AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

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

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

NONDEPARTMENTAL WITNESSES

[CLERK'S NOTE.—The subcommittee was unable to hold hearings on nondepartmental witnesses. The statements and letters of those submitting written testimony are as follows:]

PREPARED STATEMENT OF AIDS ACTION

I am pleased to submit this testimony to the members of this subcommittee on the importance of increased funding for the fiscal year 2010 HIV/AIDS portfolio. Since 1984, AIDS Action Council, through its member organizations and the greater HIV/AIDS and public health communities, has worked to enhance HIV prevention programs, research protocols, and care and treatment services at the community, State and Federal level. AIDS Action represents many AIDS service organizations located in the Nation's HIV epicenters, local health departments, smaller service providers, faith-based organizations, substance abuse treatment centers, and education and advocacy organizations from all over the country. AIDS Action's goals are to ensure effective, evidence-based HIV care, treatment, and prevention services; to encourage the continuing pursuit of a cure and a vaccine for HIV infection; and to support the development of a public health system which ensures that its services are available to all those in need. On behalf of AIDS Action Council's diverse membership I bring your attention to issues impacting funding for fiscal year 2010.

Nearly 30 years since it was first identified, the HIV/AIDS epidemic in the United States is characterized by needless mortality, inadequate access to care, persistent levels of new infection, and stark racial inequalities. Despite the good news of improved treatments, which have made it possible for people with HIV disease to lead longer and healthier lives, stark realities remain. Consider that in the United States:

—Every year, 56,300 people are newly infected with HIV—one new infection every 9½ minutes. According to the Centers for Disease Control and Prevention (CDC) the HIV infection rate has not fallen in 15 years and the new incidence figure represent a 40 percent increase from previous estimates
—CDC stated that the HIV incidence rate increased by 15 percent from 2006 to 2007.
—More than 1 million people are living with HIV or AIDS; an estimated half of people living with HIV/AIDS are not in care.
—Of those people living with HIV/AIDS 21 percent are unaware of their HIV status.
—CDC estimates in 2007, 14,561 people died from AIDS-related causes.
—African Americans represent 13 percent of the population but nearly half of all newly reported HIV infections.
—Hispanics/Latinos represent 13 percent of the population, but account for 18 percent of newly reported cases of HIV.
—The percentage of newly reported HIV/AIDS cases in the United States. among women tripled from 8 percent to 27 percent between 1985 and 2007.

—AIDS is the leading cause of death among Black women aged 25–34
—HIV is the No. 1 healthcare risk for gay men and men who have sex with men, especially in communities of color.
—More than half of all newly diagnosed individuals are identified with full-blown AIDS in less than 12 months of their initial diagnosis.
—There is neither a cure nor a vaccine for HIV and current treatments do not work for everyone.

The Federal Government's commitment to funding prevention, research, and care and treatment for those living with HIV is critical. We would be unable to respond to this epidemic without the Federal Government's increased commitment to funding HIV programs at home. However, we are not doing enough. The unsatisfactory outcomes from our country's response to AIDS have serious human and economic costs. A study published in 2003 found that failure to meet the Government's then goal of reducing HIV infections by half would lead to $18 billion in excess expenses through 2010. We need more prevention, more treatment and care and more research if we are ever to slow and eventually reverse the HIV epidemic.

It is AIDS Action's expectation that the Congress, through the good work of this subcommittee, will recognize and address the true funding needs of the programs in the HIV/AIDS portfolio. HIV is a 100 percent preventable disease that can be lessened with a focused, concentrated effort and increased funding. The community has come together under the umbrella of the AIDS Budget and Appropriations Coalition with the community funding request for the HIV/AIDS domestic portfolio for fiscal year 2010. The numbers requested represent that community work. These requests have been submitted to the subcommittee.

CDC estimate that approximately 13 percent of all HIV cases and approximately 60 percent of all hepatitis C cases in the United States are directly or indirectly related to intravenous drug use. One of the most important ways to reduce these epidemics is through the use of syringe exchange. More than eight Federal studies along with numerous scientific peer-reviewed papers published more than 15 years have conclusively established that syringe exchange programs reduce the incidence of HIV among people who inject drugs and their sexual partners. Such studies have all concluded that syringe exchange does not increase drug abuse. Instead, syringe exchange programs connect people who use drugs to healthcare services including addiction treatment, HIV and viral hepatitis prevention services and testing, counseling, education, and support.

The ban on Federal funding for syringe exchange is counterproductive and limits the ability of local and State jurisdictions to respond effectively to the twin HIV and hepatitis epidemics. AIDS Action and the HIV community recommends that the subcommittee remove any language prohibiting the use of Federal funds to establish or carry out a program of distributing sterile syringes to reduce the transmission of blood borne pathogens, including the human immunodeficiency virus (HIV) and viral hepatitis.

According to CDC estimates contained in the agency's March 2006 HIV/AIDS Surveillance Report, 1,014,797 cumulative cases of AIDS have been diagnosed in the United States, with a total of 565,927 deaths since the beginning of the epidemic. As noted above, the CDC estimates that between 1.1 and 1.2 million people are living with HIV/AIDS and that 250,000–350,000 people are unaware of their status and could unknowingly transmit the virus to another person. As funding has remained essentially flat for more than 8 years, money has shifted to new and needed HIV testing efforts and initiatives. As a result, grants to States and local communities have significantly decreased and new infections have increased to an estimated 56,300 per year, according to a CDC report released in August 2008. Therefore, AIDS Action Council, the HIV community, and the CDC in their budget justification before Congress September 2008, estimates that the CDC HIV Prevention and Surveillance programs will need $1.5 billion, an increase of $878 million, in fiscal year 2010 to address the true unmet needs of preventing HIV in the United States. In the United States, HIV is transmitted primarily through sex. In order to combat the rising rates of transmission, we must ensure that sexuality education programs are medically sound and effective in fostering healthy behavior over the long-term. Abstinence is an important component of comprehensive sexuality education and HIV prevention programs; however, when it is advocated as the only option for young people, research has shown that it is ineffective, unrealistic, and potentially harmful. We believe the Federal Government should only support those sexuality education and HIV-prevention programs that are evidence-based. For that reason we support the elimination of all funding for the Community-Based Abstinence Education (CBAE) programs. All such funds should be re-directed to evidence-based prevention and educational programs. This past World AIDS Day, President Obama affirmed that, "My administration will .work with Congress to enact an ex-

tensive program of prevention, including access to comprehensive age-appropriate sex education for all school age children." We request that at least $50 million be allocated to promote comprehensive sex education in our schools and communities nationwide.

Now in its 19th year, The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, administered by the Health Resources and Services Administration (HRSA) and funded by this subcommittee, provides services to more than 533,000 people living with and affected by HIV throughout the United States and its territories. It is the single largest source of Federal funding solely focused on the delivery of HIV services; it provides the framework for our national response to the HIV epidemic. CARE Act programs have been critical to reducing the impact of the domestic HIV epidemic. Yet in recent years, CARE Act funding has not kept pace with the epidemic and has decreased through across-the-board rescissions. It is important to remember that CARE Act programs are designed to compliment each other. It is necessary that all parts of the CARE Act receive substantial increased funding to ensure the success of the total program. AIDS Action and the HIV/AIDS community estimate that the entire Ryan White CARE Act portfolio needs $2.816 million in fiscal year 2010, an increase of $577.8 million to address the true needs of the hundreds of thousands of people living with HIV who are uninsured, underinsured, or who lack financial resource for healthcare.

Part A of The Ryan White CARE Act now includes five additional Transitional Grant Areas (TGAs). Some of the services provided under part A include physician visits, laboratory services, case management, home-based and hospice care, and substance abuse and mental health services. Under the most recent reauthorization these services are even more dedicated towards funding core medical services and to ensuring the ability of patients to adhere to treatment. These services are critical to ensuring patients have access to, and can effectively utilize, life-saving therapies. AIDS Action along with the HIV/AIDS community recommends funding part A at $766.1 million, an increase of $103 million.

Part B of the CARE Act ensures a foundation for HIV related healthcare services in each State and territory, including the critically important AIDS Drug Assistance Program (ADAP). Part B base grants (excluding ADAP) received a decrease of $28.5 million in fiscal year 2009. AIDS Action along with the HIV/AIDS community recommends funding for part B base grants at $514.2 million, an increase of $105.4 million.

The AIDS Drug Assistance Program (ADAP) provides medications for the treatment of individuals with HIV who do not have access to Medicaid or other health insurance. According to the 2009 National ADAP Monitoring Project, ADAP provided medications to approximately 183,299 clients in fiscal year 2007, including 36,354 new clients. AIDS Action along with the HIV/AIDS community recommends $1,083 million, an increase of $268.6 million, for ADAP for fiscal year 2010. This "community need" number is derived from a pharmacoeconomic model to estimate the amount of funding needed to treat ADAP eligible individuals in upcoming Federal and State fiscal years. The need number represents the amount of new funding required to allow State ADAPs to provide a minimum clinical standard formulary of HIV/AIDS medications to ADAP clients under the current eligibility rules for each State.

Part C of the Ryan White CARE Act awards grants to community-based clinics and medical centers, hospitals, public health departments, and universities in 22 States and the District of Columbia under the Early Intervention Services program. These grants are targeted toward new and emerging sub-populations impacted by the HIV epidemic. Part C funds are particularly needed in rural areas where the availability of HIV care and treatment is still relatively new. Urban areas continue to require part C funds as emerging populations as grantees struggle to meet the needs of previously identified HIV positive populations. AIDS Action, along with the HIV/AIDS community, requests $268.3 million, an increase of $66.4 million, for part C.

Part D of the Ryan White CARE Act awards grants under the Comprehensive Family Services Program to provide comprehensive care for HIV positive women, infants, children, and youth, as well as their affected families. These grants fund the planning of services that provide comprehensive HIV care and treatment and the strengthening of the safety net for HIV positive individuals and their families. AIDS Action and the HIV/AIDS community request $134.6 million, an increase of $57.7 million, for Part D.

Under Part F, the AIDS Education and Training Centers (AETCs) is the training arm of the Ryan White CARE Act; they train the healthcare providers, including the doctors, advanced practice nurses, physicians' assistants, nurses, oral health professionals, and pharmacists. The role of the AETCs is invaluable in ensuring

that such education is available to healthcare providers who are being asked to treat the increasing numbers of HIV positive patients who depend on them for care. Additionally, the AETCs have been tasked with providing training on Hepatitis B and C to CARE Act grantees and to ensure inclusion of culturally competent programs for and about HIV and Native Americans and Alaska natives. However no funding has been added for additional materials, training of staff, or programs. The AETCs received a modest increase of $0.3 million in fiscal year 2009. AIDS Action and the HIV/AIDS community request $50 million, a $15.6 million increase, for this program. Also under part F, Dental care is another crucial part of the spectrum of services needed by people living with HIV disease. Oral health problems are often one of the first manifestations of HIV disease. Unfortunately oral health is one of the first aspects of healthcare to be neglected by those who cannot afford, or do not have access to, proper medical care removing an opportunity to catch early infections of HIV. AIDS Action and the HIV/AIDS community request $19 million, a $5.6 million increase, for this program. Finally under part F, rising infections and strapped care systems necessitate the research and development of innovative models of care. The SPNS program is designed for this purpose and must continue to receive sufficient funding.

The Minority AIDS Initiative directly benefits racial and ethnic minority communities with grants to provide technical assistance and infrastructure support and strengthen the capacity of minority community based organizations to deliver high-quality HIV healthcare and supportive services to historically underserved groups. HIV/AIDS in the United States continues to disproportionately affect communities of color. According to the CDC in 2006, the overall rate of HIV diagnosis (the number of diagnoses per 100,000 population) in the 33 States (that currently report HIV data) was 18.5 per 100,000. The rate for blacks was roughly 8 times the rate for whites (67.7 per 100,000 vs 8.2 per 100,000). The Minority AIDS Initiative provides services across every service category in the CARE Act and was authorized for inclusion within the CARE Act for the first time in the 2006 CARE Act reauthorization. It additionally funds other programs throughout HHS agencies. AIDS Action and the HIV/AIDS community request a total of $610 million for the Minority AIDS Initiative.

Research on preventing, treating, and ultimately curing HIV is vital to the domestic and global control of the disease. It is essential that Office of AIDS Research continue its groundbreaking research in both basic and clinical science to develop a preventative vaccine, microbicides, and other scientific, behavioral, and structural HIV prevention interventions. The United States must continue to take the lead in the research and development of new medicines to treat current and future strains of HIV. NIH's Office of AIDS Research is critical in supporting all of these research arenas. Commitment in research will ultimately decrease the care and treatment dollars needed if HIV continues to spread at the current rate. AIDS Action requests that the NIH be funded at $34 billion in fiscal year 2010 and that the AIDS portfolio must be funded at $3.4 billion a $500 million increase.

HIV is a continuing health crisis in the United States. We must continue to work to fully fund our domestic prevention, treatment and care, and research efforts. On behalf of all HIV positive Americans, and those affected by the disease, AIDS Action Council urges you to increase funding in each of these areas of the domestic HIV/AIDS portfolio. Help us save lives by allocating increased funds to address the HIV epidemic in the United States.

PREPARED STATEMENT OF THE ALZHEIMER'S ASSOCIATION

Mr. Chairman and members of the subcommittee: As President and CEO of the Alzheimer's Association, I want to take this opportunity to thank you for the leadership role this subcommittee has played over the years in the fight to conquer Alzheimer's disease.

Indeed, it was this subcommittee that first drew attention to Alzheimer's disease in its fiscal year 1982 appropriations report. At the time, an estimated 2.5 million people were thought to be suffering with Alzheimer's disease, their families quietly bearing most of the financial, physical, and emotional burden of care giving. Even if they were personally affected, relatively few Americans had even heard of Alzheimer's disease because so many went undiagnosed or were inaccurately diagnosed; far fewer were aware of the crisis just beginning to unfold. All this is still too true today.

Alzheimer's disease now is now estimated to afflict more than 5 million Americans. It is in a virtual tie as the Nation's sixth leading cause of death, while significantly underreported and growing. It is already the third most expensive disease,

draining billions of dollars from our economy every year. But the story does not end with those grim statistics because this problem is not going to age itself away. On the contrary, as Baby Boomers shoulder their way into the age of highest risk, we will see 10 million members of this generation fall victim to Alzheimer's disease.

At times called the quiet epidemic, the great unlearning or the long dying, year by year Alzheimer's disease strips away memory, personality and independence, leaving its victims unable to handle the most basic functions of daily living. For those who do not succumb to pneumonia or other complications of Alzheimer's, there is the final act of forgetting—when the brain forgets to breathe.

