of college graduates in the world.

### U.S. 1ST IN WORLD IN COLLEGE GRADUATES BY 2020

Secretary DUNCAN. I just want to stop there for a moment. I think that is a very ambitious goal. I think it is critical. About 20 years ago, a generation ago, we led the world in the number of college graduates. It is not so much that we have declined; we have flat-lined, and other countries have passed us by. I think that presents some real challenges for our country and for our long-term economic vitality.

### AMERICAN RECOVERY AND REINVESTMENT ACT

I am extremely grateful for the work you have already done to help our Nation's schools, and I look forward to working with all of you in the future. As you know, in the American Recovery and Reinvestment Act, you provided $100 billion to schools and to students. The law provides a phenomenal start in addressing the needs at every point along the cradle-to-career spectrum. Thanks to your support, we were able to stave off an education catastrophe and save a generation of children. And we estimate as many as 375,000 jobs can be saved with the money we have given out already through the first round of stimulus funding.

As you know, ARRA had two goals in education: to create and preserve jobs and to promote school reforms. Even though the U.S. Department of Education hasn't yet distributed all of the money in the stimulus, we are seeing signs that we are meeting that goal of preserving jobs of teachers and other educators. We are collecting data on the number of jobs preserved. We can point to several districts around the country where the stimulus funding has made a dramatic difference already. Because of ARRA, Los Angeles Unified School District averted almost 3,800 layoffs; in New York, it is 14,000 jobs; 139 teachers kept their jobs in Seminole County, Florida; in Boston, the teacher union leaders say the stimulus money

ensures that the city won't lay off any teachers; and the Alabama State superintendent has said the stimulus money will help avert all layoffs in his State.

I am confident that just about all of the 15,000 districts around the country will be using stimulus money to preserve jobs that otherwise would have been lost or to create jobs they never would have been able to add if they didn't receive money from ARRA.

Before the stimulus, we were headed for an education 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.

POLICY COMMITMENTS UNDER ARRA

Through ARRA, States are promising to make commitments on policies that we consider to be essential to 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 workforce, 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 that Governors must make under the State Fiscal Stabilization Fund program, States will commit to fixing their lowest-performing schools. Finally, they will build 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 attention. This information must also be put in the hands of educators so they can use it to improve instruction.

SCHOOL REFORMS IN EXTENDING SCHOOL DAY AND YEAR

Another key ingredient to 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 critical 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, the school week, and the school year. And we are already seeing real innovation. In places like Cincinnati, that innovation is actually beginning this summer. They are adding what they call a fifth quarter and keeping students for a month after school gets out to continue to drive reform and keep teachers employed. This is a key component of our school turnaround strategy, because we know that students who are struggling need more time to catch up.

Through ARRA, we will be rewarding States, districts, and nonprofit leaders that have dedicated themselves to moving forward in each of these areas of reform. The $4.3 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 others. 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 to award grants late in the fall.

FY 2010 EDUCATION BUDGET REQUEST

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. 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.

I want to highlight our request in several important areas: investing in early childhood education, improving the pay and professional development of teachers, turning around low-performing schools, and ensuring that college students have the financial aid and student loans they need to complete college.

IMPROVING TEACHER QUALITY AND LOW-PERFORMING SCHOOLS

In K–12 education, we are requesting important investments in two of the key priorities identified under the stimulus: improving the quality of our teachers and turning around low-performing schools.

In other countries, the top third of college graduates enter the teaching workforce. Too often, here in the United States, our best choose other professions. We need to change the way we promote and compensate teachers so we can attract the best and brightest into the profession by rewarding excellence and providing supports that enable success.

ADDRESSING THE NATION'S DROPOUT PROBLEM

As for turning around low-performing schools, we know that too many of our schools are 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 freshman 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 will ask 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 those schools, with a strong focus on dropout prevention in the so-called "dropout factories."

This dropout challenge is a national plague that I think strikes a real blow to where we are trying to go as a country. Half these schools are in urban areas, 20 percent are in rural, and 30 percent are in suburban. So this is a real national problem.

And a recent study from the Alliance for Excellent Education came to the conclusion that if all the students in the class of 2008 had graduated, the benefits to our economy would have been an additional $319 billion in income over their lifetimes. And if we don't change, over the next decade another 12 million students will drop out, and the cost to our economy, to our Nation is $3 trillion. So the economic impact, as well as the loss of human potential, is absolutely devastating.

RESOURCES FOR LOW-PERFORMING SCHOOLS

Our budget includes $1.5 billion for the Title I School Improvement program. That is 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 2009 funds, we have more than $5 billion to help turn around low-performing schools.

I am talking about dramatic changes here. I won't 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 improvements in student learning and better outcomes. I want superintendents to be aggressive in taking the difficult step of shutting down a failing school and replacing it with one they know will work. When we talk about 2,000 schools producing half of our Nation's dropouts, and 75 percent from the minority community, that is the number we have to get our hands around and really challenge in a substantive way.

NATIONAL TEACHER RECRUITMENT CAMPAIGN

To improve both the quality of teachers and the 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 that I want the grants awarded in this program to be a cooperative effort between districts and teachers. The President has often said that he believes changes to the teaching profession must be made by working with teachers, 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 chose the design framework that became our foundation. Together, we created a program that emphasized improving professional practices of teachers, identifying what it takes to make teachers better, and those teachers and those schools that have improved.

TEACHER INCENTIVE FUND CHANGES

One important change that we are requesting to the Teacher Incentive Fund would allow districts to reward all employees of a school for helping to improve student achievement. Students excel and thrive when all adults in the school work together. The custodians and the cafeteria workers also need to be rewarded when the students in their school succeed. When every adult in a school building collaborates to create a culture of high expectations, magic happens for children.

STRIVING READERS PROGRAM

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 $70,000,000 for that purpose, almost double the amount in the fiscal year 2009 budget.

YOUNG READERS PROGRAMS

With the remaining $300 millions, we will create a competitive grant program to support districts that create comprehensive and coherent programs that address the needs of young readers. These programs ensure students learn all of the skills they need to become good readers, teaching them everything from phonemic awareness to reading comprehension. We intend to build upon the successes and lessons of the Reading First program while simultaneously fixing that program's problems.

ESEA, TITLE I AND IDEA STIMULUS FUNDING

I would like to say a word or two about the two largest programs for K–12 students, the Title I program and the Individuals with Disabilities Education Act. Both Title I and IDEA Grants to States programs received dramatic funding increases under ARRA. Title I received $10 billion for grants to districts, in addition to the $3 billion for the school improvement program, while IDEA Grants to States received $11.3 billion. That is almost as much as the IDEA Grants to States program 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 the money has run 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 under ARRA and the period of availability. We hope to resume our commitment to funding increases for these 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 at a crisis. More of the same in our dropout factories will not help our children succeed and beat the odds. It will only ensure that we educators actually perpetuate poverty and social failure. We have too many examples of what does work and what is possible all around the country to continue to allow this devastating failure to exist.

EXPANSION OF PRESCHOOL PROGRAMS

In fiscal year 2010, we will also be making 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 a 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. All of these changes will help push school reform in K–12 schools.

COLLEGE ACCESS AND COMPLETION BUDGET PROPOSALS

We also have significant and important policy changes for higher education. The Recovery Act made an important downpayment on our plans to expand student aid. In addition to more aid, we want to make sure that more students are not just attending college but graduating. And in our proposal is a $2.5 billion request over 5 years for a college completion and access grant. The stimulus bill provided $17.1 billion so we could raise the maximum Pell award from $4,850 to $5,350.

PROPOSED CHANGE TO MANDATORY PELL GRANT

Now, in the fiscal year 2010 budget, we propose important and permanent changes to ensure students have access to Federal grant aid and loans. The first thing we propose is to move the Pell grant program from discretionary to a mandatory appropriated entitlement.

Second, we propose to link the increase in the Pell maximum grant to the Consumer Price Index plus 1 percent every year, which will allow the maximum grant to grow at a higher rate than inflation so it can keep up with the rising cost of college.

I am grateful for the tremendous work that the appropriators have done to fund annual increases for the Pell grants, particularly in the last 4 years. But even with their 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 assurance that they will have the tuition assistance they need to make it through college.

This is absolutely a major financial commitment. We are able to pay for this change in part by streamlining and improving the Federal student loan program. We will move the 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 another dollar.

BUDGET PROPOSALS SAVINGS OFFSETS

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, and to identify programs that are ineffective or too small to have significant impact. Our student loan proposal saves more than $4 billion annually. In addition, we are proposing to eliminate 12 programs, creating an additional savings of $550.7 million.

Even though we recommend cutting these programs, we remain absolutely committed to their goals. We are eliminating the $294 million State grant program under the Safe and Drug-Free Schools

and Communities program, because several research studies have found that the program is ineffective. But we 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 programs. Even as 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 invests in our country's future economic security while also making tough decisions to eliminate programs that aren't working.

I appreciate the opportunity to discuss our fiscal year 2010 budget. I look forward to your committee's questions.

Thank you so much, Mr. Chairman.

[The information follows:]

**DEPARTMENT OF EDUCATION**

**Statement by**

**Arne Duncan**
**U.S. Secretary of Education**

**on the**

**Fiscal Year 2010 Budget Request**

Mr. Chairman and Members of the Committee:

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 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 non-profit 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 2010-11 school year. And the number of Pell Grant recipients would rise 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 five 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.

**Arne Duncan**

**U.S. Secretary of Education**

Biography

Arne Duncan was nominated to be Secretary of Education by President-elect Barack Obama and was confirmed by the U.S. Senate on Inauguration Day, Jan. 20, 2009.