But make no mistake the effects of Alzheimer's extend well beyond the human suffering and the physical and emotional strain it puts on families. Indeed, despite all that is challenging America today, Alzheimer's disease represents a grave threat to our Nation's social and economic well-being.

This year, Medicare and Medicaid will spend more than $100 billion to finance care for those struggling with Alzheimer's disease. Over the next 40 years, those two programs alone will spend almost $20 trillion on the care of Alzheimer patients.

Unless we find a way to prevent or slow its progression, by the year 2050 the annual cost of this disease to Medicare and Medicaid programs alone will be equal to one-tenth of our entire current domestic economy.

Alzheimer's disease is so expensive because, in addition to its direct costs, it greatly increases the use and costs of Medicare to treat other serious medical conditions. Ninety-five percent of Medicare beneficiaries with Alzheimer's disease have at least one co-morbid condition. Tasks such as medication management become extremely difficult and time-consuming. As a result, the health and long-term care costs of treating these individuals is more than three times that of a Medicare beneficiary without Alzheimer's disease.

BOLD ACTION IS NEEDED NOW

Over the years this body has exercised its prerogative to channel funds to the Nation's most pressing public health problems. Added funds provided by this subcommittee led to cancer patients living longer, with many beating the disease. Thanks to those investments, survival rates have steadily improved for breast, prostate, colorectal and some other types of cancer, so that today, the 5-year relative survival rate is 66 percent across all cancers. According to the most recent estimates, 10.8 million Americans with a history of cancer are alive today. As a result of this subcommittee's strong and sustained investment in cardiovascular disease research, death rates from heart disease and stroke fell by 40 percent and 51 percent, respectively, since 1975. And when challenged by the HIV/AIDS epidemic, this subcommittee responded quickly and decisively—providing a research investment that yielded vastly improved treatments and prevention strategies and a two-thirds reduction in annual deaths.

Mr. Chairman, unlike cancer, cardiovascular disease and so many other chronic conditions that have dramatically improved with significant investments in research, there are no Alzheimer's disease survivors. None. We cannot prevent, halt or reverse it. Every day some of the 5 million who have it die of this fatal disease, only to be replaced by even more who will progressively decline and die, as more replace them. Indeed, the only way to avert this rapidly developing social and economic catastrophe is if this subcommittee, once again, leads the way.

Past investments in Alzheimer's research have helped bring us to a point no one would have dreamed possible when this subcommittee first called attention to this disease. Scientists now have a much clearer, but still incomplete picture of the basic mechanisms of Alzheimer's; epidemiological research is shedding light on new targets for intervention that now must be tested in large-scale clinical trials. And work is underway to help identify potential uses of imaging and other surrogate markers to follow the progression of cognitive decline, and to assess the effectiveness of drug interventions. But we still have so much to accomplish.

Much of what we have learned came about because Congress invested in Alzheimer research throughout the 1980s and 1990s. But even those investments were not commensurate with the impact of the disease. The evidence from cancer and cardiovascular disease illustrates the returns that can be derived from additional investments in Alzheimer's research now. As the mortality rates for cancer and heart disease decline, Alzheimer's is still rising at a steady and rapid pace.

In fact, during the past 6 years we have seen a dramatic slowdown in overall research investments, signaling a slowdown in advances to come, but the effects on Alzheimer research are potentially greater as the funding stalled at such a comparatively low level. Today, the National Institutes of Health (NIH) devotes only $412 million a year for research on Alzheimer's disease—far short of the $1 billion that

leading scientific minds estimate as the minimum required investment to uncover ways to prevent, slow and more effectively treat this disease. That $412 million is also considerably less than what is spent for research on other major threats to society, such as cancer, cardiovascular disease, and AIDS. All of these problems merit significant investments, but Alzheimer's research is underfunded when measured against the suffering inflicted by the disease or by the potential cost savings in care that could be gained by investing in research today—before it's too late.

What can the subcommittee do to help stop this serious threat to America's future?

First and foremost, the Alzheimer's Association recommends that you appropriate an additional $250 million this year and next to raise the total NIH investment in Alzheimer's research up to $1 billion. These added funds will be put to use in three crucial areas:

—*Clinical Trials*.—The funding of clinical trials and epidemiological studies, particularly through the Alzheimer's Disease Cooperative Study (ADCS) national research consortium funded by the NIH, are identifying new targets for interventions, including compounds that are already widely available such as over-the-counter medications. Time is not on our side. If we hope to forestall this looming crisis, large-scale clinical trials must be undertaken soon and must be launched simultaneously, not sequentially.

—*Early Markers of Disease*.—Earlier diagnosis is critical if we hope to stop the disease before it ravages brain cells beyond repair. Additional resources are sorely needed to fully fund the next phase of a neuro-imaging initiative currently being supported at the National Institute on Aging.

—*Basic Science Research*.—Science must find new answers and ask better questions. While significant progress has been made, scientists are still searching for definitive answers to questions about the basic mechanisms of Alzheimer's disease. Congress must maintain the pipeline of basic scientific discovery to develop additional targets for treatment. At current funding levels, work on promising avenues of research is either delayed or never started. Young investigators—and their fresh new ideas—are discouraged from entering this field of study.

While research holds the answers, there are other steps we recommend you take to help forestall or lessen the impact of Alzheimer's.

EXPAND THE HEALTHY BRAIN INITIATIVE TO $5 MILLION

Four years ago, this subcommittee launched the first single-focused effort on brain health promotion at the Centers for Disease Control and Prevention (CDC). As a result of the investment that has been made in the Healthy Brain Initiative, the CDC, in partnership with the Alzheimer's Association, has developed a public health roadmap for maintaining cognitive health, implemented community education programs targeting African-American baby boomers, and developed modules for enhancing the surveillance system for cognitive decline.

The impetus for this program was the mounting scientific evidence suggesting that brain health may be maintained by preventing or controlling cardiovascular risk factors, such as high blood pressure, high cholesterol and diabetes, and by engaging in regular physical activity. In light of the dramatic aging of the population, scientific advancements in risk behaviors, and the growing awareness of the significant health, social and economic burdens associated with cognitive decline, the Federal investment in a public health response must be expanded. We recommend that this program be increased to $5 million to focus on the following activities:

—*Healthy Brain Engagement Initiative*.—The promising approaches that have been identified through the community education programs need to be expanded to additional locations and new target audiences to impact attitudes and behaviors related to cognitive health. Particularly, we must focus on other high-risk and underserved populations, specifically the Hispanic/Latino population.

—*Tracking Cognitive Impairment as America Ages*.—In order to accelerate the availability of data to clarify the burden of Alzheimer's, an enhanced surveillance system for cognitive health is required. This can be achieved through implementation of appropriate Behavioral Risk Factor Surveillance System (BRFSS) modules in as many States as possible. The development and testing of BRFSS modules is currently underway and will be available for use in 2010.

—*Tools for Care Coordination in the Face of Cognitive Impairment*.—Cognitive health challenges—from mild cognitive decline to dementia—can have profound implications on an individual's ability to self-manage other coexisting conditions. In order to effectively address this challenge, interventions that target the

coordination of care for those with cognitive impairment and coexisting chronic diseases will be adapted or developed.

—*Early Detection*.—Early recognition of Alzheimer's, an accurate diagnosis, and early intervention, including medication, can significantly improve the quality of life and mental function of people with the disease. Communications strategies that provide information on the signs and symptoms of the disease and options for maintaining brain health will be developed and disseminated, targeting consumers and providers.

CONTINUE ALZHEIMER'S DISEASE DEMONSTRATION GRANTS AND THE ALZHEIMER'S CONTACT CENTER

The Administration on Aging (AoA) operates two Alzheimer-related programs that warrant continuation. The first is a program of matching grants to States for the development of innovative, community-based services for Alzheimer patients and caregivers, especially hard-to-reach and underserved populations. For this program, we recommend an appropriation of $11.6 million.

In 2003, this subcommittee launched the Alzheimer's Contact Center, a nationwide call-in program that provides families in crisis with around-the-clock support and assistance. Services include access to professional clinicians who provide decision-making support, crisis assistance and referrals. In 2008, the center fielded more than 106,000 calls from families. The Alzheimer's Association recommends you appropriate $1 million to continue this valuable service.

Each of the recommendations I have outlined fall within the purview of this subcommittee. But I would also like to call your attention to a report issued recently, called A National Alzheimer's Strategic Plan: The Report of the Alzheimer's Study Group.

This landmark report was the culmination of nearly 2 years of work by an independent task force of prominent national leaders. It was co-chaired by former Speaker of the House Newt Gingrich and former U.S. Senator Bob Kerrey, and included other distinguished individuals such as former Supreme Court Justice Sandra Day O'Connor and Drs. Harold Varmus, David Satcher, and Mark McClellan. The Alzheimer's Study Group also drew on the knowledge and expertise of more than 100 experts in various facets of this disease.

Mr. Chairman, in a word, the Alzheimer's Study Group concluded that to achieve a world without Alzheimer's disease we do not need to re-invent the wheel; but we have to make it work more efficiently.

This report contains many important recommendations, including developing the capability to prevent Alzheimer's disease in 90 percent of individuals by 2020. But one that warrants special attention within the context of this subcommittee's deliberations is the creation of an outcomes-oriented, objective-driven Alzheimer's Solutions Project Office within the Federal Government. With support from the president and Congress, this effort would oversee a decade-long mission to undertake a coordinated and sustained attack on Alzheimer's disease.

Mr. Chairman, thank you for your time and attention. Should you have any questions or require additional information, please feel free to call on me.

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN CANCER INSTITUTES

The Association of American Cancer Institutes (AACI), representing 95 of the Nation's premier academic and free-standing cancer centers, appreciates the opportunity to submit this statement for consideration as the Labor, Health and Human Services, and Education, and Related Agencies subcommittee plans the fiscal year 2010 appropriations for the National Institutes of Health (NIH) and the National Cancer Institute (NCI).

AACI applauds recent budgetary commitments—notably, increased funding for NIH and support from the Obama administration through the American Recovery and Reinvestment Act of 2009—that have created a more encouraging landscape for cancer research compared to the last 5 years. While AACI understands and appreciates the budgetary constraints currently facing our Nation, we also believe that advances in cancer and biomedical research must remain a very high national priority. Therefore, we hope that high levels of support will continue in the years ahead, to ensure that this recognition of the importance of biomedical research is sustained.

For fiscal year 2010, AACI joined its colleagues in the biomedical research community in supporting the request in the President's initial budget proposal for $6 billion in funding for cancer research in fiscal year 2010, and his commitment to double funding for cancer research over the next 5 years.

AACI also requests that total funding to NIH be increased by 10 percent, including a 20 percent increase for NCI and a 7 percent increase for the other Institutes and Centers within NIH. The Nation's investment in the NIH and NCI helps lead to scientific advances that can save lives and improve the health of Americans. Early funding increases helped speed the pace of cancer research, and this investment can be leveraged significantly with a renewed commitment to strong, sustained Federal funding of medical research and, in particular, cancer research. AACI will work to ensure that Congress approves the maximum possible appropriations for NIH and NCI.

THE GROWING CANCER BURDEN

In 2008, there were approximately 1.44 million new cases of cancer in the United States and approximately 565,650 deaths due to the disease.[1] About 150,090 new cancer cases were expected to be diagnosed among African Americans in 2009, with about 63,360 expected to die from the disease. In men, the death rate for all cancers combined continued to be substantially higher among African Americans than whites during 1975–2005. Similar trends were seen among women, although the gap is much smaller.[2]

Looking further into the future, the need for cancer care will expand dramatically. From 2010 to 2030, the total projected cancer incidence will increase by approximately 45 percent, from 1.6 million in 2010 to 2.3 million in 2030. This increase is driven by cancer diagnosed in older adults and minorities. A 67 percent increase in cancer incidence is anticipated for older adults, compared with an 11 percent increase for younger adults. A 99 percent increase is anticipated for minorities, compared with a 31 percent increase for whites. From 2010 to 2030, the percentage of all cancers diagnosed in older adults will increase from 61 percent to 70 percent, and the percentage of all cancers diagnosed in minorities will increase from 21 percent to 28 percent.[3]

The human toll of cancer is staggering, as is its financial toll; the NCI reports that in 2006, $206.3 billion was spent on healthcare costs for cancer alone. Additionally, NCI acknowledges that the burdens of cancer—physical, emotional, and financial—are "unfairly shouldered by the poor, the elderly, and minority populations." The number of cancer diagnoses will only continue to climb as our population ages, with an estimated 18.2 million cancer survivors (those undergoing treatment, as well as those who have completed treatment) alive in 2020.

CANCER RESEARCH: BENEFITING ALL AMERICANS

Cancer research, conducted in academic laboratories across the country saves money by reducing healthcare costs associated with the disease, enhances the United States' global competitiveness, and has a positive economic impact on localities that house a major research center. While these aspects of cancer research are important, what cannot be overstated is the impact cancer research has had on individuals' lives—lives that have been lengthened and even saved by virtue of discoveries made in cancer research laboratories at cancer centers across the United States.

Though more than a half-million Americans will die this year from the many diseases defined as cancer, progress is being made. Because of continued progress made by the Nation's researchers, cancer death rates have continued to decline; between 1991 and 2004, the death rates for cancer in men and women declined 18.4 percent and 10.5 percent, respectively.[4] Similarly, death rates among African Americans for all cancers combined have been decreasing since 1991 after increasing from 1975 to 1991. The decline was larger in men (2.5 percent per year since 1995) than in women (1.3 percent per year since 1997). Similar trends were observed among whites from 1991–2005, with a greater reduction in the rate among men than women.

Biomedical research has provided Americans with better cancer treatments, as well as enhanced cancer screening and prevention efforts. Some of the most exciting breakthroughs in current cancer research are those in the field of personalized medicine. In personalized medicine for cancer, not only is the disease itself considered

[1] *Cancer Facts and Figures 2008*. American Cancer Society; 2008. (The publication of Cancer Facts & Figures 2009 has been delayed due to the late release of the US final mortality data by the National Center for Health Statistics.)

[2] American Cancer Society. *Cancer Facts & Figures for African Americans 2009–2010*. Atlanta: American Cancer Society, 2009.

[3] Smith et al., "Future of Cancer Incidence in the United States: Burdens Upon an Aging, Changing Nation", J Clin Oncol 2009; 27

[4] Cancer Statistics, 2008. CA: *Cancer Journal for Clinicians* 2008; 58(2): 71–96.

when determining treatments, but so is the individual's unique genetic code. This combination allows physicians to better identify those at risk for cancer, detect the disease, and treat the cancer in a targeted fashion that minimizes side effects and refines treatment in a way to provide the maximum benefit to the patient.

In the laboratory setting, multi-disciplinary teams of scientists are working together to understand the significance of the human genome in cancer. For instance, the Cancer Genetic Markers of Susceptibility initiative is comparing the DNA of men and women with breast or prostate cancer with that of men and women without the diseases to better understand the diseases. The Cancer Genome Atlas is in development as a comprehensive catalog of genetic changes that occur in cancer. Another initiative, the Childhood Cancer Therapeutically Applicable Research to Generate Effective Treatments Initiative, is identifying targets that can lead to better treatments for young people with cancer.

These projects—along with the work being performed by dedicated physicians and researchers at cancer centers across the United States every day—have the potential to radically change the way cancer, as a collection of diseases, affects the people who live with it every day. Every discovery contributes to a future without cancer as we know it today.

THE NATION'S CANCER CENTERS

The nexus of cancer research in the United States is the Nation's network of cancer centers that are represented by AACI. These cancer centers conduct the highest-quality cancer research anywhere in the world and provide exceptional patient care. The Nation's research institutions, which house AACI's member cancer centers, receive an estimated $3.17 billion[5] from NCI to conduct cancer research; this represents 66 percent of NCI's total budget. In fact, 85 percent of NCI's budget supports research at nearly 650 universities, hospitals, cancer centers, and other institutions in all 50 States. Because these centers are networked nationally, opportunities for collaborations are many—assuring wise and nonduplicative investment of scarce Federal dollars.

In addition to conducting basic, clinical, and population research, the cancer centers are largely responsible for training the cancer workforce that will practice in the United States in the years to come. Much of this training is dependent on Federal dollars, via training grants and other funding from NCI. Sustained Federal support will significantly enhance the centers' ability to continue to train the next generation of cancer specialists—both researchers and providers of cancer care.

By providing access to a wide array of expertise and programs specializing in prevention, diagnosis, and treatment of cancer, cancer centers play an important role in reducing the burden of cancer in their communities. The majority of the clinical trials of new interventions for cancer are carried out at the Nation's network of cancer centers.

Beyond their healthcare and research roles, cancer centers are also reliable engines of economic activity for the Nation as a whole, and for the communities and regions that they serve. For every $1 spent on biomedical research, a national average of $2.21 in economic benefit results.[6]

ENSURING THE FUTURE OF CANCER CARE AND RESEARCH

Because of an aging population, an increasing number of cancer survivors require ongoing monitoring and care from oncologists, and new therapies that tend to be complex and often extend life.

Demand for oncology services is projected to increase 48 percent by 2020. However, the supply of oncologists expected to increase by only 20 percent and 54 percent of currently practicing oncologists will be of retirement age within that timeframe. Also, alarmingly, there has been essentially no growth over the past decade in the number of medical residents electing to train on a path toward oncology as a specialty.[7]

Cancer physicians—while essential—are only one part of the oncology workforce that is in danger of being stretched to the breaking point. The Health Resources and Services Administration predicted that by 2020, more than 1 million nursing

[5] *National Cancer Institute 2007 Fact Book*. U.S. Department of Health and Human Services, U.S. National Institutes of Health, 2007.

[6] In Your Own Backyard: How NIH Funding Helps Your State's Economy, Families USA, June 2008

[7] Forecasting the Supply of and Demand for Oncologists: A Report to the American Society of Clinical Oncology (ASCO) from the AAMC Center for Workforce Studies. American Society of Clinical Oncology, 2007.

positions will go unfilled, and a 2002 survey by the Southern Regional Board of Education projected a 12 percent shortage of nurse educators by last year.[8]

Without immediate action, these predicted shortages will prove disastrous for the state of cancer care in the United States. The discrepancy between supply and demand for oncologists will amount to a shortage of 9.4 to 15.1 million visits, or a shortage of 2,550 to 4,080 oncologists. The Department of Health and Human Services projects that today's 10-percent vacancy rate in registered nursing positions will grow to 36 percent, representing more than 1 million unfilled jobs by 2020.

Greater Federal support for training oncology physicians, nurses, and other professionals who treat cancer must be enacted to prevent a disaster within our healthcare system when demand for oncology services far outstrips the system's ability to provide adequate care for all.

AMERICANS SUPPORT FEDERAL FUNDING FOR RESEARCH

The research community has long understood the obstacles that are facing cancer research. Though the nuances of R01 grants and oncology workforce training may not be well understood by the average American, the people of the United States believe in supporting the disparate activities that make up America's biomedical research infrastructure.

In a 2007 Research!America poll, 91 percent of those surveyed believed it was somewhat or very important for policymakers to create more incentives to encourage individuals to pursue careers as nurses, while 89 percent believed the same for encouraging careers as physicians. Forty-seven percent of those surveyed agreed that he United States must increase investment in NIH to ensure our future health and economic security, and 54 percent favored annual 6.7 percent increases in funding for NIH in 2008, 2009, and 2010. An overwhelming majority—70 percent—agreed that the United States is losing its global competitive edge in science, technology, and innovation.

We encourage our Members of Congress to respond to the concerns of the American people by enhancing support for biomedical research that will lead to improved health for everyone in the United States and around the world.

CONCLUSION

These are exciting times in science and, particularly, in cancer research. The AACI cancer center network is unrivaled in its pursuit of excellence, and place the highest priority on affording all Americans access to that care, including novel treatments and clinical trials. It is through the power of collaborative innovation that we will accelerate progress toward a future without cancer, and research funding through the NIH and NCI is essential to achieving our goals.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF NURSING

The American Association of Colleges of Nursing (AACN) respectfully submits this statement highlighting funding priorities for nursing education and research programs in fiscal year 2010. AACN represents more than 640 schools of nursing at public and private institutions with baccalaureate and graduate nursing programs that include more than 270,000 students and 13,000 faculty members. These institutions educate almost half of our Nation's Registered Nurses (RNs) and all of the nurse faculty and researchers. Many of these nursing schools sponsor intensive research programs and training activities that are funded by the National Institute of Nursing Research (NINR).

THE NATIONWIDE NURSING SHORTAGE

The United States is in the midst of a nursing shortage that has expanded over the last decade. The current economic downturn has led to a false impression that the nursing shortage is "easing" in some parts of the country because hospitals are enacting hiring freezes and nurses are choosing to delay retirement. However, this trend is only temporary. More positions continue to open for RNs across the country, and the shortage is projected to intensify as the baby-boomer population ages and the need for healthcare grows. The U.S. Bureau of Labor Statistics (BLS) recently reported that the healthcare sector of the economy is continuing to expand, despite significant job losses in nearly all other major industries. Hospitals, long-term care facilities, and other ambulatory care settings added 27,000 new jobs in February

[8] ONS: Ready to Collaborate with Other Policymakers to Ensure Future of Quality Cancer Care, Oncology Times, August 25, 2007; (29): 8–9.

2009, a month when 681,000 jobs were eliminated across the country. As the largest segment of the healthcare workforce, RNs likely will be recruited to fill many of these new positions. Moreover, according to the latest projections from the BLS, more than 1 million new and replacement nurses will be needed by 2016. Unless we act now, this shortage will further jeopardize patient access to quality care.

Nursing and economic research clearly indicate that today's shortage is far worse than those of the past. The current supply and demand for nurses demonstrates two distinct challenges. First, due to the present and looming demand for healthcare by American consumers, the supply is not growing at a pace that will adequately meet long-term needs, including the demand for primary care, which is often provided by Advanced Practice Registered Nurses (APRNs). This is further compounded by the number of nurses who will retire or leave the profession in the near future, ultimately reducing the nursing workforce. Second, the supply of nurses nationwide is stressed due to an ongoing shortage of nurse faculty. The nurse faculty shortage continues to inhibit nursing schools from educating the number of nurses needed to meet the demand. According to AACN, 49,948 qualified applicants were turned away from baccalaureate and graduate nursing programs in 2008 primarily due to a lack of faculty. Of those potential students, nearly 7,000 were students pursuing a master's or doctoral degree in nursing, which is the education level required to teach.

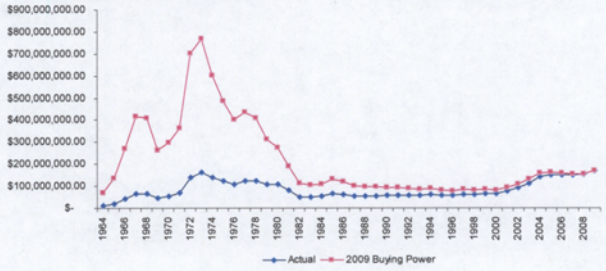
NURSING WORKFORCE DEVELOPMENT PROGRAMS: A PROVEN SOLUTION

For nearly five decades, the Nursing Workforce Development Programs have supported hundreds of thousands of nurses and nursing students. The title VIII programs award grants to nursing education programs, as well as provide direct support to nurses and nursing students through loans, scholarships, traineeships, and programmatic grants.

The Nursing Workforce Development Programs are effective and meet their authorized mission. In a 2009 survey by AACN, 1,501 title VIII student recipients reported that these programs played a critical role in funding their nursing education. An overwhelming number of respondents (92.7 percent), reported that title VIII paid for a portion of their tuition and, of those students, approximately 11 percent reported their tuition was paid in full. While millions of Americans are struggling during this economic downturn and thousands of students need to obtain student loans for their education, Federal support is greatly appreciated and needed. The nursing students responding to this study expressed overwhelming gratitude for the funding they receive through title VIII. Nursing remains an attractive and rewarding career with more than 135,000 current vacant positions, and according to the BLS, more than 587,000 new nursing positions will be needed by 2016. Providing support for title VIII is the key to filling these vacant positions and, in turn, improving healthcare quality.

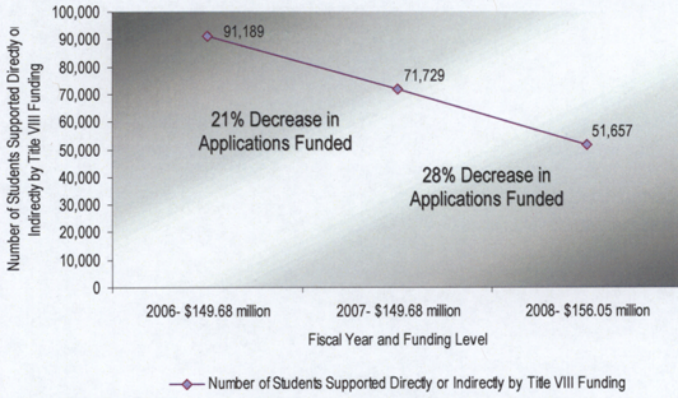
Over the last 45 years, Congress has used the title VIII authorities as a mechanism to address nursing shortages. When the need for nurses was great, higher funding levels were appropriated. During the nursing shortage of the 1970s, Congress provided $160.61 million to the title VIII programs in fiscal year 1973. Adjusting for inflation to address the 36-year difference, the fiscal year 2009 funding level of $171.03 million in 1973 dollars would be approximately $820 million today (see Figure 1). More recently, slow rising funding levels between fiscal year 2006 and fiscal year 2008 for title VIII, coupled with inflation and rising educational costs, have greatly decreased the purchasing power of these programs, resulting in a 43 percent decrease in the number of nurses supported by the programs (see Figure 2).

Figure 1: Historical Funding for Title VIII Nursing Workforce Development Programs (in millions) and Adjusted for Inflation



Source: Health Resources and Services Administration (HRSA), Division of Nursing, 2008 & U. S. Bureau of Labor Statistics, Inflation Calculator, 2009.

Figure 2: Nurses and Nursing Students Supported by Title VIII: FY 2006-2008



Source: Division of Nursing, Health Resources and Services Administration, 2006, 2007, 2008.

AACN is delighted that President Obama has noted the need for increased title VIII funding in his fiscal year 2010 budget proposal. Therefore, AACN respectfully requests the subcommittee's support for the President's proposal of $263.4 million for title VIII Nursing Workforce Development Programs in fiscal year 2010, an additional $92 million more than the fiscal year 2009 level. New monies would expand nursing education, recruitment, and retention efforts to help resolve all aspects contributing to the shortage.

NINR: SUPPORTING HEALTH PROMOTION AND DISEASE PREVENTION

As the scientific and research nucleus for nursing science, the NINR funds research that establishes the scientific basis for health promotion, disease prevention, and high-quality nursing care services to individuals, families, and populations. NINR is one of the 27 Institutes and Centers at the National Institutes of Health (NIH). Often working collaboratively with physicians and other researchers, nurse scientists are vital in setting the national research agenda. While medical research focuses on curing diseases, nursing research is conducted to prevent disease. The four strategic areas of emphasis for research at NINR are:

—Promoting health and preventing disease;
—Improving quality of life;
—Eliminating health disparities; and
—Setting directions for end-of-life research.

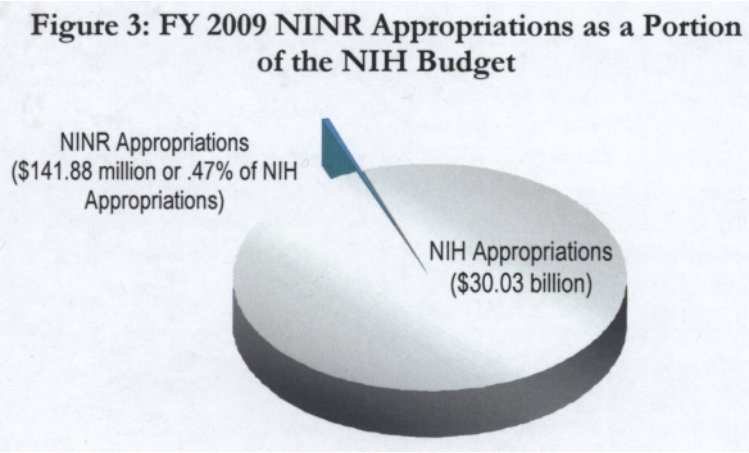
The science advanced at NINR is integral to the future of the Nation's healthcare system. With a renewed national priority on utilizing cost-effective treatment modal-

ities and preventive interventions, NINR has developed research programs in these areas:

Comparative Effectiveness Research.—Has been an NINR funding priority for many years. Comparative effectiveness research demonstrates how prevention strategies or interventions can impact system-wide savings. At a time when healthcare consumers and reformers are seeking quality care focused on prevention that is affordable and accessible by all, comparative effectiveness research is a critical area of inquiry.