Prior to his appointment as secretary of education, Duncan served as the chief executive officer of the Chicago Public Schools, a position to which he was appointed by Mayor Richard M. Daley, from June 2001 through December 2008, becoming the longest-serving big-city education superintendent in the country.

Prior to joining the Chicago Public Schools, Duncan ran the non-profit education foundation Ariel Education Initiative (1992-1998), which helped fund a college education for a class of inner-city children under the I Have A Dream program. He was part of a team that later started a new public elementary school built around a financial literacy curriculum, the Ariel Community Academy, which today ranks among the top elementary schools in Chicago.

Duncan formerly served on the boards of the Ariel Education Initiative, Chicago Cares, the Children's Center, the Golden Apple Foundation, the Illinois Council Against Handgun Violence, Jobs for America's Graduates, Junior Achievement, the Dean's Advisory Board of the Kellogg School of Management, the National Association of Basketball Coaches' Foundation, Renaissance Schools Fund, Scholarship Chicago and the South Side YMCA. He also served on the Board of Overseers for Harvard College and the Visiting Committees for Harvard University's Graduate School of Education and the University of Chicago's School of Social Service Administration.

Last year, he was honored by the Civic Federation of Chicago and the Anti-Defamation League. In 2007, he received the Niagara Foundation's Education Award, the National Foundation for Teaching Entrepreneurship Enterprising Educator Award and the University High School Distinguished Alumni Award. He also received honorary degrees from the Illinois Institute of Technology, Lake Forest College and National-Lewis University. In 2006, the City Club of Chicago named him Citizen of the Year. He was a member of the Aspen Institute's Henry Crown Fellowship Program, class of 2002, and a fellow in the Leadership Greater Chicago's class of 1995.

From 1987 to 1991, Duncan played professional basketball in Australia, where he also worked with children who were wards of the state.

Duncan graduated magna cum laude from Harvard University in 1987, majoring in sociology. He was co-captain of Harvard's basketball team and was named a first team Academic All-American. He credits basketball with his team-oriented and highly disciplined work ethic.

Duncan is married to Karen Duncan and has two children, daughter Clare, 7, and son Ryan, 4.

NCLB REQUIREMENTS FOR SPECIAL NEEDS STUDENTS

Mr. OBEY. Thank you.

Mr. Tiahrt.

Mr. TIAHRT. Thank you, Mr. Chairman.

We had a little discussion earlier about No Child Left Behind. I didn't support it. I thought there were better methods of achieving the same goal. And I have seen some really dramatic problems with the legislation, and let me give you an example in rural Kansas.

There is a young man named Joshua in a high school, in Chaparral High School. He struggles with his grades. He suffers from Tourette's Syndrome, which he is on medication for. His parents were called in to the school, where the superintendent informed them that he needed to be removed from school. And they suggested he go to a nearby small town and enroll in a learning center.

The parents didn't know how to react to all this. They ended up taking him down to the center. They found out that 40 other students from that high school were also enrolled in the learning center, all of whom were struggling with their grades. Since that time, there have been several other students come in to that center.

IMPACT OF REQUIREMENTS ON SOME LEAS AND SCHOOLS

What it appears to be is that, because of the demands of No Child Left Behind and the stringent percentages of students that are special-needs students, many school systems cannot meet that small percentage. And there is no variable system to allow them to accommodate these students, and so principals simply force them out of the school.

These are the small high schools in rural Kansas, and they really have very little places to go, very little choices. So this child has to carpool with other kids and travel a significant amount of distance to go to an alternative learning center so that this school system can abide by No Child Left Behind.

Part of this reform has to take into consideration that, in many areas, some schools systems have actually specialized because they are compassionate and they want to help these kids achieve their greatest potential. But because of the rigidity in the program, we can't accommodate them. And so, you know, they fail on these five categories and the two major categories—math and reading. It just takes one and the whole school system fails.

So we have instituted a program that forces students out of schools. And I don't think that is your goal. It is not my goal. And it is certainly not fair to Joshua. He comes from a good family, pillars in their community, a well-respected family. He is the third child. The other two kids are doing very well and moving on to higher education. But here he is left without the high school experience, without the opportunity, because of a system that we put in place here in Washington that I disagree with.

NCLB GOALS, ACCOUNTABILITY AND FLEXIBILITY

How can we change the system so that we don't leave children behind? And can't we find some flexibility here? And accountability

is good; I don't disagree with the concept. But I don't think it should be so inflexible that we can't accommodate kids like Joshua.

Secretary DUNCAN. The NCLB reauthorization is probably a couple-hour conversation. I will try to keep my remarks pretty quick.

And, just to give you context, obviously I lived on the other side of the law for 7 1/2 years, so I have my own strong opinions. But I am in the midst of traveling to 15 different States and meeting with teachers and meeting with parents and meeting with children and principals to really get the pulse of the Nation to figure out what folks think is working, and what is not.

Let me start with what I think is working. I think the idea of accountability, the idea of disaggregating data and shining a spotlight on the horrendous achievement gap between white students and African American and Latino students, I think that is very important. And, as a country, we can no longer sweep that conversation, that tough conversation, under the rug. And we want to keep that front and center.

There are also numerous challenges. As Chairman Obey said, one of the biggest challenges was a dramatic underfunding of the law. And with his leadership, now there is a step in the right direction, unprecedented steps in the right direction, to add unprecedented resources to helping students and schools be successful.

Big picture, I will just say what I think fundamentally happened—I don't know if it was intended or unintended, it was wrong. I think any time you are trying to manage, whether it is a business or an education system, locally or nationally, you have to be very thoughtful about what you manage loose and what you manage tight. And what NCLB did is, it was very loose on the goals. You have 50 different States, 50 different goalposts all over the map. And, due to political pressure, many of those got watered down to the point that we were lying to children.

Where they were very tight and very prescriptive is in terms of how you try and succeed, how you try and improve. But when I was in Chicago, I didn't think all the good ideas came out of Washington. And now that I am in Washington, I know all the good ideas don't come out of Washington.

What I want to do is fundamentally flip that on its head. I want to think about a high common bar, common standards, rigorous goals that we all have to hold ourselves accountable for, that really provide creativity and flexibility at the local level; hold folks accountable, but give them their chance to innovate and be successful.

INCREASING GRADUATION RATES

Secondly, I am a big believer in looking at outcomes. And we ultimately have to help more students graduate. We can't push the special education students out the door. We can't hide from those challenges.

And I want us to think about what we do to dramatically improve our graduation rate. When we talk about 30 percent of our Nation's students dropping out, the economic cost to our country, the loss of human potential, is absolutely unacceptable. And, as you well know, a couple of decades ago, there actually was an acceptable dropout rate. You could drop out and go get a job and support

a family and own your own home and make a good living. Today, every child who drops out is basically condemned to social failure.

And we have to stop pushing students out. We have to start finding ways to keep those students in, and reward those schools and those school districts that are working with the hardest-to-serve students and keeping them on track.

Mr. TIAHRT. Thank you. I know our time is limited so I will wait for future comment. Thank you.

Mr. OBEY. Thank you.

Ms. DeLauro.

EVEN START PROGRAM—FAMILY LITERACY SERVICES

Ms. DELAURO. Thank you very much, Mr. Chairman.

Welcome, Mr. Secretary. It is another opportunity to be with you, and I appreciate your testimony before the Budget Committee some time ago.

You have an extraordinary commitment to education and to our children, as does the President, which is why, quite frankly, I am puzzled. I am puzzled by the Administration's—I will put it this way—Bush-inspired elimination of the Even Start family literacy services. Ninety-one percent of families in the program are at or below the poverty level. Ninety percent of the parents in the program do not have a high school diploma or a GED. This program serves children, and it serves their parents and those who are in the greatest need.

Even with the decline in funding that we have seen through years, I will be specific and parochial about how the program continues to thrive in my State of Connecticut. We have had a Wesleyan University study of the Middletown, Connecticut, Even Start Program. Parent outcomes showed positive results, showed that Even Start parents are more likely than a control group to advocate for their children's educational needs and discuss educational progress with their kids. Even Start parents were also found to have higher educational aspirations for their children.

EVEN START EVALUATIONS

Your budget documents justified a cut by citing an evaluation using data now 10 years old and based on a program reformed 9 years ago. Let me just ask you why you took a page out of the Bush budget proposals and proposed to eliminate this critical program.

Secretary DUNCAN. We looked at three national evaluations, and these three separate national evaluations reached the same conclusion: that Even Start did not result in significantly greater gains for children or adults participating in the program than for nonparticipants.

STRIVING READERS PROGRAM

We also added money to the Striving Readers program, $370 million, to try and help both the young children and adolescent literacy.

So, again, we are absolutely committed to the goal. But that program, from a few different national evaluations, didn't seem to be producing the results that we wanted.

Ms. DELAURO. Well, I would have to say to you that to suggest that Even Start services can be replaced by either adult ed funding or Title I preschool ignores, I think, the tenets and the structure of the program.

I am not about protecting programs. I mean, I think if programs are not working, I think we ought to, you know, shut them down. But I am about helping those that need some sort of a comprehensive approach for their entire family. And, you know, adult education is one component of family literacy.

EARLY LEARNING CHALLENGE FUND

Secretary DUNCAN. Let me be clear. It is not just adult data. We add up to $300 million for the Early Learning Challenge fund. So there is a significant pool of money to make sure that we are getting students off to a good start and getting those early literacy skills intact.