Promoting Health and Preventing Disease.—Is vital considering that more than 1.7 million Americans die each year from chronic diseases. Nurse researchers focus on investigating wellness strategies to prevent these chronic diseases. A healthcare system which promotes prevention promises to be a major focus of health reform, and NINR is a leader in funding scientific research to discover optimal prevention methods.

NINR's fiscal year 2009 funding level of $141.88 million is approximately 0.47 percent of the overall $30.03 billion NIH budget (see Figure 3). Spending for nursing research is a modest amount relative to the allocations for other health science institutes and for major disease category funding. For NINR to adequately continue and further its mission, the Institute must receive additional funding. Cuts in funding have impeded the Institute from supporting larger comprehensive studies needed to advance nursing science and improve the quality of patient care.



Therefore, AACN respectfully requests $178 million for NINR, an additional $36.12 million more than the fiscal year 2009 level. Considering that NINR presently allocates 7 percent of its budget to training that helps develop the pool of nurse researchers, additional funding would support NINR's efforts to prepare faculty researchers needed to educate new nurses.

THE CAPACITY FOR NURSING STUDENTS AND FACULTY PROGRAM, SECTION 804 OF THE HIGHER EDUCATION OPPORTUNITY ACT OF 2008 (PUBLIC LAW 110–315)

According to AACN (2009), the major barriers to increasing student capacity in nursing schools are insufficient numbers of faculty, admission seats, clinical sites, classroom space, clinical preceptors, and budget constraints. The Capacity for Nursing Students and Faculty Program, a recently passed section of the Higher Education Opportunity Act of 2008, offers capitation grants (formula grants based on the number of students enrolled/or matriculated) to nursing schools allowing them to increase the number of students. AACN respectfully requests $50 million for this program in fiscal year 2010.

CONCLUSION

AACN acknowledges the fiscal challenges within which the subcommittee and the entire Congress must work. However, the title VIII authorities provide a dedicated, long-term vision for educating the new nursing workforce and the next cadre of nurse faculty. NINR invests in developing the scientific basis for quality nursing care. The Capacity for Nursing Students and Faculty Program will allow schools to

increase student capacity. To be effective these programs must receive additional funding. AACN respectfully requests $263.4 million for title VIII programs, $178 million for NINR, and $50 million for the Capacity for Nursing Students and Faculty Program in fiscal year 2010. Additional funding for these programs will assist schools of nursing to expand their educational and research programs, educate more nurse faculty, increase the number of practicing RNs, and ultimately improve the patient care provided in our healthcare system.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

On behalf of the American Association of Colleges of Osteopathic Medicine (AACOM), I am submitting this testimony in support of increased funding in fiscal year 2010 for the title VII health professions education programs, the National Health Service Corps (NHSC), the National Institutes of Health (NIH), and the Agency for Healthcare Research and Quality (AHRQ). AACOM represents the administrations, faculty, and students of the Nation's 25 colleges of osteopathic medicine and three branch campuses that offer the doctor of osteopathic medicine degree. Today, more than 15,500 students are enrolled in osteopathic medical schools. Nearly 1 in 5 U.S. medical students is training to be an osteopathic physician, a ratio that is expected to grow to 1 in 4 by 2019.

TITLE VII

The health professions education programs, authorized under title VII of the Public Health Service Act and administered through the Health Resources and Services Administration (HRSA), support the training and education of health practitioners to enhance the supply, diversity, and distribution of the healthcare workforce, filling the gaps in the supply of health professionals not met by traditional market forces. Title VII and title VIII nurse education programs are the only Federal programs designed to train clinicians in interdisciplinary settings to meet the needs of special and underserved populations, as well as increase minority representation in the healthcare workforce.

According to HRSA, an additional 30,000 health practitioners are needed to alleviate existing health professional shortages. Combined with faculty shortages across health professions disciplines, racial and ethnic disparities in healthcare, and a growing, aging population, these needs strain an already fragile healthcare system. AACOM recommends $330 million in fiscal year 2010 for the title VII programs. Investment in these programs, including the Training in Primary Care Medicine and Dentistry Program, the Health Careers Opportunity Program, and the Centers of Excellence, is necessary to address the primary care workforce shortage. Such an investment will help sustain the health workforce expansion supported by the American Recovery and Reinvestment Act (ARRA) and restore funding to critical programs that suffered drastic funding reductions in fiscal year 2006 and remain well below fiscal year 2005 levels.

AACOM is pleased that President Obama requested considerable increases in the following title VII programs: Training in Primary Care Medicine and Dentistry ($56.4 million requested/16.5 percent increase); Centers of Excellence ($24.6 million requested/19.4 percent increase); and Health Careers Opportunity Program ($22.1 million requested/15.7 percent increase).

NHSC

Approximately 50 million Americans live in communities with a shortage of health professionals, lacking adequate access to primary care. Through scholarships and loan repayment, HRSA's NHSC supports the recruitment and retention of primary care clinicians to practice in underserved communities. The NHSC is comprised of more than 4,000 clinicians, with more than half working in community health centers. Growth in HRSA's Health Center Program must be complemented with increases in the recruitment and retention of primary care clinicians to ensure adequate staffing. ARRA funding for the NHSC is vital in this regard, and additional investment will be necessary to sustain the progress once the ARRA funding period ends. AACOM recommends $235 million in fiscal year 2010 for NHSC, the amount authorized under the Health Care Safety Net Amendments of 2002.

AACOM notes that President Obama requested significant increases for NHSC field placement ($46 million requested/6 percent increase) and recruitment ($123 million requested/29.5 percent increase).

NIH

Research funded by the NIH leads to important medical discoveries regarding the causes, treatments, and cures for common and rare diseases as well as disease prevention. These efforts improve our Nation's health and save lives. The NIH funding under the ARRA will produce more high-quality research. To seize the momentum created by the ARRA and maintain a robust research agenda, further investment will be needed. AACOM recommends $33.35 billion in fiscal year 2010 for the NIH.

In today's increasingly demanding and evolving medical curriculum, there is a critical need for more research geared toward evidence-based osteopathic medicine. AACOM believes that it is vitally important to maintain and increase funding for biomedical and clinical research in a variety of areas related to osteopathic principles and practice, including osteopathic manipulative medicine and comparative effectiveness. In this regard, AACOM encourages support for the NIH's National Center for Complementary and Alternative Medicine (NCCAM) to continue fulfilling this essential research role.

AACOM appreciates President Obama requesting increases for NIH ($31 billion requested/1.45 percent increase) and NCCAM ($127 million requested/1.6 percent increase).

AHRQ

AHRQ supports research to improve healthcare quality, reduce costs, advance patient safety, decrease medical errors, and broaden access to essential services. AHRQ plays an important role in producing the evidence base needed to improve our Nation's health and healthcare. The incremental increases for AHRQ's Effective Health Care Program in recent years, as well as the funding provided to AHRQ in the ARRA, will help AHRQ generate more comparative effectiveness research and expand the infrastructure needed to increase capacity to produce this evidence. More investment is needed, however, to fulfill AHRQ's mission and broader research agenda. AACOM recommends $405 million in fiscal year 2010 for AHRQ. This investment will preserve AHRQ's current programs while helping to restore its critical healthcare safety, quality, and efficiency initiatives.

AACOM greatly appreciates the support of the subcommittee for these funding priorities in an ever increasing competitive environment and is grateful for the opportunity to submit its views. AACOM looks forward to continuing to work with the subcommittee on these important matters.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF PHARMACY

The American Association of Colleges of Pharmacy (AACP) and its member colleges and schools of pharmacy appreciate the continued support of the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies. Our Nation's 111 accredited colleges and schools of pharmacy are engaged in a wide-range of programs supported by grants and funding administered through the agencies of the Department of Health and Human Services (HHS) and the Department of Education. We also understand the difficult task you face annually in your deliberations to do the most good for the nation and remain fiscally responsible to the same. AACP respectfully offers the following recommendations for your consideration as you undertake your deliberations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES SUPPORTED PROGRAMS AT COLLEGES AND SCHOOLS OF PHARMACY

Agency for Healthcare Research and Quality (AHRQ)

AACP supports the Friends of AHRQ recommendation of $405 million for AHRQ programs in fiscal year 2010.

Pharmacy faculty are strong partners with AHRQ. Academic pharmacy researchers are working to develop a sustainable health services research effort among faculty with AHRQ grant support. As partners in the AHRQ Effective Healthcare programs (CERTs, DeCIDE), pharmacy faculty researchers improve the effectiveness of healthcare services. Some of this research will take place through the development of practice-based research networks focused on improving the medication use process.

—Last fall, AHRQ expanded its Centers for Education and Research on Therapeutics (CERTs) program by awarding $41.6 million over the next 4 years for a new coordinating center, 10 research centers and four new centers receiving first-time funding. The University of Illinois at Chicago College of Pharmacy

joins the 13 CERTs program centers in efforts to conduct research and provide education that advances the optimal use of therapeutics.
http://www.aacp.org/news/academicpharmnow/Documents/MarApr%202008%20APN.pdf

—Pharmacy faculty researchers, supported by AHRQ grant HS016097, determined that children who are prescribed medications related to their diagnosis of attention deficit/hyperactivity disorder were not at increased risk for hospitalization for cardiac events. The results of this research will be presented in a web conference sponsored by AHRQ and APhA on May 1, 2009.

Centers for Disease Control and Prevention (CDC)

AACP supports the CDC Coalition recommendation of $8.6 billion for CDC core programs in fiscal year 2010.

The educational outcomes of a pharmacist's education include those related to public health. When in community-based positions, pharmacists are frequently providers of first contact. The opportunity to identify potential public health threats through regular interaction with patients provides public health agencies such as the CDC with on-the-ground epidemiologists. Pharmacists support the public health system through the risk identification of patients seeking medications associated with preventing and treating travel-related illnesses. Pharmacy faculty are engaged in CDC-supported research in areas such as immunization delivery, integration of pharmacogenetics in the pharmacy curriculum and inclusion of pharmacists in emergency preparedness. Information from the National Center for Health Statistics (NCHS) is essential for faculty engaged in health services research and for the professional education of the pharmacist.

—Grace Kuo, CDC-supported member of the faculty at the University of California, San Diego, is engaged in research aimed at improving the safety of medication use in primary care settings.

—Jeanine Mount, CDC-supported member of the faculty at the University of Wisconsin, is engaged in research to determine how pharmacists can be better utilized in increase the vaccination rates across our Nation.

Health Resources and Services Administration (HRSA)

AACP supports the Friends of HRSA recommendation of $8.5 billion.

HRSA is a Federal agency with a wide-range of policy and service components. Faculty at colleges and schools of pharmacy are integral to the success of many of these. Colleges and schools of pharmacy are the administrative units for interprofessional and community-based linkages programs including geriatric education centers and area health education centers. Pharmacy faculty are supported in their research efforts regarding rural health issues through the Office of Rural Health Policy. Pharmacy students benefit from diversity program funding including Scholarships for Disadvantaged Students.

OFFICE OF PHARMACY AFFAIRS (OPA)

AACP recommends a program funding of $5 million for fiscal year 2010 for OPA.

AACP member institutions are actively engaged in OPA efforts to improve the quality of care for patients in federally qualified health centers and entities eligible to participate in the 340B drug discount program. The success of the HRSA Patient Safety and Clinical Pharmacy Collaborative is a direct result of past OPA actions linking colleges and schools of pharmacy with federally qualified health centers (www.hrsa.gov/patientsafety). The result of these links has been the establishment of medical homes that improve health outcomes for underserved and disadvantaged patients through the integration of clinical pharmacy services. The Office of Pharmacy Affairs would benefit from a direct line-item appropriation so that public-private partnerships aimed at improving the quality of care provided at federally qualified health centers can be sustained and expanded.

POISON CONTROL CENTERS

Colleges and schools of pharmacy are supported by HRSA grant funding for the operation of 9 of the 42 poison control centers administered by HRSA.

—Jill E. Michels, faculty member from the University of South Carolina—South Carolina College of Pharmacy (USC), and the Palmetto Poison Center (PPC) were awarded a $310,000 grant from HRSA. The PPC is housed at the College of Pharmacy and serves all 46 counties in South Carolina receiving more than 37,000 calls per year for information and advice. A recent USC study found that for every $1 spent on the Palmetto Poison Center, more than $7 was saved in unnecessary healthcare costs, including emergency room and physician visits,

ambulance services, and unnecessary medical treatments. http://poison.sc.edu/about.html

BUREAU OF HEALTH PROFESSIONS (BHPr)

AACP supports the Health Professions and Nursing Education Coalition (HPNEC) recommendation of $550 million for title VII and VIII programs in fiscal year 2010.

AACP member institutions are active participants in BHPr programs. Two colleges of pharmacy are current grantees in the Centers of Excellence program (Xavier University—Louisiana and the University of Montana) which focuses on increasing the number of underserved individuals attending health professions institutions. Colleges and schools of pharmacy are also part of title VII interprofessional and community-based linkages programs including Geriatric Education Centers and Area Health Education Centers. These programs are essential for creating the educational approaches that align with the Institute of Medicine's recommendations for improving quality through team-based, patient-centered care.

OFFICE OF TELEHEALTH ADVANCEMENT

Technology is an important component for improving healthcare quality and maintaining or increasing access to care. Colleges and schools of pharmacy utilize technology to increase the reach of education to aspiring and current professionals.

—*Massachusetts College of Pharmacy and Health Sciences—Worcester Campus Distance Learning Initiative—Phase II*.—Grant support for this program will allow the expansion of health profession education programs throughout Massachusetts and New Hampshire. http://hrsa.gov/telehealth/granteedirectory/overview__ma.htm

—North Dakota State University College of Pharmacy, Nursing, and Allied Sciences uses grant funding to maintain access to pharmacy services in rural, underserved areas of North Dakota. This program helps more than 40,000 rural citizens maintain access to pharmacy services and also supports rural hospital pharmacies. http://hrsa.gov/telehealth/granteedirectory/overview__nd.htm

FOOD AND DRUG ADMINISTRATION (FDA)

AACP recommends a funding level of $3 billion for FDA programs in fiscal year 2010.

Academic pharmacy is working with the FDA to fulfill its strategic goals and the responsibilities assigned to the agency through the Food and Drug Administration Amendments Act. The FDA sees the colleges and schools of pharmacy as essential partners in assuring the public has access to a healthcare professional well versed in the science of safety.

—Carole L. Kimberlin, a professor, and Almut G. Winterstein, an assistant professor at the University of Florida College of Pharmacy Department of Pharmaceutical Outcomes and Policy, received a 1-year $184,229 award from the FDA to conduct an evaluation of Consumer Medication Information leaflets on selected prescription medications from community pharmacies throughout the United States.

—Thomas C. Dowling's research, "Evaluation of Biopharmaceutics Classification System Class 3 Drugs for Possible Biowaivers," is supported by an FDA grant.

—The FDA-supported National Institute of Pharmaceutical Technology and Education is funding research at the University of Connecticut focused on the development of freeze-dried products.

NATIONAL INSTITUTES OF HEALTH (NIH)

AACP supports the Ad Hoc Group for Medical Research recommendation of $32.4 billion for fiscal year 2010.

Pharmacy faculty are supported in their research by nearly every Institute at the NIH. The NIH-supported research at AACP member institutions spans theresearch spectrum from the creation of new knowledge through the translation of that new knowledge to providers and patients. In 2008, pharmacy faculty researchers received more than $260 million in grant support from the NIH.

—Researchers at the University of Illinois at Chicago College of pharmacy have received a $1.7 million 5-year Federal grant to develop a new approach to treat brain tumors. The novel approach stabilizes the drug and provides better control of the time and location of its activity, thereby reducing its side effects.

—University of Nebraska Medical Center (UNMC) received $10.6 million from the National Center for Research Resources (NCRR) to research nanomedicine, drug delivery, therapeutics, and diagnostics. UNMC researcher, Dr. Alexander V.

Kabanov, is the principal investigator on the $10.6 million COBRE (Centers for Biomedical Research Excellence) grant, which will be awarded by the NIH/NCRR over the next 5 years.

—Dr. Maria Croyle, associate professor of pharmaceutics at The University of Texas at Austin College of Pharmacy, has received $2.6 million from NIH to develop a vaccine against Ebola virus infection.

—As part of NIH funding for the new NIH Roadmap Epigenomics Program, Dr. Rihe Liu, associate professor at the University of North Carolina at Chapel Hill Eshelman School of Pharmacy, received a technology development grant to support the advancement of innovative technologies that have the potential to transform the way that epigenomics research can be performed in the future.

—A project funded by the National Institute of General Medical Sciences takes computer-aided drug design to the next level with the help of a University of Michigan College of Pharmacy professor.

—Fourteen additional universities were awarded the Clinical and Translational Science Award in May 2008. Five colleges of pharmacy are included in this group and will play significant collaborative roles with the new consortium members as the NIH provides $533 million over 5 years to help enable researchers to provide new treatments more efficiently and effectively to patients.

—Dr. Laurence H. Hurley, professor of pharmaceutical sciences at The University of Arizona College of Pharmacy, is 1 of 38 scientists to receive the 2009 NIH EUREKA grant.

DEPARTMENT OF EDUCATION SUPPORTED PROGRAMS AT COLLEGES AND SCHOOLS OF PHARMACY

AACP supports the recommendation of the Student Aid Alliance that the:

—Perkins Loan Program Federal Capital Contribution should be increased to the newly reauthorized level of $300 million and loan cancellations should be increased to $125 million.

—Pell Grant maximum be increased to $5,500.

—Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) should be increased to the authorized level of $400 million.

—Graduate level programs should be increased to $77 million.

AACP recommends a funding level of $140 million for the Fund for the Improvement of Post Secondary Education (FIPSE).

The Department of Education supports the education of healthcare professionals by:

—assuring access to education through student financial aid programs;

—supporting educational research allows faculty to determine improvements in educational approaches; and

—maintaining the quality of higher education through the approval of accrediting agencies.

AACP actively supports increased funding for undergraduate student financial assistance programs. Admission to into the pharmacy professional degree program requires at least 2 years of undergraduate preparation. Student financial assistance programs are essential to assuring colleges and schools of pharmacy are accessible to qualified students. Likewise, financial assistance programs that support graduate education are an important component of creating the next generation of scientists and educators that both our Nation and higher education depend on.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR CANCER RESEARCH

The American Association for Cancer Research (AACR) recognizes and expresses its thanks to the United States Congress for its longstanding support and commitment to funding cancer research. The recent large-scale investment in research through the American Recovery and Reinvestment Act (ARRA) and the fiscal year 2009 budget will support current projects and provide for new efforts in the fight against cancer. These new efforts promise to yield innovative and potentially breakthrough approaches to understanding, preventing, treating, and ultimately curing cancer. The full potential, however, will not be fully realized in a short 1- or 2-year period. Sustained, stable funding through regular appropriations will be necessary to allow researchers to make the key investments that will leverage the ARRA funds so that they both create jobs today and save lives tomorrow.

Unquestionably, the Nation's investment in cancer research is having a remarkable impact. Cancer deaths in the United States have declined in recent years. This progress occurred in spite of an aging population and the fact that more than three-quarters of all cancers are diagnosed in individuals aged 55 and older. Yet this good

news will not continue without stable and sustained Federal funding for critical cancer research priorities.

AACR urges the United States House of Representatives to support President Obama's vision for doubling cancer research funding over the next 5 years and strongly support other biomedical research funding at the National Institutes of Health (NIH). AACR supports the $6 billion for cancer research highlighted in the President's fiscal year 2010 budget outline, which would be best allocated to the National Cancer Institute (NCI). The AACR also supports the biomedical community's recommendation of a 7 percent increase for the NIH, which, when combined with President Obama's vision for cancer research, would fund NIH at a level of $33.3 billion in fiscal year 2010.

AACR: FOSTERING A CENTURY OF RESEARCH PROGRESS

The American Association for Cancer Research has been moving cancer research forward since its founding in 1907. Celebrating its 100th annual meeting, the AACR and its more than 28,000 members worldwide strive tirelessly to carry out its important mission to prevent and cure cancer through research, education, and communication. It does so by:

—fostering research in cancer and related biomedical science;
—accelerating the dissemination of new research findings among scientists and others dedicated to the conquest of cancer;
—promoting science education and training; and
—advancing the understanding of cancer etiology, prevention, diagnosis, and treatment throughout the world.

FACING AN IMPENDING CANCER "TSUNAMI"

Over the past 100 years, enormous progress has been made toward the conquest of the Nation's second most lethal disease (after heart disease). Thanks to discoveries and developments in prevention, early detection, and more effective treatments, many of the more than 200 diseases called cancer have been cured or converted into manageable chronic conditions while preserving quality of life. The 5-year survival rate for all cancers has improved over the past 30 years to more than 65 percent. The completion of the doubling of the NIH budget in 2003 is bearing fruit as many new and promising discoveries are unearthed and their potential realized. However, there is much left to be done, especially for the most lethal and rarer forms of the disease.

We recognize that the underlying causes of the disease and its incidence have not been significantly altered. The fact remains that men have a 1 in 2 lifetime risk of developing cancer, while women have a 1 in 3 lifetime risk. The leading cancer sites in men are the prostate, lung and bronchus, and colon and rectum. For women, the leading cancer sites are breast, lung and bronchus, and colon and rectum. And cancer still accounts for 1 in 4 deaths, with more than half a million people expected to die from their cancer in 2009. Age is a major risk factor—this Nation faces a virtual "cancer tsunami" as the baby boomer generation reaches age 65 in 2011. A renewed commitment to progress in cancer research through leadership and resources will be essential to avoid this cancer crisis.

BLUEPRINT FOR PROGRESS: NCI'S STRATEGIC OBJECTIVES

Basic, translational, and clinical cancer research in this country is conducted primarily through three venues—Government, academia and the nonprofit sector, and the pharmaceutical/biotechnology industry. The Congress provides the appropriations for the National Institutes of Health and the NCI through which most of the Government's research on cancer is conducted. The NCI has developed documents and processes that describe and guide its priorities—established with extensive community input—for the use of these finite resources. "The NCI Strategic Plan for Leading the Nation" and "The Nation's Investment in Cancer Research: An Annual Plan and Budget Proposal fiscal year 2010" are the recognized professional blueprints for what needs to be done to accelerate progress against cancer.

AACR and many in the cancer research community concur that if the NCI receives the increased investment of $2.1 billion as proposed for fiscal year 2010, the Director's proposed budget will enable the NCI to rebuild America's research infrastructure capacity and accelerate research progress in critical priority areas.

FEDERAL INVESTMENT FOR LOCAL BENEFIT

More than half of the NCI budget is allocated to research project grants that are awarded to outside scientists who work at local hospitals and universities through-

out the country. More than 6,500 research grants are funded at more than 150 cancer centers and specialized research facilities located in 49 States. More than half the States receive more than $15 million in grants and contracts to institutions located within their borders. This Federal investment provides needed economic stimulus to local economies: on average, each dollar of NIH funding generated more than twice as much in State economic output in fiscal year 2007. Many AACR member scientists across the Nation are engaged in this rewarding work, and many have had their long-term research jeopardized by grant reductions caused by the flat and declining overall funding for the NCI since 2003. The recent increase in fiscal year 2009 appropriations and the funds from the American Recovery and Reinvestment Act of 2009 will help to revitalize America's research infrastructure; however, sustained and stable funding is critical to reap the benefits of this investment. Thus, the AACR supports the request in the President's budget proposal for $6 billion in funding for cancer research in fiscal year 2010 and his commitment to double funding for cancer research over the next 5 years and, thus, recommends a 20 percent increase in funding for the NCI to enable it to continue and expand its important work.

UNDERSTANDING THE CAUSES AND MECHANISMS OF CANCER

Basic research into the causes and mechanisms of cancer is at the heart of what the NCI and many of AACR's member scientists do. The focus of this research includes: investigating the underlying basis of the full spectrum of genetic susceptibility to cancer; identifying the influence of the macroenvironment (tumor level) and microenvironment (tissue level) on cancer initiation and progression; understanding the behavioral, environmental, genetic, and epigenetic causes of cancer and their interactions; developing and applying emerging technologies to expand our knowledge of risk factors and biologic mechanisms of cancer; and elucidating the relationship between cancer and other human diseases.

Basic research is the engine that drives scientific progress. The outcomes from this fundamental basic research—including laboratory and animal research in addition to population studies and the deployment of state-of-the-art technologies—will inform and drive the cancer research enterprise in ways and directions that will lead to unparalleled progress in the search for cures.

DEVELOPING EFFECTIVE AND EFFICIENT TREATMENTS

The future of cancer care is all about developing individualized therapies tailored to the specific characteristics of a patient's cancer. The NCI research in this area concentrates on: identifying the determinants of metastatic behavior; validating cancer biomarkers for prognosis, metastasis, treatment response, and progression; accelerating the identification and validation of potential cancer molecular targets; minimizing the toxicities of cancer therapy; and integrating the clinical trial infrastructure for speed and efficiency. The completion of the Human Genome Project has opened the door to the promise of personalized medicine.

TRAINING AND CAREER DEVELOPMENT FOR THE NEXT GENERATION OF RESEARCHERS

Of critical importance to the viability of the long-term cancer research enterprise is supporting, fostering, and mentoring the next generation of investigators. The NCI historically devotes approximately 4 percent of its budget to multiple strategies to training and career development, including sponsored traineeships, a Medical Scientist Training Program, special set-aside grant programs and bridge grants for early career cancer investigators. Increased funding for these foundational opportunities is essential to retain the scientific workforce that is needed to continue the fight against cancer.

AACR'S INITIATIVES AUGMENT SUPPORT FOR THE NCI

The NCI is not working alone or in isolation in any of these key areas. NCI research scientists reach out to other organizations to further their work. The AACR is engaged in scores of initiatives that strengthen, support, and facilitate the work of the NCI. Just a few of AACR's contributions include:

—sponsoring the largest meeting of cancer researchers in the world, with more than 14,000 scientists, where 6,000 scientific abstracts featuring the latest basic, translational, and clinical scientific advances are presented;

—publishing more than 3,400 original research articles each year in six prestigious peer-reviewed scientific journals, including cancer research, the most frequently cited cancer journal;

—sponsoring the annual International Conference on Frontiers of Cancer Prevention Research, the largest such prevention meeting of its kind in the world;
—supporting the work of its Chemistry in Cancer Research Working Group;
—convening an AACR–FDA–NCI Think Tank on Clinical Biomarkers;
—hosting, with NCI, the Molecular Targets and Cancer Therapeutics Conference;
—sponsoring and supporting a Minorities in Cancer Research Council and a Women in Cancer Research Council;
—Conducting the scientific review and grants administration for the more than $100 million donated to Stand Up To Cancer;
—raising and distributing more than $5 million in awards and research grants.

STABLE, SUSTAINED INCREASES IN RESEARCH FUNDING

Remarkable progress is being made in cancer research, but much more remains to be done. Cancer costs the Nation more than $219 billion in direct medical costs and lost productivity due to illness and premature death. Respected University of Chicago economists Kevin Murphy and Robert Topel have estimated that even a modest one percent reduction in mortality from cancer would be worth nearly $500 billion in social value. Investments in cancer research stimulate the local economy today have huge potential returns in the future. Thanks to successful past investments, promising research opportunities abound and must not be lost. To maintain our research momentum, the AACR urges the United States House of Representatives to support a budget of $33.3 billion for the NIH, including $6 billion for the NCI.

LETTER FROM THE AMERICAN ASSOCIATION OF COLLEGES FOR TEACHER EDUCATION

APRIL 30, 2009.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

DEAR CHAIRMAN HARKIN: I want to extend my appreciation to you and your colleagues in Congress for your support of Federal education programs. Your commitment makes a significant difference for the education of our millions of PK–12 and postsecondary students.

As you and your colleagues begin the fiscal year 2010 appropriations process, the American Association of Colleges for Teacher Education (AACTE) urges you to increase the Federal Government's investment in the preparation of professional educators. While there are significant funds behind title II of the No Child Left Behind Act in the Improving Teacher Quality State Grants, the vast majority of these funds, and other funds in title II, go towards class size reduction and the professional development of practicing teachers. Equally important, though, is the initial preparation of teachers and other school personnel. And, in this respect, the Federal Government's investment, until very recently, has declined over the years. As this Nation is in the midst of teacher retention and shortage crises, it is critical that the Government responds with a plan that provides for systemic change.

There are several programs within the Department of Education intended to strengthen and improve educator recruitment and preparation efforts. We are working with program authorizers in Congress and staff within the agencies to ensure that these programs work in concert with each other. However, one of the key factors that prevents these programs from becoming levers for systemic change is their consistent underfunding. The cost of preparing school personnel is significant.