COMPREHENSIVE APPROACH TO FAMILY LITERACY

Ms. DELAURO. Uh-huh. Well, I think that if you take a look at how you impact the lives of children, I think that you would concur with this. And this is not something that I have invented. I think you would hear from people who have spent a lifetime in education, Dr. Heckman and others, who are very clear about the role of parents and their influence on their children.

And unless, quite frankly, we deal in a comprehensive way, and whether that is literacy, whether that is economic concerns and jobs, et cetera, if we do not address the needs of parents and their literacy skills, then, quite frankly, we are not going to really be making a difference in the lives of these children.

Secretary DUNCAN. I appreciate your concerns.

AFTER-SCHOOL PROGRAMS AND LENGTHENING THE SCHOOL DAY

Ms. DELAURO. Okay, thank you.

Let me then ask you about after-school programs, another area. I was a teacher in the after-school programs many, many years ago, so I am a strong believer in these efforts.

And I know you are supportive of this, but how will the Administration demonstrate its support for after-school when it has only proposed level funding for the 21st-Century Community Learning Centers program? And that is the only Federal funding stream, as far as I know, that is dedicated to after-school.

Secretary DUNCAN. Yeah, obviously, this is a really important issue. And when I talk to students, this is the line that usually gets booed, not applause. But I think we have to think dramatically differently about time. We need our days to be longer, we need our weeks to be longer, and we need our school year to be longer——

Ms. DELAURO. I agree.

Secretary DUNCAN [continuing]. And that after-school timeframe is hugely important.

FUNDING SOURCES TO EXTEND LEARNING OPPORTUNITIES

There are a number of different funding sources for this in the budget. You are starting to see some really creative things. You

have, obviously, the stimulus dollars that can be used to lengthen time, after-school, during the summer. You have Title I dollars. This is a great, great use of these funds. I worry particularly about children who come from poor families who aren't being read to at home. That is a huge use for these increased Title I dollars, to do more after school.

And then there are significant competitive grants: again, the $4.3 billion Race to the Top Fund and the $650 million What Works and Innovation Fund. So there are multiple pools of money for States and school districts to start to think very differently about time.

And, again, just one quick example. This summer, Cincinnati, using stimulus dollars, is keeping school open a month longer. I think that is a great step in the right direction, and you are going to see lots of other folks do that. So there are unprecedented resources available for schools to think about longer days, longer weeks, longer years.

We have put out clear guidance with all of our funding that we think this is a very important use of money and a great strategy to help students who are historically low-performing and come to school from a disadvantaged background. It is a great way to level the playing field. So we are going to continue to provide incentives for this, to encourage this, to highlight those best practices. And there has never been more flexible money to use to extend learning time.

Ms. DELAURO. My time has expired. Mr. Chairman, thank you. And I hope we will have a second round.

Thank you very much, Mr. Secretary.

Mr. OBEY. Mr. Rehberg.

Mr. REHBERG. Thank you, Mr. Chairman.

RURAL EDUCATION CONCERNS

And I appreciate you having traveled to Montana just 6 days ago. I am a little disappointed you are not wearing your War Bonnet blanket that you were given.

Just to put it into perspective, both my grandmother and mom were teachers and came from Landyer, which is where you were. And so you know particularly the problem that exists within education in rural communities.

I am, I guess, a little surprised and perhaps a little disappointed in the budget presentation as we see it as it relates to the rural educational needs. While I may have had heartache with many areas of No Child Left Behind, I found the Bush Administration at least amenable to flexibility. And I hope that you will be, as well, as you manage many of the programs within the budget.

But, in particular, the shift from formula to grants within the budget is something that scares me a bit. Because coming from a rural area like Montana, we find that we don't have maybe the level of expertise to have grant writing as other areas that have economy of scale. So I would like to point that out to you, in particular.

RURAL EDUCATION CAUCUS

And I have a letter that is outside. I have the preliminary report from the Rural Education Caucus, just talking a little bit about

your budget. I formerly chaired the Rural Education Caucus and turned that over to other more capable individuals. But I would like to have this presented to the record, as soon as it gets here.

TRIO PROGRAMS AND POSTSECONDARY SUCCESS

Mr. REHBERG. Some of the words you used in your presentation were "perpetuate poverty and social failure," and not just attending but graduating from college.

Having traveled to now the Cheyenne reservation and seeing the kinds of students—Mr. Chairman, I just might point out that your numbers were impressive, but our unemployment rate on the Cheyenne reservation is 70 percent. That is 7–0. And that is something that definitely concerns us.

One of the programs that is very successful in Montana, may not be so much in other areas, is the TRIO program. And if you want to do something to not perpetuate poverty and social failure, and not just attending but graduating from college, it really is important not to necessarily create a mandatory program in Pell grants but to fund appropriately programs like TRIO, which are a more holistic approach to providing assistance to graduating seniors going on to college.

And just real quickly, I looked up the numbers. Nationwide, the percentage of low-income high school graduates enrolling in postsecondary education is 24 percent. In Montana, it is 73 percent. So this is really a program that has given us an opportunity to take our kids and give them something more so that they can compete when they get to college.

And it is more of the holistic approach that I would hope that you would seriously take a look at and see that perhaps these funding levels aren't necessarily appropriate for the assistance of rural education.

And I will give you a chance to respond.

CHEYENNE RESERVATION IN MONTANA

Secretary DUNCAN. Let me just start. I am learning so much every day about, you know, not just there but West Virginia and Vermont. But let me tell you, my visit to Northern Cheyenne, to the reservation there, is something I will never forget. And I have been in some pretty tough areas in my life and worked in some pretty tough areas, and the level of desperation, the level of poverty, was heartbreaking.

And the high school I visited—this is not a scientific study, but the teacher said, to the best of their knowledge, they had had one child in the past 6 years graduate from college—one. And as I talked to the students, they were smart, they were committed, they wanted more, and they were desperately pushing against expectations. They repeatedly told me that they are being told on multiple fronts that they are not good enough and they can't make it, and they are fighting that.

So let me tell you, there are lots of areas of this country where we need to improve the quality of education, but that is not one that I am going to forget. That is one that is very personal to me. And I am going to figure out, not just there but in other places, how we help children who have been trapped in—you know, I can't

even imagine 70 percent unemployment. I am still trying to get my head around that number; it is almost incomprehensible.

We have to do something there. And, again, I am convinced the only way we get to there is through better education. So I don't have all the answers, but I want you to know I am absolutely committed to trying to make a difference there.

TRIBAL COLLEGES

Mr. REHBERG. And I appreciate your recognition of the tribal college issue, as well. We are very proud of the fact that I think we are the only State that has a tribal college on each of the seven reservations.

Secretary DUNCAN. Yeah. And it is pretty remarkable leadership. I met with a number of those tribal college presidents.

TRIO AND GEAR UP PROGRAMS

I will just say quickly that I am a big fan of the TRIO program, a big fan of GEAR UP. We haven't talked about dual-enrollment programs, where high school students start to take classes on college campuses and get exposure there. And the more we can bridge that divide and help students really believe that college is a possibility for them, that is hugely important.

And we have too many children around the country, including those I met there, who are smart enough, who are working hard enough, but are being told college is not for them, it is a different world. And we need to break through that psychological barrier and raise our expectations dramatically.

Mr. REHBERG. Thank you.

Thank you, Mr. Chairman.

Mr. OBEY. Ms. Roybal-Allard.

PROPOSED EVEN START ELIMINATION AND FAMILY LITERACY

Ms. ROYBAL-ALLARD. Thank you, Mr. Chairman.

And welcome, Mr. Secretary.

First of all, let me associate myself with the concerns that were raised by Congresswoman DeLauro about the elimination of the Even Start program, particularly since it has been based on this 2003 study in which the evaluators themselves said, and this is a direct quote: "Care should be given in applying the findings to Even Start as a whole." And then, furthermore, a 2007 Pennsylvania State University study found that the 2003 evaluation had inherent design flaws. So eliminating a program as important as this based on questionable studies I think is something to be concerned about.

And also, although I realize money is being shifted to other places, the point that Ms. DeLauro made I think is very, very valid. And those programs do not provide family literacy. And family literacy, as you know, is key to having parents involved with their children. And when parents are involved, the research has shown that children succeed at a much higher rate.

So I just want to associate myself with the comments that were made by Ms. DeLauro, in also hoping that you will take another look at this proposal.

EDUCATION TECHNOLOGY FUNDING

Another concern that I have about the budget deals with education technology funding. Now, President Obama has spoken at length about the importance of equipping our schools, our community colleges and public universities with 21st-century classrooms. The Enhancing Education Through Technology Grant program was designed to achieve those very goals. Yet, the budget cuts this already underfunded program from $269 million to $100 million.

Now, while it is true the program receives $650 million in the stimulus bill, there is a problem using that as the rationale. First of all, the fact is that the stimulus was intended to supplement and to not supplant existing funding. Furthermore, the drastic cuts put the only significant technology program that the Department of Education has at a terrible disadvantage, because, by funding the technology program at $100 million in fiscal year 2010, you are lowering the baseline for future funding. And it could take years for this program to regain even its 2009 funding level of $269 million.

Can you explain the rationale for such a dramatic cut in funding for education technology, especially now when it is more needed than ever?

Secretary DUNCAN. Again, I mean, you hit on both the challenges and the opportunities. But when we have, as you have stated, $650 million in new money—unprecedented increases for education technology. There is a huge influx of money to go across the country to folks to work very, very hard in this area. And we have never seen that kind of support, ever, for education technology.