The primary Federal program in this area is the Teacher Quality Partnership (TQP) Grants (title II, Higher Education Opportunity Act). During the reauthorization of the Higher Education Act we supported several changes to title II of the bill that have resulted in a much stronger TQP program. Under this program, these grants go to partnerships of institutions of higher education, high-need local educational agencies, and high-need K–12 schools to prepare teachers and other school personnel to effectively serve in the schools. The grants are particularly focused on strengthening the clinical component of preparation programs—research has shown that preservice clinical experiences are essential to preparing effective teachers and to teacher retention.

Grants can be used to strengthen prebaccalaureate preparation programs and/or to develop 1-year master's degree level teaching residency programs. In exchange for receiving a living stipend during the residency, teachers would commit to teaching for at least 3 years in a shortage field in a high-need school. The residency programs are targeted to recruiting career-changers and recent college graduates. In these

times of rising unemployment, these programs are ideal for those who have been laid off and are seeking a stable and rewarding new career. President Obama wrote the legislation for the teaching residency programs when he was a Senator on the HELP Committee. During his Presidential campaign and since his election he has stated that he wants to prepare 30,000 new educators through the residency programs.

In order to meet that goal, and to provide sufficient support to the partnerships that carry out TQP Grants, we ask that you fund the TQP program at the $150 million level in fiscal year 2010. The TQP program received $50 million in fiscal year 2009, and $100 million in the stimulus package. This is a significant boost to the program which was funded in fiscal year 2008 at $33 million. The $150 million in fiscal year 2010 appropriations will maintain the current level of funding when the stimulus funding concludes.

Below you will find AACTE's recommendations for funding additional programs in fiscal year 2010.

—*Fund Teachers for a Competitive Tomorrow at the $60 Million Level*.—This program was authorized in the America Competes Act, and it is currently funded at $2.18 million. This program and the TQP program are the only two Federal education program directed targeted to higher-education-based educator preparation programs. With the teacher shortage and retention crisis acutely felt in the math and science teaching fields, this program is a crucial piece of the response to ameliorate the teacher shortage challenges. This competitive grant program helps higher education institutions build baccalaureate and master's degree programs that allow students to major in STEM fields while working toward teacher certification.

—*Fund the Transition to Teaching program at the $60 Million Level*.—This program, authorized in title II of the No Child Left Behind Act at the $150 million level and currently funded at $43.7 million, supports the development of teacher preparation programs suited for career-changers and others who enter teaching through nontraditional routes. Higher education institutions and other entities have used funds from this program to develop innovative preparation programs that accommodate the needs of a diverse educator candidate pool while ensuring that candidates are prepared to teach in today's K–12 classrooms.

—*Fund the Troops-to-Teachers program at the $25 Million Level*.—Like Transition to Teaching, this program aims to attract teachers from another profession into the classroom. Troops-to-Teachers has been very successful at recruiting retired military into the teaching profession. By funding the program at $25 million, this would almost double the Government's investment in the program (currently at $14.4 million) during a time in which there is higher military interest in entering the K–12 teaching ranks.

—*Fund the IDEA Personnel Preparation Program at the $120 Million Level*.—Currently funded at $90.65 million, this program provides essential funds to prepare and develop special educators. Special education teachers, much like math and science teachers, are in high demand in the K–12 schools with the shortage being significant. With the wide breadth and increasing number of special need students there needs to be an adequate supply of teachers who can work with them to ensure student learning.

—*Fund the Centers for Excellence Program at the $20 Million Level*.—This new program was authorized in title II of the Higher Education Opportunity Act and is currently unfunded. Grants would support the strengthening of educator preparation programs at institutions that serve historically under-represented populations.

—*Fund the Teach to Reach Grant Program at the $15 Million Level*.—This new program was authorized in title II of the Higher Education Opportunity Act and is currently unfunded. Institutions of higher education would use grants to ensure that all of their teacher candidates were prepared to teach children with disabilities. Almost every K–12 classroom has students with learning, intellectual, and/or physical disabilities. It is critical that every teacher is prepared with instructional skills that will assure that every child has the opportunity to learn.

—*Fund the Graduate Fellowships To Prepare Faculty at Colleges of Education Program at the $15 Million Level*.—This new program was authorized in title II of the Higher Education Opportunity Act and is currently unfunded. The current shortage of K–12 teachers in the math, science, special education, and English language learners fields is directly correlated with the shortage of faculty at institutions of higher education who prepare teachers in these fields. This program would support doctoral students who intend to become faculty who prepare teachers in these shortage areas.

The AACTE is a national voluntary association of higher education institutions and other organizations and is dedicated to ensuring the highest-quality preparation and continuing professional development for teachers and school leaders. Our overarching mission is to enhance PK–12 student learning. Collectively, the AACTE membership prepares more than two-thirds of the new teachers entering schools each year in the United States.

Thank you for your consideration of the perspective of AACTE and its membership of close to 800 private, State, and municipal colleges and universities—large and small—located in every State, the District of Columbia, the Virgin Islands, Puerto Rico, and Guam.

Sincerely,

SHARON P. ROBINSON, ED.D.,
President and CEO.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR DENTAL RESEARCH

The American Association for Dental Research (AADR) is a nonprofit organization with more than 4,000 individual members and 100 institutional members within the United States. The AADR's mission is to advance research and increase knowledge for the improvement of oral health for all Americans.

The AADR thanks the subcommittee for this opportunity to testify about the exciting advances in oral health science. Americans are living better and healthier lives into old age due to recent advances in healthcare, including dental care and oral health research, thanks to the efforts of the National Institute of Dental and Craniofacial Research (NIDCR). NIDCR was formed in 1948 by the National Institutes of Health (NIH). Its staff has conducted research, trained researchers, and disseminated health information to improve the health of Americans and make it possible for them to live longer and healthier lives.

On February 17 of this year, President Barack Obama signed into law the $787 billion stimulus package known as the American Recovery and Reinvestment Act (ARRA). This legislation will provide NIH with $8.2 billion to conduct additional scientific research. AADR members, researchers across the country, would like to thank the committee for its past support and in particular for the funds contained in the stimulus package. The past investment in NIH has paid a dividend to taxpayers in the form of improved oral health.

HEALTH DISPARITIES

One very challenging issue we face in this country is health disparities. We must learn more about the causes of cultural inequality among individual members of society if we are to conduct more effective research.

The NIDCR's mission is to train and engage as many young investigators as possible in oral health disparities research to develop various methods of research to eliminate these disparities. They hope that this will improve the oral, dental, and craniofacial health of diverse populations.

Health disparities are the persistent gaps between the health status of minorities and nonminorities in the United States. Despite continued advances in healthcare and technology, racial and ethnic minorities continue to have higher rates of disease, disabilities, and premature death than nonminorities. African Americans, Hispanics/Latinos, American Indians and Alaska natives, Asian Americans, Native Hawaiians, and Pacific Islanders have higher rates of infant mortality, cardiovascular disease, diabetes, AIDS, and cancer, and lower rates of immunizations and cancer screening.

There is debate about what causes health disparities between ethnic and racial groups. However, it is generally accepted that disparities can result from three main areas:

—from the personal, socioeconomic, and environmental characteristics of different ethnic and racial groups;
—from the barriers certain racial and ethnic groups encounter when trying to enter into the healthcare delivery system; and
—from the quality of healthcare different ethnic and racial groups receive.

These are all considered possible causes for disparities between racial and ethnic groups. However, most attention on the issue has been given to the health outcomes that result from differences in access to medical care among groups and the quality of care that various groups receive. Since many scientific discoveries do not reach all people, there are disparities in the health and healthcare among various groups in the United States. Even though data on racial and ethnic disparities are rel-

atively widely available, data on socioeconomic healthcare disparities are collected less often.

The Health Disparities Research Program responds to the growing awareness that, despite improvements in some oral health status indicators, the burden of disease is not evenly distributed across all segments of our society. The program supports research that explores the multiple and complex factors that may determine oral and craniofacial health, diseases, and conditions in disadvantaged and underserved populations. Funds go to a wide variety of different scientific approaches designed to reduce and eventually eliminate oral and craniofacial diseases and conditions in disadvantaged and underserved populations. The program supports both qualitative and quantitative approaches.

The NIDCR will support interventional research that will have a meaningful impact on caries, oral and pharyngeal cancer, and periodontal disease, and that will influence clinical practice, health policy, community and individual action, ultimately eliminating disparities in vulnerable people. NIDCR will also fund health disparities interventional research beyond that conducted through the Centers for Research to Reduce Disparities in Oral Health program.

SALIVARY DIAGNOSTICS

For many oral and systemic diseases, early detection offers the best hope for successful treatment. Oral and systemic diseases can be difficult to diagnose, involving complex clinical evaluation and/or blood and urine tests that are labor-intensive, expensive, and invasive. Now, after many years of research, saliva is poised to be used as a noninvasive diagnostic fluid for a number of oral and systemic conditions. Saliva, a protective fluid of the oral cavity, combats bacteria and viruses that enter the mouth and serves as a first line of defense in oral and systemic diseases. It contains many compounds indicating a person's overall health and disease status, and, like blood or urine, its composition may be affected by a disease—therefore, saliva is a mirror of the body. Since saliva is easy to collect, it is a good alternative to using blood or urine for diagnostic tests.

The year 2008 was exciting in the incremental development of salivary diagnostics. A consortium of NIDCR-supported scientists completed the first catalogue of the human salivary proteome, or the full set of 1,166 proteins present in saliva. This will help facilitate the future testing of saliva as a standard body fluid to detect early signs of disease. A team of NIDCR grantees also assembled the first panel of salivary protein biomarkers to detect oral squamous cell carcinoma (OSCC). This is the most common form of the oral cancers.

Salivary diagnostic techniques have already been developed for and are being used to detect HIV. Saliva could be used as a potential monitor of disease progression in systemic disorders, including Alzheimer's disease, cystic fibrosis, and diabetes. Specific protein markers in human saliva are being investigated that can be identified and quantified to provide an early, noninvasive diagnosis for even cancers distant from the oral cavity, such as pancreatic and breast cancer. Getting a diagnosis used to entail making a trip to the doctor's office. The doctor's examination often required the patient providing a blood and/or urine sample. Even though getting a diagnosis still requires a trip to the doctor's office, scientists are now identifying the genes and proteins that are expressed in the salivary glands that will help define the patterns and certain conditions under which these genes and proteins are expressed in the salivary glands. Building on this research, saliva will become a more commonly used diagnostic fluid.

ORAL CANCER

Oral cancer affects 38,000 Americans each year and 350,000 people worldwide. The death rate associated with this cancer is especially high, due to delayed diagnosis. Oral cancer is any cancerous tissue growth located in the mouth. About two-thirds of oral cancers occur in the mouth, and about one-third are found in the pharynx. On average, only 60 percent of people with the disease will survive more than 5 years. However, here again, disparities play a role, and only 35 percent of black men will survive 5 years. Oral cancer occurs most in people over the age of 40 and affects more than twice as many men as women. Researchers are developing a Point of Care diagnostic system (real-time) for rapid on-site detection of saliva-based tumor markers. Early detection of oral cancer will increase survival rates, improve the quality of life of cancer patients, and result in a significant reduction in healthcare costs.

Oral cancer forms in tissues of the lip or mouth. In 2008, approximately 22,900 new cases of oral cancer occurred in the United States. Oral cancer claimed roughly 5,390 deaths that year. It represents approximately 3 percent of all cancers. This,

however, translates to 30,000 new cases every year in the United States. More than 34,000 Americans will be diagnosed with oral or pharyngeal cancer this year. It will cause more than 8,000 deaths, killing roughly 1 person per hour, 24 hours per day. Of those 34,000 newly diagnosed individuals, only half will be alive in 5 years. The death rate for oral cancer is higher than that of cancers such as cervical cancer, laryngeal cancer, thyroid cancer, or skin cancer. Worldwide, the problem is much greater, with more than 400,000 new cases being found each year.

Survival rates can be calculated by different methods for different purposes. If oral cancer is caught when the disease has not spread beyond the original tumor site, the 5-year relative survival rate is 82 percent. However, half of oral cancers are not diagnosed until the cancer has spread to nearby tissues. At this stage, the 5-year relative survival rate drops to 53 percent. Those diagnosed when the cancer has spread further, to distant organs, have only a 28 percent 5-year relative survival rate. It's important to detect oral cancer early, when it can be treated more successfully. Typically, the earlier cancer is detected and diagnosed, the more successful the treatment, thus enhancing the survival rate.

CONCLUSION

There are many research opportunities with an immediate impact on patient care that need to be pursued. A consistent and reliable funding stream for NIH overall, and for NIDCR in particular, is essential for continued improvement in the oral health of Americans. Oral cancer is one of the most expensive cancers to treat—the average cost for treating an advanced case is $200,000. Overcoming cancer health disparities is one of the best opportunities we have for lessening the burden of cancer. But the burden of cancer is too often greater for the poor, for ethnic minorities, and for the uninsured than for the general population.

A great amount of promising research is under way, and the potential to improve oral health specifically, and overall health in general, is significant. Therefore, we are requesting that NIDCR receive a fiscal year 2010 appropriation of $442 million, not including the ARRA funding, to help sustain and build upon the discoveries and employment opportunities that were created using stimulus funding. Thank you for the subcommittee's support of NIH programs in the past, and we are grateful for this opportunity to present our views.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

On behalf of the American Academy of Family Physicians (AAFP), I commend President Barack Obama for demonstrating a commitment to a strong primary care workforce by seeking to increase training under title VII, section 747 of the Public Health Services Act in his fiscal year 2010 budget. As one of the largest national medical organizations, representing family physicians, residents, and medical students, the AAFP recommends that the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies build on that commitment to title VII section 747 in fiscal year 2010 and increase funding for other key HHS programs to allow healthcare reform to succeed and support better healthcare all.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

HRSA is charged with improving access to healthcare services for people who are uninsured, isolated, or medically vulnerable. One of the most critical aspects of this mission is ensuring a healthcare workforce which is sufficient to meet the needs of patients and communities.

HRSA—HEALTH PROFESSIONS

For 40 years, the training programs authorized by title VII of the Public Health Services Act evolved to meet our Nation's healthcare workforce needs. While it is increasingly clear that our Nation has a worsening shortage of primary care physicians, many "studies have found a strong, sometimes dose-dependent associations between title VII funding and increased production of primary care graduates, and physicians who eventually practice in rural areas and federally designated physician shortage areas."[1]

---

[1] Robert Graham Center. Specialty and Geographic Distribution of Physician Workforce: What Influences Medical Student & Resident Choices? 2009 Washington, DC.