Ms. ROYBAL-ALLARD. So you are basically supplanting, then, in other words. And the program, as I said, is going to be put in a terrible disadvantage in the future, because that then becomes the baseline.

Secretary DUNCAN. I understand the concern. Again, there was two to three times as much money going in through the stimulus package than this program has ever seen before.

Ms. ROYBAL-ALLARD. Okay, but that doesn't address the problem it creates in the future.

Secretary DUNCAN. No, I understand that challenge. I totally understand that challenge.

SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES STATE GRANTS

Ms. ROYBAL-ALLARD. Okay. The Safe and Drug-Free Schools and Communities program provides very effective, research-based approaches to drug abuse and violence prevention. And the program reaches about 37 million students in every school district across the United States.

Now, the President's budget eliminates the $295 million State grant program and replaces it with a much smaller $100 million competitive grant program. And it is my understanding that the Department justifies eliminating this program on an old 2001 study.

Many changes have been made to this program in the last 8 years. And not only will there be less money available for school drug programs—which, I might add, are badly needed. We defi-

nitely have a drug and alcohol problem with our young people. But by making it competitive, the result will be that some school districts will be left without these vital funds, because they will not be able to compete and get that money to support their programs.

And in cases where schools were getting just a small amount, what they are able to do is use that small amount of Federal money to leverage other State and local funding. So they are going to lose that ability.

So, again, what is the rationale for limiting the scope and the reach of this program? And what will be done to help those schools that will not be able to compete and get the money and will no longer be able to leverage even a small amount of Federal money in order to help them to be able to have these drug prevention programs in their schools?

Secretary DUNCAN. I really appreciate the question. Obviously, these are huge, important issues, and continuing to make sure our schools are violence-free and drug-free is hugely important. And, Mr. Chairman, we made tough cuts. They are hard and controversial and not easy, and I understand that.

It wasn't just a 2001 study, just to be clear on the facts base. There was a 2007 study, as well, that talked about these programs not really making a significant difference. That is much more current than the 2001 study.

And what we really found was that money that was trickling out to States wasn't making a big difference. And we want to get that money directly to schools and into school districts, and to be much more tangible, much more hands-on with students. And that was the shift in strategic focus. We remain absolutely committed to the goals.

Mr. OBEY. Let me explain. We have four votes coming up. And the Majority Leader has announced that, in contrast to recent practice, he is going to hold these votes to a tight timeframe. So if we don't want to miss the votes, I would suggest that we go over to the House now.

I am sorry, Mr. Secretary, but we are going to be stuck over there; my guess would be for about 30 to 40 minutes.

[Recess.]

Mr. OBEY. Mr. Secretary, I know this is a wonderfully productive use of your time, but we will try to screw things up again in about 10 minutes.

So, having said that, Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chair.

## NATIONAL EDUCATION STANDARDS AND GOALS

And, Mr. Secretary, it is good to see you again. When you were before the Budget Committee, we had an opportunity to speak a little bit about national standards and national goals development. And I know that you are working with NCSL and school boards and superintendents and parents all over across the country to work on that. So I hope to talk to you more about that and how my concern that is going to come up shortly about funding is going to fit in.

NATIVE AMERICAN STUDENTS

But I do want to thank you for your sincere acknowledgment of what our tribal schools need, as well as, as you become even more immersed in this issue for our young children and leaving truly no one behind, the needs that many Native American children face in our urban and suburban settings, as well as what you have seen on the reservations.

I was just at Mille Lacs and Leech Lake, where I saw great things going on in school buildings that were second-rate, but the hearts of those kids were first-rate in being there and learning, and so were their elders and their community behind them 100 percent.

STATE BUDGET DEFICITS AND ACCOUNTABILITY

I want to talk to you for a second about what I consider becoming near a national security issue, and that is the economy and the role of education in the economy. And, as the economy has worsened, I am afraid we are seeing opportunities for education, for many of the things that you want to do, and President Obama and I and the parents in my district, slip through our fingers. That is, as I said, a national security issue, not only as, I think, making us being able to compete in this world, but also for keeping our democracy vibrant and strong and a beacon for other countries to look at.

The Center on Budget and Policy Priorities recently issued a paper on Federal fiscal assistance for State governments. It has seen what the recovery package has done. It has enabled States to not decrease their budgets quite as much as they might have with the shortfalls that they are seeing. In other words, it is smaller cuts for education than what would have been.

And I am concerned about this, because if you look at what is going on in 46 of the States, they have deficits for fiscal 2010 and beyond. The gaps total $133 billion for 45 States, and they are estimating the size of these gaps could grow. Minnesota alone has a $654 million mid-year budget deficit.

ACCOUNTABILITY FOR USE OF RECOVERY FUNDS

So what I am concerned about is that Recovery funds are really supplanting regular education funds. This Congress made a decision not to do matching funds to give States some flexibility. We gave governors and their departments of education the dollars without going through their legislative branches, assuming that these funds would be used, yes, to maybe supplant a little, but they are being supplanted for everything.

So how do we move forward? And I agree with Chairman Obey. With all the goals, all the wonderful goals in this budget, and with the money that you have planned to achieve these goals, if we send the money to the States and they just use it to provide basic education and still cut basic education, then we are set up for failure, President Obama is set up for failure, but, most importantly, our children are set up for failure.

So how are we going to hold these school districts accountable? Where is the shared responsibility for our children's future?

Secretary DUNCAN. That is a great question. And I am a believer in both awards and consequences, and let me tell you what we are doing at both ends of the spectrum.

First of all, in the first round of the stimulus package, we put out tens of billions of dollars, and our staff has gotten that money out extraordinarily quickly. We committed to putting it out within 14 days, and our staff has been getting it out in closer to 6 days. They have been working nights and weekends to really respond to the urgent need.

But we also held back billions of dollars. And where we see States playing shell games or acting in bad faith, we have the opportunity not to put out that second tranche of money. And we are not looking for a fight, we are not looking to be the tough guy or the bad guy, but we are absolutely prepared to do that, if necessary. So we have a real significant stick there.

Secondly, we talked about unprecedented discretionary resources: $4.3 billion for the Race to the Top Fund, $650 million invested in the What Works and Innovation Fund. And where we see States playing games or acting in bad faith and doing the wrong thing by children, they will basically eliminate themselves from that competition.

So they have a chance to bring in, on top of unprecedented stimulus resources, a chance to bring in hundreds of millions of dollars into their States if they are creative, if they are innovative, if they are pushing the status quo and challenging the status quo. But if they are doing the wrong thing, they could lose out in the second set of stimulus money, and they would absolutely put themselves at huge risk, huge jeopardy, of just being eliminated from the competition for discretionary dollars.

So I think we have real carrots and real sticks to try to encourage States to act in good faith and do the right thing by children.

Ms. MCCOLLUM. Thank you, Mr. Chairman.

Mr. OBEY. We now have another vote going on with 12 minutes left.

Mr. Moran, why don't we take you? And then I am afraid we will have to go vote again.

Mr. MORAN. Who is in charge of this place anyway?

Mr. OBEY. Nobody.

Mr. MORAN. Okay.

## EDUCATION FUNDING DISPARITIES

I want to ask you, on a macro issue, Mr. Secretary, related to the geographic and economic disparity in our public school system, bearing in mind that what the Federal Government does is at most capacity-building and gap-filling. It is a relatively small fraction of the public education budget. But some trends have been occurring that have been exacerbated in the last several years.

One is geographic. It is clear that the best, from an academic and creative standpoint, students in much of the heartland of the country, they are moving. They are moving to the coast, the east or west coast, to what Richard Florida calls the "creative class communities." They prefer, you know, Metro and the coffee shops and so on, or the principal suburbs. You are aware of that geographic

disparity. And it is causing a major employment and economic potential gap.

But the other problem is an economic one, and it is really based upon the way we fund public education. As you very well know, we are too reliant upon property taxes. The problem there is that the parents who have the most at stake in our public school system are the least likely to own much property. And so they really are kind of powerless in terms of putting adequate resources into the public school system.

Those who have the money are either retired, or they are in their fifties or whatever, they have accumulated some wealth, so they have substantial property, or they are wealthy enough that they send their kids to private school. And we are seeing that over and over again, particularly in inner-cities and some of the exurban areas. There is a lessening of the political support for adequate investment in education.

So, of all the things that we do, perhaps the best thing we could do is to try to restructure our national system for funding education. It is regressive now; there is a built-in perverse incentive. And it is one of the reasons why, in terms of comparativeness to the rest of the world, we tend to be dropping each successive year in terms of our global competitiveness and the preparation of the workforce.

So I would like to get some thoughts from you, because I have heard you express yourself before and you, I think, would have some useful suggestions. But I would like to know if the Administration has thought about taking this issue on.

Secretary DUNCAN. It is another long, long conversation, but this issue is very personal for me. I come from a State, Illinois, and my numbers may not be exactly right, but we were 48th in the amount of money going to education, so we were virtually dead-last. And we were 43rd in the disparities between wealthy districts and poor districts. And I was at the poor end of that. I worked in a district that was 90 percent minority, and 85 percent of my students lived below the poverty line.

EQUALIZING ASPECT OF EDUCATION

And when the children of the rich get dramatically more spent on them than the children of the poor, it exacerbates the great disparities and outcomes. I think public education, at its heart, should be the great equalizer. And every child, regardless of whether he or she is wealthy, poor, black, white, Asian, Latino, it doesn't matter, every child should have a chance to get a great education.

And money doesn't begin to answer all our problems, and we have seen lots of money spent on things that don't make sense. But it is interesting, in every wealthy district they seem to spend a lot of money on education, and there is a value there. And it needs to be spent well.

And so, this is one that I think we have to really think about. And I don't have answers today. You know, our folks are thinking about it and looking at it. But when we are contributing, when we are perpetuating a system of haves and have-nots, I think that is not the principle upon which our country is based and that is not the point of public education in our country. And we need to be

very, very thoughtful about what we are doing to give every child the chance to have a great education.

TAX REMEDIES VS. PROGRAM PROLIFERATION

Mr. MORAN. Yeah. Well, I hear you, and obviously no one could disagree with you. But I think if we were to reassess this whole situation and come up with a far-ranging plan that addressed it from a tax standpoint, it might be the most important thing we could do, instead of this proliferation of programs trying to meet needs where it is really a marginal improvement we can make to fixing of the underlying cause of the disparity.

We have very little time, so I won't pursue it further or even ask further questions, because we are going to have to go vote. But I thank you for your thoughtfulness and your background. We are going to have a lot of time to work together. But I am glad you are on board.

Mr. OBEY. I am going to suggest, Ms. Lee, it is futile to try to come back here, with what is going on on the floor. We have 6 minutes and 40 seconds left to vote. It is going to be a short vote, so I would suggest you take 2 minutes to ask a question. And then we will have to hang it up or we will all miss the votes.

Ms. LEE. Okay.

MINORITY DROPOUT RATES

Well, first, welcome, Secretary Duncan. It is good to see you again. And, again, I just want to reiterate a couple of things we talked about at your meeting with the Congressional Black Caucus. I serve as Chair, as you know, and one the areas that we are extremely concerned about is dropout rates in minority communities, especially with young African American and Latino boys.

The statistics are African American men have a 30 percent chance of serving in prison before the age of 30, but among young African American men who drop out of high school it jumps to 60 percent. And so it is just outrageous. It is astounding. And I need to look at your budget and just look at how you are really beginning to address this dropout rate, especially among minority groups.

EDUCATION—A CIVIL RIGHTS ISSUE

And, finally, let me just say I am very pleased to see that you acknowledge that education is the civil rights issue of our time and that it is a truly effective weapon in our Nation's long war on poverty, because you are absolutely correct. And to have that perspective coming from your department I think is wonderful.

Thank you.

ADDRESSING THE DROPOUT PROBLEM

Secretary DUNCAN. Thank you. And just quickly, as we talked about, I think there is nothing more important we can do as a country than dramatically reduce that dropout rate. And the economic cost to the country and the personal loss is tremendous.

We can identify 2,000 high schools around the country that produce half of our Nation's dropouts and 75 percent of our minor-

ity students' dropouts. And so what we want to do is not tinker around the edges, not just effect incremental change. We want to—and this is tough, tough work, but I think we have to do it—we have to engage these tough issues in a real and honest way. We need to fundamentally turn around, over time, not overnight but over time, those schools and those feeder middle schools and elementary schools.

We can identify the problem. And this has been going on for far too long, and these children do not have a chance at being successful when we have these kinds of dropout rates.

Ms. LEE. But, Mr. Secretary, I hope—and could you follow up with us, or in writing perhaps to the committee, how in your budget, what is the strategy, because I don't see this targeted in your budget.

Secretary DUNCAN. $5 billion in school improvement money, Title I—unprecedented dollars going in to help the neediest of schools.

Mr. OBEY. I am going to have to call this hearing to an end. I will save my questions for another time, Mr. Secretary. I apologize for the discombobulation, but that is life around here. Thank you.

Secretary DUNCAN. No problem. Thank you so much for the opportunity, and thanks for your leadership, Mr. Chairman.

[The following questions were submitted to be answered for the record:]

## TITLE I GRANTS TO LOCAL EDUCATIONAL AGENCIES

Mr. Jackson: If districts are forced to take some of their ARRA funding to cover a potential cut in Title I, do you worry about reducing the impact of the ARRA funding?

Secretary Duncan: Actually, we believe our proposal would help maximize the impact of the American Recovery and Reinvestment Act (ARRA) Title I funding by effectively shifting a portion of these funds to where they are most needed and can do the most good—to provide a significant increase for Title I School Improvement Grants to help turn around our lowest-performing schools.

Mr. Jackson: In addition, what would you suggest districts do if they are forced to cut teachers or programming due to a cut in Title I?

Secretary Duncan: We believe that because of the windfall experienced by nearly all Title I districts under the ARRA, and the fact that most, if not all, of these districts will have a large portion of their ARRA Title I funds available in fiscal year 2010, our proposed reduction in the 2010 appropriation for Title I is unlikely to lead to cuts in teachers or programming.

## HISTORICALLY BLACK COLLEGES AND UNIVERSITIES

Mr. Jackson: While there is an increase from the fiscal year 2009 levels for the Strengthening Historically Black Colleges and Universities (HBCUs) program, fiscal year 2010 does not include the additional $85 million that was included in the College Cost Reduction and Access Act. The $85 million brought the account to $323 million for fiscal year 2009. Many members are very interested in ensuring that the funding for the HBCU account is significantly increased over time. Are you willing to support our efforts on this?

Secretary Duncan: The Administration is committed to assisting institutions that enroll a large proportion of minority and disadvantaged students by providing funds to improve institutions' academic programs and administrative and fundraising capabilities. The fiscal year 2010 request demonstrates the Administration's continued support of these institutions that play a unique and vital role in providing higher education opportunity to minority and disadvantaged students.

The College Cost Reduction and Access Act of 2008 (P.L. 110-84) provided mandatory funding for the Strengthening HBCUs program for 2 years—2008 and 2009. Authority to award new grants under this Act expires at the end of fiscal year 2009. Congress appropriated $238.1 million in discretionary funding for the Strengthening HBCUs program in fiscal year 2009. The Administration's fiscal year 2010 request for the Strengthening HBCUs discretionary program is $250 million. This represents a 5 percent increase over the 2009 discretionary level.

The Administration's request for HBCUs and other higher education programs serving large proportions of disadvantaged and minority students are among a select few Department of Education programs slated for funding increases in fiscal year 2010.

There are other investments that will make a real difference for students who attend HBCUs and other minority serving institutions. The fiscal year 2010 budget proposal would make funding for the Pell Grant program mandatory and ensure that grant amounts keep pace with inflation. The budget requests $28.7 billion in mandatory funding for fiscal year 2010 to fully fund $28.6 billion in Pell Grants to nearly 7.6 million students. The Pell maximum award for the 2010-2011 academic year would be $5,550. In academic year 2010-2011, under the President's budget request, there would be an estimated 198,000 Pell recipients at HBCUs, receiving almost $799 million in Pell funds, an increase of more than $80 million over the prior academic year for HBCU students and the institutions they attend.

In addition, the fiscal year 2010 budget would almost double the HBCU Capital Financing Program—from $10.4 million to $20.6 million. The requested amount would enable $178.2 million in new loans in fiscal year 2010. This program provides key resources for HBCUs to repair, modernize, and renovate their facilities.

**ARRA FUNDS AND HBCUs**

Mr. Jackson: What steps are being taken by the the Department to ensure the engagement of HBCUs in receipt of ARRA funding, as well as funding made available through the College Completion and Access initiative?

Secretary Duncan: For the student aid programs, ARRA funds were provided directly to institutions participating in the Pell Grant and Work-Study programs as part of their normal student awards or institutional allocation. While final decisions on the College Access and Completion Fund have not been made, it is our intention the majority of the funds will be directed by States. Clearly, we would expect States to use those funds to meet the needs of institutions, like some historically Black colleges and universities, which enroll students that are more likely to leave without a degree either to enroll at another institution or drop out. Some of the funds will be retained for national activities. It is conceivable that some amount could be reserved and used to address the needs of unique populations like tribal colleges and historically Black colleges and universities.

Mr. Jackson: Similar to funding made available through the ARRA, it is my understanding that the Administration intends for the College Completion funding to be directed to the States. Is this correct?

Secretary Duncan: No ARRA student aid funds are distributed to States. As noted above, we intend that the majority of the College Access and Completion Fund awards will be directed by States. As indicated, we expect, however, that some of the funds will be retained for national activities, and perhaps some amount could be reserved

and used to address the needs of unique populations like tribal colleges and historically Black colleges and universities.

**ENCOURAGING STATES TO ENGAGE WITH HBCUs**

Mr. Jackson: If funding will be sent directly to the States, can you please tell the committee how the Department will ensure that the States engage HBCUs, including the private HBCUs -- all of which have not received adequate funding from the States historically? After all, if the States have supported these institutions properly, this Congress and the Executive branch would not have had to establish the programs that have been established in the Higher Education Act (including Title III) and elsewhere.

Secretary Duncan: For the student aid programs, ARRA funds were provided directly to institutions participating in the Pell Grant and Work-Study programs as part of their normal student awards or institutional allocation. No ARRA funding for these programs was awarded through States.

Clearly, we would expect States to use awards under the College Access and Completion Fund to meet the needs of institutions, like some historically Black colleges and universities, which enroll students that are more likely to leave without a degree either to enroll at another institution or drop out. We will monitor the steps States take to use the funds provided to ensure that they appropriately address the needs of these institutions and their students.

**ARRA STUDENT AID FUNDING BY STATE**

Mr. Jackson: In terms of the ARRA monies that have been released and which will be released to the States, to what extent have the States engaged or awarded funding to HBCUs and predominantly Black institutions? Can you please provide me and this subcommittee a State breakdown and list any participating institutions including the amount of funding received by the institutions and the total amount going to all institutions of higher education in each State?