The sixth report of the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry recommended an annual minimum level of $215 million for the title VII section 747 grant program. The subcommittee reasoned that:

Title VII funds are essential to support major primary care training programs that train the providers who work with vulnerable populations. It is critical that funds not only be restored to 2005 levels, but that funding be increased, as the need for healthcare of the public, including those high-risk groups identified in this report, increases. It is critical that funds offset the acknowledged rate of inflation. This additional funding is also necessary to prepare current and future primary care providers for their critical role in responding to healthcare challenges including demographic changes in the population, increased prevalence of chronic conditions, decreased access to care, and a need for effective first-response strategies in instances of acts of terrorism or natural disasters.

Healthcare reform demands that we must modernize workforce and education policies to ensure an adequate number of primary care physicians trained to serve in the new healthcare delivery model. The patient centered medical home will give patients access to preventive care and coordination of the care needed to manage chronic diseases as well as appropriate care for acute illness. The medical home practice model provides improved efficiency and better health because it serves as a principal source of access and care. As a result, duplication of tests and procedures and unnecessary emergency department visits and hospitalizations can be avoided

Section 747 of title VII, the Primary Care Medicine and Dentistry Cluster, is aimed at increasing the number of primary care physicians (family physicians, general internists and pediatricians). Section 747 offers competitive grants for family medicine training programs in medical schools and in residency programs. Section 747 is vital to stimulate medical education, residency programs, as well as academic and faculty development in primary care to prepare physicians to support the patient centered medical home.

The value of title VII grants extends far beyond the medical schools that receive them. The United States lags behind other countries in its focus on primary care. However, the evidence shows that countries with primary care-based health systems have population health outcomes that are better than those of the United States at lower costs.[2] Health Professions Grants are one important tool to help refocus the Nation's health system on primary care.

Although HRSA has not released the spending plan for the American Recovery and Reinvestment Act (ARRA) health professions training funds for fiscal year 2009–2010, the omnibus appropriation increased section 747 by less than 1 percent more than the final fiscal year 2008 amount to $48,425,000 for fiscal year 2009. It remains well below the $92 million provided for Primary Care Medicine and Dentistry Training in fiscal year 2003. The Nation needs significant additional support from section 747 because it is the only national federally funded program that provides resources for important innovations necessary to increase the number of physicians who will lead the primary care teams providing care in patient-centered medical homes.

AAFP recommends a substantial increase in the fiscal year 2010 appropriation bill for the Health Professions Training Programs authorized under title VII of the Public Health Services Act. We respectfully request that the subcommittee provide $215 million for the section 747, the Primary Care Medicine and Dentistry Cluster, which will signal the commitment of Congress to reform healthcare delivery in this Nation.

HRSA—NATIONAL HEALTH SERVICE CORPS (NHSC)

NHSC offers scholarship and loan repayment awards to primary care physicians, nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, certified nurse-midwives, and dental hygienists serving in underserved communities. Research has shown that debt plays a complex yet important role in shaping career choices for medical students. The NHSC offers financial incentives for the recruitment and retention of family physicians to practice in underserved communities without adequate access to primary care. The AAFP supports the work of the NHSC toward the goal of full funding for the training of the health workforce and zero disparities in healthcare.

[2] Starfield B, et al. The effects of specialist supply on populations' health: assessing the evidence. *Health Affairs*. 15 March 2005

AAFP respectfully requests that the subcommittee fully fund these important scholarship and loan repayment programs by providing the authorized amount of $235 million for NHSC in fiscal year 2010.

HRSA—RURAL HEALTH

Americans in rural areas face more barriers to care than those in urban and suburban areas. Rural residents also struggle with the higher rates of illness associated with lower socioeconomic status.

Family physicians provide the majority of care for America's underserved and rural populations.[3] Despite efforts to meet scarcities in rural areas, the shortage of primary care physicians continues. Studies, whether they be based on the demand to hire physicians by hospitals and physician groups or based on the number of individuals per physician in a rural area, all indicate a need for additional physicians in rural areas.

HRSA's Office of Rural Health administers a number of programs to improve healthcare services to the quarter of our population residing in rural communities. Rural Health Policy Development and Outreach Grants fund innovative programs to provide healthcare in rural areas. State rural health offices, funded through the NHSC budget, help States implement these programs so that rural residents benefit as much as urban patients.

AAFP encourages the subcommittee to provide adequate funding in the fiscal year 2010 appropriation bill for the important programs administered by HRSA's Office of Rural Health to address the many unique health service needs of rural communities.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The mission of AHRQ—to improve the quality, safety, efficiency, and effectiveness of health care for all Americans—closely mirrors AAFP's own mission. AHRQ is a small agency with a huge responsibility for research to support clinical decision-making, reduce costs, advance patient safety, decrease medical errors, and improve healthcare quality, and access. Family physicians recognize that AHRQ has a critical role to play in promoting healthcare safety, quality, and efficiency initiatives.

AHRQ—COMPARATIVE EFFECTIVENSS RESEARCH

One of the hallmarks of the patient centered medical home is evidence-based medicine. Comparative effectiveness research, which compares the impact of different options for treating a given medical condition, is vital to quality care. Studies comparing various treatments (e.g., competing drugs) or differing approaches (e.g., surgery and drug therapy) can inform clinical decisions by analyzing not only costs but the relative medical benefits and risks for particular patient populations.

AAFP commends the Congress for including $1.1 billion in ARRA for comparative effectiveness research which holds out the promise of reducing healthcare costs while improving medical outcomes.

AAFP respectfully suggests that the subcommittee provide at least $405 million for AHRQ in the fiscal year 2010 appropriations bill, an increase of $32 million above the fiscal year 2009 level.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY

The American Association for Geriatric Psychiatry (AAGP) appreciates this opportunity to comment on issues related to fiscal year 2010 appropriations for mental health research and services. AAGP is a professional membership organization dedicated to promoting the mental health and well being of older Americans and improving the care of those with late-life mental disorders. AAGP's membership consists of approximately 2,000 geriatric psychiatrists as well as other health professionals who focus on the mental health problems faced by aging adults. Although we generally agree with others in the mental health community about the importance of sustained and adequate Federal funding for mental health research and treatment, AAGP brings a unique perspective to these issues because of the elderly patient population served by our members.

[3] Hing E, Burt CW. Characteristics of office-based physicians and their practices: United States, 2003–04. Series 13, No. 164. Hyattsville, MD: National Center for Health Statistics. 2007.

A NATIONAL HEALTH CRISIS: DEMOGRAPHIC PROJECTIONS AND THE MENTAL DISORDERS OF AGING

With the baby boom generation nearing retirement, the number of older Americans with mental disorders is certain to increase in the future. By the year 2010, there will be approximately 40 million people in the United States older than the age of 65. More than 20 percent of those people will experience mental health problems.

The cost of treating mental disorders can be staggering. For example, it is estimated that total costs associated with the care of patients with Alzheimer's disease is more than $100 billion per year in the United States. Psychiatric symptoms (including depression, agitation, and psychotic symptoms) affect 30 to 40 percent of people with Alzheimer's and are associated with increased hospitalization, nursing home placement, and crippling family burden. These psychiatric symptoms, associated with Alzheimer's disease, can increase the cost of treating these patients by more than 20 percent. However, these costs pale when compared to the costs of not treating mental disorders including lost work time, co-morbid illness, and increased nursing home utilization. It is also important to note the added burden, financial and emotional, on family caregivers, as the Nation's informal caregiving system is already under tremendous strain and will require more support in the years to come.

PREPARING A WORKFORCE TO MEET THE MENTAL HEALTH NEEDS OF THE AGING POPULATION

In 2008, the Institute of Medicine (IOM) released a study of the readiness of the Nation's healthcare workforce to meet the needs of its aging population. The Re-tooling for an Aging America: Building the Health Care Workforce called for immediate investments in preparing our healthcare system to care for older Americans and their families. Virtually all healthcare providers need to be fully prepared to manage the common medical and mental health problems of old age. In addition, the number of geriatric health specialists, including mental health providers, needs to be increased both to provide care for those older adults with the most complex issues and to train the rest of the workforce in the common medical and mental health problems of old age. The small numbers of specialists in geriatric mental health, combined with increases in life expectancy and the growing population of the nation's elderly, foretells a crisis in healthcare that will impact older adults and their families nationwide. Unless changes are made now, older Americans will face long waits, decreased choice, and suboptimal care.

In order to implement the IOM report, AAGP believes that there are several critical issues that this subcommittee should address:

IOM Study on Geriatric Mental Health Workforce

AAGP believes that the broad scope of the 2008 IOM study, while meeting a crucial need for information on the many issues regarding the health workforce for older adults, precluded the in-depth consideration of the workforce needed for treating mental illness. The study should be followed by a complementary study focused on the specific challenges in the geriatric mental health field. This study should follow up the general IOM study in two specific ways: it should examine the access and workforce barriers unique to geriatric mental healthcare services; and, in discussing possible alternative models of geriatric service delivery (such as medical homes, PACE programs, collaborative care models like those demonstrated in the IMPACT and PROSPECT studies), it should articulate the importance of integrating geriatric mental health services as intrinsic components. "The Retooling the Health Care Workforce for an Aging America Act," S. 245/H.R. 46, contains a provision mandating this additional study.

In discussions with AAGP, the senior staff of IOM suggested the following language for inclusion in the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill:

The subcommittee provides $1,000,000 for a study by the Institute of Medicine of the National Academy of Sciences to determine the multi-disciplinary mental health workforce needed to serve older adults. The initiation of this study should be not later than 60 days after the date of enactment of this act, whereby the Secretary of Health and Human Services shall enter into a contract with the IOM to conduct a thorough analysis of the forces that shape the mental healthcare workforce for older adults, including education, training, modes of practice, and reimbursement.

Title VII Geriatric Health Professions Education Programs

The Bureau of Health Professions in the HHS Health Resources and Services Administration (HRSA) administers programs aimed to help to assure adequate numbers of healthcare practitioners for the Nation's geriatric population, especially in underserved areas.

The geriatric health professions program supports three important initiatives. The Geriatric Education Center (GEC) Program, within defined geographic areas, provides interdisciplinary training for healthcare professionals in assessment, chronic disease syndromes, care planning, emergency preparedness, and cultural competence unique to older Americans. The Geriatric Training for Physicians, Dentists, and Behavioral and Mental Health Professionals (GTPD Program) provides fellows with exposure to older adult patients in various levels of wellness and functioning and from a range of socioeconomic and racial/ethnic backgrounds. The Geriatric Academic Career Awards (GACA) support the academic career development of geriatricians in junior faculty positions who are committed to teaching geriatrics in medical schools across the country. GACA recipients are required to provide training in clinical geriatrics, including the training of interdisciplinary teams of healthcare professionals. AAGP supports increased funding for these programs as a means to increase geriatric specialist healthcare providers.

Specifically, AAGP supports expanding the number of GECs across the Nation; expanding GEC grants to offer mini-fellowships in geriatrics to faculty members of health professions schools in all disciplines; enhancing GACA awards to support and retain clinician educators from a variety of disciplines as they advance in their careers; and providing full funding for the National Center for Workforce Analysis to analyze current and projected needs for healthcare professionals and paraprofessionals in the long-term care sector.

NATIONAL INSTITUTES OF HEALTH (NIH) AND NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

With the graying of the population, mental disorders of aging represent a growing crisis that will require a greater investment in research to understand age-related brain disorders and to develop new approaches to prevention and treatment. Even in the years in which funding was increased for NIH and the NIMH, these increases did not always translate into comparable increases in funding that specifically address problems of older adults. For instance, according to figures provided by NIMH, NIMH total aging research amounts decreased from $106,090,000 in 2002 to $85,164,000 in 2006 (dollars in thousands: $106,090 in 2002; $100,055 in 2003; $97,418 in 2004; $91,686 in 2005; and $85,164 in 2006).

The critical disparity between federally funded research on mental health and aging and the projected mental health needs of older adults is continuing. If the mental health research budget for older adults is not substantially increased immediately, progress to reduce mental illness among the growing elderly population will be severely compromised. While many different types of mental and behavioral disorders occur in late life, they are not an inevitable part of the aging process, and continued and expanded research holds the promise of improving the mental health and quality of life for older Americans. This trend must be immediately reversed to ensure that our next generation of elders is able to access effective treatment for mental illness. Federal funding of research must be broad-based and should include basic, translational, clinical, and health services research on mental disorders in late life.

As the NIMH utilizes the new funding from "The American Recovery and Reinvestment Act of 2009," it is necessary that a portion of those funds be used to invest in the future evidence-based treatments for our Nation's elders. Beginning in fiscal year 2010, annual increases of funds targeted for geriatric mental health research at NIH should be used to: (1) identify the causes of age-related brain and mental disorders to prevent mental disorders before they devastate lives; (2) speed the search for effective treatments and efficient methods of treatment delivery; and (3) improve the quality of life for older adults with mental disorders.

Participation of Older Adults in Clinical Trials

Federal approval for most new drugs is based on research demonstrating safety and efficacy in young and middle-aged adults. These studies typically exclude people who are old, who have more than one health problem, or who take multiple medications. As the population ages, that is the very profile of many people who seek treatment. Thus, there is little available scientific information on the safety of drugs approved by the Food and Drug Administration (FDA) in substantial numbers of older adults who are likely to take those drugs. Pivotal regulatory trials never address

the special efficacy and safety concerns that arise specifically in the care of the nation's mentally ill elderly. This is a critical public health obligation of the nation's health agencies. Just as the FDA has begun to require inclusion of children in appropriate studies, the agency should work closely with the geriatric research community, healthcare consumers, pharmaceutical manufacturers, and other stakeholders to develop innovative, fair mechanisms to encourage the inclusion of older adults in clinical trials. Clinical research must also include elders from diverse ethnic and cultural groups. In addition, AAGP urges that Federal funds be made available each year for support of clinical trials involving older adults.

As little emphasis has been placed on the development of new treatments for geriatric mental disorders, AAGP would encourage the NIH to promote the development of new medications specifically targeted at brain-based mental disorders of the elderly. AAGP urges this subcommittee to request a Government Accountability Office (GAO) study on spending by NIH on conditions and illnesses related to the mental health of older individuals. The NIH has already undertaken, in its Blueprint for Neuroscience Research, an endeavor to enhance cooperative activities among NIH Institutes and Centers that support research on the nervous system. A GAO study of the work being done by these 16 Institutes in areas that predominately involve older adults could provide crucial insights into possible new areas of cooperative research, which in turn will lead to advances in prevention and treatment for these devastating illnesses.