Secretary Duncan: As noted above, ARRA funding for the Pell Grant and Work-Study programs was awarded directly to participating schools rather than through States. These funds support normal program operations; schools did not apply for these funds separately, but rather received funding as part of their normal Pell Grant awards and Work-Study allocation. Accordingly, the Department does not differentiate between awards under these programs supported by ARRA funding and funding provided through the normal appropriation process. Overall, students at HBCU's will receive over $700 million in Pell Grants during the 2009-2010 award year.

**WHITE HOUSE INITIATIVE ON HBCUs**

Mr. Jackson: Will the President be issuing an Executive Order establishing the White House Initiative on HBCUs, and if so, when?

Secretary Duncan: The President's Board of Advisors on Historically Black Colleges and Universities (Executive Order 13256) is scheduled to terminate September 30, 2009. We expect the President to issue an executive order continuing the President's Board of Advisors on HBCUs prior to September 30, 2009. The President is committed to ensuring that HBCUs have the opportunity to fully and successfully participate in the programs of the Federal Government.

## ENGAGING HBCUs IN TEACHER EDUCATION, SCHOOL REFORM, AND TEACH FOR AMERICA

Mr. Jackson: What proactive steps is the Department of Education taking to ensure the robust engagement of HBCUs as it relates to teacher education, school reform and efforts supporting Teach for America?

Secretary Duncan: On June 9, 2009, the Department hosted a Historically Black Colleges and Universities (HBCUs) Teaching and Teacher Education Forum sponsored by the White House Initiative on Historically Black Colleges and Universities in collaboration with the National Board for Professional Teaching Standards. In my remarks at this forum, I noted that graduates of HBCUs account for 50 percent of African Americans teaching in public schools in the United States and that HBCUs will continue to play a critical role in helping States and districts meet the demand for effective teachers. The Department is committed to work with HBCUs to support and strengthen their teacher preparation programs and to encourage HBCU graduates trained in critical fields with teacher shortages, including mathematics and science, to enter the teaching profession.

## TRANSITION TO TEACHING PROGRAM AND HBCUs

The Transition to Teaching program provides grants to programs that recruit and retain highly qualified midcareer professionals (including highly qualified paraprofessionals) and recent graduates of institutions of higher education, as teachers in high-need schools, including recruiting teachers through alternative routes to teacher certification. Grants also support the development and expansion of alternative routes to certification under State approved programs that enable individuals to be eligible for accelerated teacher certification based on experience, expertise, academic and other qualifications, in lieu of traditional course work in the field of education. The following HBCUs administer Transition to Teaching grants or serve as partner institutions for other entities administering grants under this program: Howard University, University of the District of Columbia, Xavier of Louisiana (grantee and partner institution), Jackson State University (partner institution with grantee Jackson Public Schools), Elizabeth City State University, North Carolina A&T State University, and North Carolina Central University.

Since 2001, the Department has awarded nearly $30.7 million in grants through the Fund for the Improvement of Education in the Innovation and Improvement Account to Teach for America, Inc., to support and expand its efforts to recruit, select, and support

outstanding recent college graduates who commit to serve as teachers for at least 2 years in high-need schools and districts in low-income urban and rural communities across the United States. Although the Department has not specifically addressed the participation of HBCUs in the activities supported by these grants, Teach for America is committed to ensuring the diversity of its corps members and places particular emphasis on recruiting applicants who share the racial and/or socioeconomic backgrounds of the students Teach for America corps members teach.

At the 400 colleges and universities at which Teach for America most heavily recruits, African American students represent only 5.1 percent of graduates, but 10 percent of Teach for America corps members are African-American. One of the strategies Teach for America employs to increase the participation of African Americans in its ranks is to actively recruit at HBCUs. In 2008, 25 percent of the graduating class at Spelman College, an HBCU in Atlanta, Georgia, applied to be Teach for America corps members.

Teach for America recently inaugurated a Community Speakers Series designed to engage communities and colleges in insightful and compelling town hall discussions about the educational opportunities and challenges affecting communities of color in this country. Teach for America's purpose in establishing this series of events is to stimulate dialogue and enlist these communities more broadly in the work of closing the achievement gap. The first Community Speakers Series event, entitled "Black Men and Education: A Discussion on the Pursuit of Excellence" was held on November 20, 2008, on the campus of Morehouse College, an HBCU in Atlanta, GA, and focused on African American men and their quest for educational excellence. The forum featured dynamic African American male panelists who represented varied experiences and perspectives. The event attracted more than 2,000 individuals, including student leaders, educators, politicians, business and civic leaders and community members.

**COLLEGE COMPLETION RATES**

Mr. Jackson: What proactive and strategic steps are being taken by the Department to ensure the robust engagement of HBCUs in meeting the President's goals of doubling college completion rates?

Secretary Duncan: The fiscal year 2010 request demonstrates the Administration's investment to make college more affordable and accessible and to help more students succeed once they get there. These investments will make a real difference for students who attend HBCUs and other Minority Serving Institutions (MSIs). Although African American students have made significant gains in college enrollment, they still lag behind their white peers in the rate in which they complete college. Historically Black Colleges and Universities continue to play an important role in graduating African American students.

- Together, the recently enacted American Recovery and Reinvestment Act (ARRA) and the fiscal year 2010 budget invest nearly $200 billion in Pell Grants, new college tax credits, and other initiatives.

- A 5-year $2.5 billion College Access and Completion Fund would support efforts to increase college enrollment and completion rates for low-income students, including those attending HBCUs.

- The Administration's fiscal year 2010 budget request for discretionary funding for Strengthening HBCUs and Strengthening Historically Black Graduate Institutions is $250 million and $61.4 million, respectively. These amounts represent a 5 percent increase over the 2009 discretionary level. In addition, first-time discretionary funding of $7.9 million is requested for Predominantly Black Institutions.

- Maintaining funding for Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) and the Federal TRIO Programs will also help many low-income students and first generation college students successfully enroll in and complete their education at HBCUs.

- The Administration intends to continue the work of the White House Initiative on Historically Black Colleges and Universities ensuring the HBCUs have the opportunity to fully and successfully participate in the programs of the Federal Government.

**HBCUs AND DIRECT LENDING**

Mr. Jackson: Have you assessed the impact these changes would have on HBCUs and will you be able to provide any technical assistance to HBCUs that may be adversely affected by implementation of the new proposal? Please advise.

Secretary Duncan: We have already contacted the HBCU community to discuss the implementation process for moving to Direct Loans. In addition to making available all the normal technical support and other resources available to schools moving to Direct Loans, we are also working with HBCU's to identify specific additional support needed to address any unique concerns or requirements these schools may have.

**BULLYING**

Mr. Jackson: As the Department plans for appropriations for FY 2010, how do you plan to utilize programs and resources to combat bullying in our Nation's schools?

Secretary Duncan: In several ways. A new initiative concerning school culture and climate is included within the 2010 budget request for Safe and Drug-Free Schools and Communities (SDFSC) National Programs. It is designed to support efforts to address problems related to disruption and disorder in schools, and to assist schools that are experiencing serious violent and criminal behavior. The budget requests $100 million

in FY 2010 for an estimated 400 new grants under this initiative. The program will encourage the use of research-based interventions as well as the involvement of partners from the community, including representatives from law enforcement, juvenile justice, and public mental health systems that also frequently interact with troubled students. We expect that applicants will propose strategies to reduce bullying and harassing behaviors, and to provide needed supports for victims, as well as bullies.

We also plan to continue other, related activities. For example, Safe Schools/Healthy Students grants to local educational agencies (which are funded in part under SDFSC National Programs and administered jointly by the Departments of Education, Health and Human Services (HHS), and Justice) also provide for bullying prevention efforts in schools and communities. In addition, Education has provided joint funding to, and collaborated with, the Health Resources and Services Administration (HRSA) in HHS for the development and implementation of an anti-bullying campaign, "Stop Bullying Now!" The campaign includes materials and technical assistance for children and adults to help them learn about and prevent bullying. The campaign has been broadly disseminated and is available online at: http://www.stopbullyingnow.hrsa.gov/kids/.

**CHARTER SCHOOLS -- PROMOTING ACCOUNTABILITY AND HIGH STANDARDS**

Mr. Jackson: Could you share your thoughts on stronger quality controls - like adopting contracts and annual audits - within the CSP, to allow for greater accountability and transparency in the system?

Secretary Duncan: The Administration is committed to supporting successful models of school reform, including high-quality charter schools. In the President's FY 2010 Budget, we have proposed $268 million, an increase of $52 million, for the Charter School Program (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 and, most importantly, promote greater accountability and transparency in the system.

The Administration is focused on creating autonomy for charter schools combined with greater accountability and more rigorous authorizing practices. This focus on accountability already exists in how current law defines a charter school. We are calling on States to reform their charter laws and lift caps that limit growth among excellent charter schools in order to promote the growth of successful, high-quality charter schools. In addition to these policy changes, the Department continues to encourage States and, more specifically, authorizers to put in place stronger controls for approving, renewing, and revoking charter school performance contracts.

## STAUTORY PROVISIONS PROMOTING ACCOUNTABILITY AND HIGH STANDARDS

Our efforts to promote accountability and high standards in charter schools are supported first and foremost by the program statute. Under Title V, Part B of the Elementary and Secondary Education Act (ESEA) a charter school must have in place "a written performance contract with the authorized public chartering agency in the State that includes a description of how student performance will be measured in charter schools..." and also "agree to comply with the same Federal and State audit requirements as do other elementary and secondary schools in the State..." Beyond the statutorily defined accountability requirements, the Department has taken several steps to put a rigorous system of program accountability in place. In recent CSP grant competitions, the Department has given priority to States that have multiple chartering agencies or an appeals process for prospective charter schools that initially fail to be approved by a single agency, ensure the accountability of public charter schools in their State, and provide public charter schools with a high degree of autonomy over their budgets and expenditures.

## THREE-PART ACCOUNTABILITY AND TECHNICAL ASSISTANCE MODEL FOR CHARTER SCHOOL PROGRAMS

In addition, the Department, in 2006, initiated an ambitious three-part accountability and technical assistance model to help ensure that all CSP grantees meet program, fiscal, and accountability requirements. The first part of the model involved the development of the CSP-grantee award database, including State educational agency (SEA), Non-SEA, and school-level data. These grantee-level data are then merged with the Department's ED*Facts* system to extract student demographic and performance information. This integrated data collection system allows the Department to monitor CSP grant performance, program accountability, fiscal management, and, most importantly, charter schools' impact on student achievement.

The second part of the model consists of a series of technical assistance meetings with CSP grantees to provide information on a range of Department and program-specific requirements, including grant administration, performance measures, regulatory guidance, and charter school resources. These annual meetings provide grantees with an opportunity to exchange ideas and share information on successful practices and, in turn, allow for greater transparency in the program. The Department's technical assistance contractor also meets with grantees individually to assess the extent to which their proposed program objectives, performance measures, and related evaluation plans align and will yield meaningful performance data. The contractor also works with grantees to revise and strengthen their program objectives, so as to produce more transparent and measurable outcomes.

The third part of the model consists of ongoing monitoring and on-site technical assistance to help the Department evaluate the progress of SEA and non-SEA grantees in implementing their CSP programs and completing the objectives of their approved

application. These monitoring and technical assistance services help to ensure that grantees are using Federal CSP funds to plan, design, and implement high-quality charter schools through such actions as disseminating information and resources about successful State sub-recipient awards and monitoring practices, promising charter school models, instructional practices, teacher professional development, student academic achievement, and guidance on the program statute, governance, as well as finance and facilities issues.

## DEPARTMENT PROGRAMS HELPING VETERANS TRANSITION TO COLLEGE

Ms. Royal-Allard: Last year, as part of the reauthorization of the Higher Education Act, Congress authorized a new competitive grant program to assist veterans who are making the transition to colleges and universities. The program is called "Centers of Excellence for Veteran Student Success." It would support the development of model programs across the country to provide services to address the academic, financial, physical, and social needs of veteran students, and help veterans enroll, persist in and complete postsecondary educational goals.

This new program is especially timely because of the upcoming implementation of the Post 9/11 GI bill this fall and the expected increase in veterans enrolling in colleges throughout the Nation. However, this important program was unfunded in the President's budget. What was the rationale for excluding this program, especially in light of the President's goal to increase college graduation rates?

Secretary Duncan: We share your concerns about ensuring that veterans receive the support they need to successfully make the transition to college. The Department has requested funding for the TRIO Veterans Upward Bound program, which under the Administration's request would receive approximately $14 million in 2010. Our 2010 request, while level with 2009, represents an increase of about 17 percent over 2008.

Veterans Upward Bound—a special component of the Upward Bound Program—assists veterans in enrolling in—and graduating from—postsecondary educational institutions. The program pursues this goal by offering many of the services authorized under the Centers of Excellence for Veteran Student Success program, including academic advice and tutoring, counseling, assistance in applying for college admission and financial aid, exposure to cultural events and academic programs, and other services designed to aid the transition to college. Veterans also can participate in other Department of Education programs designed to increase college enrollment and graduation rates, including the TRIO Educational Opportunity Centers (EOC) and Student Support Services (SSS) programs. EOC provides counseling and information on college admissions, and SSS offers a broad range of support services designed to increase postsecondary retention and graduation. The 2010 request includes $46.8 million for EOC and $295.5 million for SSS.

In addition, the Department has requested $2.5 billion over 5 years to finance the President's new College Access and Completion Fund program. This initiative

establishes Federal-State partnerships dedicated to implementing and evaluating college retention programs. The purpose of these programs is to improve college completion rates throughout the country. Veterans—particularly those who come from disadvantaged backgrounds—would, of course, have access to the services provided through this new initiative.

**SUPPORT FOR LATINO STUDENTS**

Ms. Roybal-Allard: Latino students represent almost 20 percent of students in public schools and almost 40 percent of Latino students are English language learners. English language learners face the daunting challenge of acquiring English literacy skills while simultaneously mastering the academic content they will need to compete in our competitive global economy. Yet the President's budget proposes level funding for English Language Acquisition State grants that help States and schools build their capacity to teach English language learners effectively. In addition, the President's budget also level funds several other programs that have been proven to help Latino students succeed in school, such as the Migrant Education Program, TRIO, GEAR UP and the Parental Information and Resource Center.

How does the Department of Education plan to address the real and growing needs of Latino students if not through funding these critical programs?

Secretary Duncan: Since 2007, the appropriation for the English Language Acquisition State Grants program has increased by more than 9 percent. We believe that maintaining this significant increase in funding demonstrates the Department's commitment to supporting the needs of English language learners. Further, the Department has requested a $7 million increase for English literacy and civics education services under the Adult Education State Grants program and a $2.5 million increase for the High School Equivalency (HEP) and College Assistance Migrant (CAMP) programs.

The Department's 2010 budget request includes increases or initial funding in many other programs that provide services to improve the education of all students, including the Latino students who make up a very significant portion of the Nation's children who are in need of services under the various programs. The request includes $500 million for the new Title I Early Childhood grant program, $300 million for a new Early Learning Challenge Fund, $10 million for the Promise Neighborhoods initiative, $50 million for a High School Graduation Initiative, an additional $50 million for Early Reading First, and an additional $335 million for Striving Readers.

The Department believes that level funding for the TRIO programs is warranted because TRIO received a large increase in 2008, including an additional $57 million for the Upward Bound program to support additional grant awards, and in 2009, when funding was increased by another $19.9 million to provide a significant increment for the Student Support Services program as well as to fund additional Upward Bound Math/Science, Upward Bound Veterans, and McNair grantees. We believe that this 9.3 percent increase over 2 years provides a sufficient level of support for the program.

The Department also believes that level funding for GEAR UP, which will allow it to serve over 765,000 students in 2010, is appropriate at this time.

Early performance data indicate that the Parental Information and Resource Center (PIRC) program has been successful in reaching out to parents in Latino families through both direct and indirect contact, and level funding will allow the program to maintain efforts to provide leadership, technical assistance, and financial support to nonprofit institutions and LEAs that implement effective parental involvement policies, programs, and activities to improve student achievement.

**ENGLISH LANGUAGE ACQUISITION PROGRAM EVALUATIONS**

Ms. Roybal-Allard: It is my understanding that the Department has conducted several evaluations of English Language Learning programs. What are the conclusions from these evaluations? Have exemplary programs been identified on how to teach English to low-income children who do not speak English at home? Has the Department identified what the average length of time non-English speaking children spend in English Language Learning classrooms? How has the Department responded to school districts in nontraditional immigrant receiving States, like North Carolina, Arkansas and Georgia, that are now receiving non-English speaking students? Have the evaluations noted differences in educational outcomes based on the timing of reclassification into an English only classroom?

Secretary Duncan: The Department has not addressed the specific issues you have identified. However, we have funded different studies to learn more about the diverse population of English language learners and how best to meet their needs. Beginning in FY 2004, using funds from the English Language Acquisition State Grants program set-aside for evaluation, the Department entered into 5-year cooperative agreements with 3 institutions of higher education (IHEs). One of the IHEs is measuring the relative effects on student literacy outcomes of Spanish-dominant children using a structured English immersion approach versus a transitional bilingual education or two-way bilingual education approach. The other two IHEs are using different approaches to study the impact of structured English immersion programs and transitional bilingual education programs on the outcomes of English language learners. Final reports are expected in December 2009.

The Department has funded three studies with FY 2008 funds. The first study is a response to a GAO recommendation that the Department determine the relative accuracy of the two available data sources for determining State grants allocations for the English Language Acquisition State Grants program. The Department has contracted with the National Academy of Sciences for expert advice on this issue. The second study is a review of the research on the impact of academic English on English language learners. The third study is an evaluation of the implementation of the Title III State Grants program. In addition to completing a final evaluation report, the contractor will provide short, interim issue briefs to the Department this summer in order to inform our thinking as we proceed with development of an ESEA reauthorization proposal.

**SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES STATE GRANTS**

Ms. Roybal-Allard: During the hearing, the Secretary referred to a 2007 study as a justification for eliminating the Safe and Drug Free Schools and Communities State grants program. As I understand it, this was not a study but a report from a statutorily convened advisory committee, which did not reaffirm the previous findings from the 2001 RAND evaluation of the State grant program. In fact the committee reported that: "At the outset, the Committee notes that none of the witnesses testifying before the committee or any of the committee's members suggested that the State Grants Program is no longer necessary. Rather, the committee believes the program is crucial because safe and drug-free schools are the foundation for improved learning."

I've been informed that members of the Advisory Committee are concerned that their findings have been mischaracterized and are in the process of writing to Secretary Duncan about the misrepresentation of their report.

So, again, what is the rationale for limiting the scope and reach of this vital program and how will the Department of Education ensure that all districts, even those without skilled grant writers on staff, have an equal opportunity to receive funds through the competitive grant program?

Secretary Duncan: The study to which I referred was not the report of the advisory committee. Rather, it an evaluation prepared for the Department by an independent contractor. That study is now going through final revision and review, and we hope to release it later this summer.

The Administration believes that the State Grants program does not target funds adequately on schools most in need of support and spreads funds too thinly to be effective. The RAND study identified that problem, which was also referenced in the final report of the advisory committee. (You are correct, however, that the advisory committee did not recommend elimination of the program.) Rather than continuing to use a very flawed funding mechanism, the Administration believes that we should provide targeted support for interventions that have strong evidence of effectiveness or that are designed to build the national knowledge base on what works in school drug and violence prevention. We should direct that support to school districts and communities that have the greatest need, and we should rigorously assess the results generated by those interventions and make the results know nationally. (Assessment and evaluation have been very difficult under the State grants program, because the variety of services and activities funded at the local level has been so wide and the amount of money received by most districts has been too small to support meaningful evaluation.)

You are correct that not all school districts would receive funding under our proposal. Only those that have a clear need and can present a strong proposal would be assisted. But I don't agree that only the largest districts, those that have full-time "grant-writers" on staff, will be funded. Our experience in administering many competitive

programs indicates that a wide range of districts – rural, suburban, and urban – can be successful in those competitions.

## EQUITY

Mr. Honda: What metrics will the Department be using to determine the effectiveness of the reforms outlined in the American Recovery and Reinvestment Act (ARRA), specifically how will you measure a State's success at improving educational opportunity and establishing equity for each child regardless of where they attend school?

Secretary Duncan: In the near future, the Department will publish in the Federal Register for public comment a notice detailing the proposed phase-two application process for the State Fiscal Stabilization Fund (Stabilization). The notice will describe the proposed metrics and descriptors for the four reform areas (including achieving equity in teacher distribution) for which States would be required to collect and report data in a manner easily accessible and in a format easily understandable by the public. For example, the Department will propose to require States to confirm the number and percentage of core academic courses taught, in the highest-poverty and lowest-poverty schools, by teachers who are highly qualified consistent with section 9101(23) of the Elementary and Secondary Education Act. The notice will also describe the plan that States would execute to gather the required data and the criteria that the Department will use to evaluate State plans. The Department will encourage the public to comment on the proposed metrics and plan requirements, and will consider all comments before issuing final requirements for phase-two Stabilization awards.

## RACE TO THE TOP

Mr. Honda: In your testimony you stated that States that are not within the intent of the law as to their use of ARRA funds will not be eligible for Race to the Top funds. It is not unimaginable that many students whose leadership (the Governor or the Legislature) have taken steps to subvert the intent of the funding will be adversely impacted by not having access to Race to the Top Funds. What steps will the Department take to enact similar reforms and to support these ineligible schools?

Secretary Duncan: I share your concern that State educational agencies (SEAs) and local educational agencies (LEAs) would bear the consequences of actions that their State governments may take that would put them at a competitive disadvantage for Race to the Top funds. While the Race to the Top program will be a key driver of the Department's reform efforts, it is important to note that the ARRA made available unprecedented amounts for other programs as well. For example, SEAs and LEAs will receive over $48 billion through the State Fiscal Stabilization program and $10 billion in Title I, Part A funds. The Department will also leverage funds from other competitive programs to support the four reform areas included in the ARRA. For example, the Department will award Title I School Improvement Grants to SEAs to support the improvement of struggling schools; SEAs must subgrant 95 percent of their allocations to LEAs with schools identified for improvement, corrective action, or restructuring. Both

SEAs and LEAs could also compete for Teacher Incentive Fund grants to reform teacher and principal compensation systems. Further, all States will have the opportunity to compete for the ARRA State Longitudinal Data Systems money.

**ASIAN AMERICAN AND NATIVE AMERICAN PACIFIC ISLANDER-SERVING INSTITUTION PROGRAM (AANAPISI)**

Mr. Honda: What is your long term plan for funding minority-serving institutions like the Asian American and Native American Pacific Islander-Serving Institution Program (AANAPISI), given this program has been reduced 66 percent in the 2010 budget?

Secretary Duncan: The Administration is committed to assisting institutions that enroll a large proportion of minority and disadvantaged students by providing funds to improve institutions' academic programs and administrative and fundraising capabilities. The fiscal year 2010 request demonstrates the Administration's continued support of these institutions that play a unique and vital role in providing higher education opportunity to minority and disadvantaged students.

The College Cost Reduction and Access Act of 2008 (P.L. 110-84) provided mandatory funding for the AANAPISI program for 2 years—2008 and 2009. Authority to award new grants under this Act expires at the end of fiscal year 2009. In addition to the $5 million in mandatory funding available in fiscal year 2009, Congress appropriated $2.5 million in discretionary funding for this program in fiscal year 2009. The Administration's fiscal year 2010 request for the AANAPISI program is $2.6 million. This represents a 5 percent increase over the 2009 discretionary level.

**IMPROVING STEM EDUCATION**

Mr. Honda: What are your plans for improving the coordination of the STEM programs within the Department?

Secretary Duncan: Improving the coordination and quality of Science, Technology, Engineering and Mathematics (STEM) programs is a priority at the Department, and we are currently evaluating strategies for implementing that priority. For example, we are considering the creation of a new Advisor to the Secretary on STEM programs, and deciding who might best fill this role and how his or her position would best fit within the Department.

Mr. Honda: What steps are you taking to improve STEM education?

Secretary Duncan: First and foremost we are looking at ongoing evaluations to determine the strengths and weaknesses of current programs. Second, our budget would provide either increased or level funding for most of the Department's STEM education programs at the Department have received increased or level funding in FY 2010. Furthermore, the Secretary recently announced up to $350 million for developing

assessments to support common core standards being developed by a coalition of States. At the same time, we are mindful of the President's commitment to fiscal responsibility and recommending the termination of programs deemed ineffective.

In his speech at the National Academies in April, the President specifically mentioned that States making progress in STEM education will be able to compete for additional funding under the competitive "Race to the Top" grant program. His emphasis on STEM education sends a strong message of support to the States and to the STEM community. By developing an effective framework and guidelines for this competitive grant program, we will support the efforts of States, LEAs, and their partners as they develop effective approaches to STEM education.

**RECOVERY ACT AND IDEA FUNDS**

Mr. Honda: Taking into account the Recovery Act IDEA doubled in 2009 and in this budget proposal IDEA is nearly halved, what impact will this funding oscillation have on students with special needs and our schools?

Secretary Duncan: The Administration's request for FY 2010 includes $11.5 billion for the Part B Special Education Grants to States program, $374 million for Part B Preschool Grants program, and $439 million for the Part C Grants for Infants and Families program, the same levels provided for these programs in the regular FY 2009 appropriation. The Recovery Act provided an additional $12.2 billion over the regular FY 2009 appropriation for these programs, funds which are available for obligation by the States and districts through September 30, 2011.

We regard the Recovery Act funds provided for the IDEA programs as a one-time increase to address the significant problems the States and districts are having because of the economy. We also hope that the IDEA Recovery funds will be used, where feasible, for short-term investments that have long-lasting benefits to children with disabilities such as intensive professional development for teachers that focuses on putting into place evidence-based strategies for improving instruction in reading or providing for positive behavioral supports, or developing the capacity to use data to improve teaching and learning.

We have already distributed 50 percent of the IDEA Recovery Act funds to States, but do not plan to distribute the remaining funds until the fall. Because of the availability of other IDEA funds during the same period as the Recovery funding for IDEA and the size of the supplement provided under the Recovery Act, we expect that the Recovery funds will be there to help meet the needs of districts over the next 2 school years, that is, through the end of school year 2010-2011. We expect States and districts to have billions of Recovery Act IDEA funds at their disposal, in addition to the IDEA funds appropriated in FY 2010, for use in the 2010-2011 school year.

## LONG TERM PLAN TO MEET FEDERAL FINANCIAL OBLIGATIONS UNDER IDEA

Mr. Honda: What is the long term plan to meet the Federal financial obligation enumerated in IDEA?

Secretary Duncan: The Administration is committed to helping States and local school districts appropriately meet the needs of children with disabilities. While I cannot speak directly to future budget policy for special education, I expect that the Administration will be requesting increases for special education over time.

## ACCESS TO ACG/SMART

Mr. Honda: What is your strategy for broadening access to the Academic Competitiveness Grant (ACG) and National Science and Mathematics Access to Retain Talent (National SMART Grant) programs, to help low-income students majoring in critical foreign languages, science, and math attend college?

Secretary Duncan: The Department has undertaken extensive outreach efforts with high schools, State education agencies, and institutions of higher education to encourage participation in the program. The Department has provided guidance and training to colleges and universities to help aid administrators implement the Academic Competitiveness Grant and National SMART Grant programs. When the grant programs were implemented in 2006, we provided written guidance to financial aid administrators, incorporated ACG and SMART Grant information in training sessions at regional and national financial aid conferences, and posted information to the agency's Information for Financial Aid Professionals (IFAP) Web site. We also reached out to institutions that appeared to be underutilizing these grant programs so that we could better understand the problems they were facing.

We also worked with States to obtain information on the States' rigorous curricula to determine whether they met the definition of a "rigorous program of study" for the ACG program. With that said, we have no specific plans to promote the programs at the high school level in light of pending expiration of ACG and National SMART Grants at the conclusion of academic year 2010-2011. To encourage these students to take a rigorous curriculum in order to get an additional grant would be misleading at this point.

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