CENTER FOR MENTAL HEALTH SERVICES (CMHS)

It is critical that there be adequate funding for the mental health initiatives under the jurisdiction of the CMHS within the Substance Abuse and Mental Health Services Administration (SAMHSA). While research is of critical importance to a better future, the patients of today must also receive appropriate treatment for their mental health problems. The final SAMHSA budgets for the last 8 years have included $5 million for evidence-based mental health outreach and treatment to the elderly. AAGP urges an increase in funding from $5 million to $20 million for this essential program to disseminate and implement evidence-based practices in routine clinical settings across the States. Of that $20 million appropriation, AAGP believes that $10 million should be allocated to a National Evidence-Based Practices Program, which will disseminate and implement evidence-based mental health practices for older persons in usual care settings in the community. This program will provide the foundation for a longer-term national effort that will have a direct effect on the well-being and mental health of older Americans.

CONCLUSION

AAGP recommends:

—An IOM study on the geriatric mental health workforce to examine the access and workforce barriers unique to geriatric mental healthcare services and, to articulate the importance of integrating geriatric mental health services as intrinsic components;

—Increased funding for the geriatric health professions education programs under title VII of the Public Health Service Act;

—A GAO study on spending by NIH on conditions and illnesses related to the mental health of older individuals.

—Increased funding for evidence-based geriatric mental health outreach and treatment programs at CMHS.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF IMMUNOLOGISTS

The American Association of Immunologists (AAI), a not-for-profit professional society representing more than 6,000 of the world's leading experts on the immune system, appreciates having this opportunity to submit testimony regarding fiscal year 2010 appropriations for the National Institutes of Health (NIH). The vast majority of AAI members—research scientists and physicians who work in academia, Government, and industry—depend on NIH funding to advance their work and the field of immunology.[1] With approximately 83 percent of NIH's approximately $29 billion budget awarded to scientists throughout the United States and around the

[1] The majority of AAI members receive grants from the National Institute of Allergy and Infectious Diseases or the National Cancer Institute; some receive grants from the National Institute on Aging, the National Institute of Arthritis and Musculoskeletal and Skin Diseases, or other Institutes or Centers.

world, NIH funding advances not only immunological and biomedical research, but also regional and national economies.[2]

THE SCOPE AND IMPORTANCE OF IMMUNOLOGY

From infectious diseases including influenza, HIV/AIDS, malaria, smallpox, and the common cold, to chronic diseases like cancer, diabetes, rheumatoid arthritis, asthma, and lupus, the immune system plays a central role in human and animal health.[3] Whether protecting the body from disease—or causing it (as in the case of autoimmune disease or the rejection of transplanted organs)[4]—the immune system is critical to maintaining individual human life and pivotal to community and global public health.[5] Prevention, treatments, and cures depend on our understanding of a scientific field that is relatively new: although the first vaccine was developed in 1798 (to protect against smallpox), most of our basic understanding of the immune system has developed in the past 30–40 years, making immunology ripe for the many new discoveries that are unfolding every day. Emerging areas in immunology involve understanding the immune response to environmental threats, to pathogens that threaten to become the next pandemic, and to manmade and natural infectious organisms that are potential agents of bioterrorism (including plague, smallpox, and anthrax). For all of these urgent needs, basic research on the immune system provides a crucial foundation for the development of diagnostics, vaccines, and therapeutics.

RECENT IMMUNOLOGICAL DISCOVERIES

Immunologists are making significant advances in the development of treatments and vaccines against pernicious viruses such as influenza strains and HIV. Recently, commonalities were identified among the viruses causing seasonal flu, avian flu, and the 1918 pandemic flu, indicating that some of the antibodies will react against all these strains. Such antibodies could be developed for therapeutic use in the case of a flu outbreak. In studies on HIV, immunologists have also identified a unique small antibody fragment that is able to stop a broad range of HIV strains from entering their target cells. This offers hope for a therapy against HIV, which mutates too quickly to be responsive to most traditional vaccine strategies.

An explosion of research has followed the major recent discovery of the central role of the inflammasome in immunity. Inflammasomes are broadly important molecular complexes within cells that sense infections, environmental pollutants, and other "danger" signals and control the activation of the pro-inflammatory, hormone-like molecules interleukin-1 and interleukin-18. Although it may help protect against infection, inflammasome-induced interleukin-1 has also been found to be a key "offender" in many inflammatory and autoimmune diseases. Inhibitors of these inflammatory molecules have already demonstrated significant clinical efficacy in autoimmune diseases, gout, and inherited periodic fever syndromes and are being investigated in other illnesses given the potential of the inflammasome to be relevant to almost any type of disease.

Immunologists have made important progress against the increasing prevalence of childhood peanut allergies by developing a mouse model that is being used to study the basis of this allergy. They have also identified a possible treatment course that might reverse the resulting potentially life-threatening anaphylaxis.

Immunologists are also focusing research efforts in the area of cancer vaccines. Novel delivery strategies, to effectively present tumor antigens or portions of the tumors themselves, have allowed the redirection of the immune system to attack cancerous cells within the body. Other strategies that manipulate molecules (including

---

[2] NIH funding supports "almost 50,000 competitive grants to more than 325,000 researchers at over 3,000 universities, medical schools, and other research institutions in every state and around the world." NIH Website: http://www.nih.gov/about/NIHoverview.html (April 28, 2009)

[3] Research on the immune system is also of enormous benefit to pets and livestock.

[4] The immune system works by recognizing and attacking "foreign invaders" (e.g., bacteria and viruses) inside the body and by controlling the growth of tumor cells. A healthy immune system can protect its human or animal host from illness or disease either entirely—by attacking and destroying the virus, bacterium, or tumor cell—or partially, resulting in a less serious illness. It is also responsible for the rejection responses observed following transplantation of organs or bone marrow. The immune system can malfunction, causing the body to attack itself, resulting in an "autoimmune" disease, such as Type 1 diabetes, multiple sclerosis, or rheumatoid arthritis.

[5] NIH funds research "on 'neglected infectious diseases' such as malaria, tuberculosis, and a host of tropical diseases—diseases that are most prevalent in low-income countries, and that are insufficiently researched by the drug industry." Testimony of Ron Pollack, Executive Director, Families USA, before the House Energy and Commerce Subcommittee on Health, hearing on "Treatments for an Ailing Economy: Protecting Health Care Coverage and Investing in Biomedical Research," November 13, 2008, page 4.

the inhibitory receptor CTLA4) on immune cells have shown remarkable clinical promise for melanoma and prostate cancer. In addition, our understanding of how tumors evade and suppress immunity is evolving, providing new options for therapy, such as altering the function of T-regulatory cells, which normally suppress immunity and thereby promote tumor growth.

Immunologists have also made significant progress in understanding autoimmune disease by discovering that furin, a catalytic enzyme, prevents some forms of systemic autoimmunity. Scientists have found that mice lacking this enzyme had overactive effector T cells as well as suppressive T cells with impaired activity, a key finding which may lead to treatment of autoimmune disease without suppressing basic immunity.

THE NIH BUDGET: GREAT PROMISE—AND GRAVE DANGER

AAI is very grateful to this subcommittee and the Congress for doubling the NIH budget from fiscal year 1999 to fiscal year 2003 and for addressing the extremely serious problem caused by post-doubling subinflationary budget increases through passage of both The American Recovery and Reinvestment Act of 2009 (ARRA), which provided $10.4 billion to NIH, and the fiscal year 2009 Appropriations Act, which provided a 3.2 percent ($938 million) budget increase more than fiscal year 2008. NIH is now in the extraordinary position of being able to fund many worthy projects that had been denied funding, to invest in modernizing and enhancing the Nation's research infrastructure, and to support scientific and administrative jobs that are crucial to the scientific enterprise. This infusion of funds, together with the exceptional commitment to advancing scientific research articulated by President Obama, is also giving our brightest young students the confidence and desire to pursue careers in biomedical research, a crucial factor in helping research advances today become cures tomorrow.

Passage of ARRA acknowledged the multi-faceted impact of investing in biomedical research and the NIH: improving individual and global health, and stimulating local and national economic activity and job creation. NIH has estimated that each NIH grant supports on average, "6 to 7 in-part or full scientific jobs."[6] Families USA, a not-for-profit consumer advocacy organization, has reported that (1) on average, each $1 of NIH funding going into a State generates more than twice as much in State economic output, and (2) in fiscal year 2007, NIH funding created and supported more than 350,000 jobs that generated wages in excess of $18 billion, with an average wage of $52,000 (nearly 25 percent higher than the average U.S. wage).[7]

While AAI—and the entire biomedical research community—is deeply grateful for ARRA's tremendous influx of funds and support, some of the constraints accompanying the ARRA funding (i.e., that the funds must be obligated by the end of fiscal year 2010 and must be used for immediate economic impact, including creating jobs) are somewhat inconsistent with the longer view and nature of science and the strong need for reliable, sustained funding. Although significant advances can be made in 2 years, few projects can be completed in that time. As such, AAI looks ahead with concern to future years, when advances poised to be made may not come to fruition should ARRA funds end without adequate regular appropriations to cushion the reduction. AAI's appropriations recommendations for fiscal year 2010 (and ultimately for 2011, though not offered here), are premised on that concern and designed to address that future.

AAI RECOMMENDS A 7 PERCENT BUDGET INCREASE FOR FISCAL YEAR 2010

AAI urges the subcommittee to increase the NIH budget by 7 percent in fiscal year 2010. Such an increase would help ensure that research and jobs supported by ARRA funds are not lost, and that ongoing research would be on track to reach its full potential even after the ARRA funding is spent. A 7 percent budget increase would also put NIH on the path that most scientists have long sought and urgently

[6] Testimony of Raynard S. Kington, M.D., Ph.D., Acting Director, National Institutes of Health, Witness appearing before the House Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee, March 26, 2009. Dr. Kington was citing the NIH report: "Estimating the Number of Senior/Key Personnel Engaged in NIH Supported Research," study issued October 2008.

[7] "In Your Own Backyard: How NIH Funding Helps Your State's Economy," Families USA, (June 2008). The report cited numerous economic benefits of NIH funding, including: (1) The amount of new business activity generated ranged from $8.39 billion in California to $13 million in Wyoming; (2) In 14 States, NIH funding generated more than $1 billion in new business activity; 3) In 10 States, each $1 of NIH funding generated at least $2.26 in economic activity; and (4) In 6 States, more than 20,000 new jobs were created.

need: a path of predictable, sustained funding that stabilizes ongoing research projects and the overall research enterprise.

AAI also supports President Obama's request for an additional $1.5 billion to specifically address recent developments regarding the emergent H1N1 (swine) influenza virus. This is an important investment in pandemic preparedness, whether that pandemic proves to be influenza or a pathogen not yet predicted.

OTHER KEY ISSUES

Seasonal Influenza and Pandemics.—Seasonal influenza leads to an average of more than 200,000 hospitalizations and about 36,000 deaths nationwide annually. An influenza pandemic could occur at any time; a pandemic as serious as the 1918 pandemic could result in the illness of almost 90 million Americans and the death of more than 2 million.[8] While researchers and public health professionals must respond to emergent threats (such as the current concern related to the H1/N1 flu virus), AAI believes that the best preparation for a pandemic is to focus on basic research to combat seasonal flu, including building capacity, pursuing new production methods (cell based), and seeking optimized flu vaccines and delivery methods.

Bioterrorism.—To best protect against bioterrorism, scientists should focus on basic research, including working to understand the immune response, identifying new and potentially modified pathogens, and developing tools (including new and more potent vaccines) to protect against these pathogens.

The NIH "Common Fund".—The NIH Reform Act of 2006 established within NIH a "Common Fund" (CF) to support trans-NIH initiatives. Although AAI recognizes the value of interdisciplinary research, the existence of the CF should not permit the funding of lesser quality research. Instead, all CF applications should be subject to a transparent and rigorous peer-review process like all other funded research grant applications. In addition, AAI recommends that the CF not grow faster than the overall NIH budget.

The NIH Public Access Policy ("Policy").—AAI continues to believe that the Policy will duplicate, at great cost to NIH and to taxpayers, publications and services which are already provided cost-effectively and well by the private sector. Therefore, AAI respectfully requests that the subcommittee require that NIH publicly report on the cost to date of implementing the Policy (both voluntary and mandatory), and projected future costs (including all personnel, administrative, infrastructure and enforcement costs) incurred by the various NIH Institutes, Centers, and Offices involved.

Preserving High-quality Peer Review.—NIH's recent completion of its "Peer Review Self-Study" has resulted in the adoption and implementation of numerous changes to its internationally respected and highly successful peer review system. While AAI applauds this effort to address some legitimate problems with the system, AAI urges that NIH be required to conduct timely and transparent evaluation of all pilot projects and permanent changes, and provide ample opportunity for public comment.

Ensuring NIH Operations and Oversight.—AAI urges the subcommittee to ensure adequate funding for the NIH Research, Management, and Services (RM&S) account, which supports the management, monitoring, and oversight of all research activities. Particularly with the infusion and rapid dissemination of ARRA funds, NIH must be able to properly supervise and oversee its increasingly large and complex portfolio.

CONCLUSION

AAI greatly appreciates this opportunity to submit testimony and thanks the Chairman and members of the subcommittee for their strong support for biomedical research, the NIH, and the scientists who devote their lives to preventing, treating, and curing disease.

---

[8] A report issued by Trust for America's Health ("Pandemic Flu and the Potential for U.S. Economic Recession") predicted that a severe pandemic flu outbreak could result in the second worst recession in the United States since World War II, resulting in a projected cost of $683 billion. (March 2007)

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

FISCAL YEAR 2010 APPROPRIATIONS REQUEST SUMMARY

[Dollars in thousands]

	Fiscal year 2009 actual	Fiscal year 2010 budget	AANA fiscal year 2010 request
HHS /HRSA /BHPr Title VIII Advanced Education Nursing, Nurse Anesthetist Education Reserve.	Awaiting grant allocations—in fiscal year 2008 awards amounted to approximately $3,500.	Grant allocations not specified.	$4,000 for nurse anesthesia education
Total for Advanced Education Nursing, from Title VIII.	$64.44 for Advanced Education Nursing.	$64.44 for Advanced Education Nursing.	$79.55 for Advanced Education Nursing
Title VIII HRSA BHPr Nursing Education Programs.	$171,031	$263,403	$263,403

The AANA is the professional association for more than 40,000 Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists, representing more than 90 percent of the nurse anesthetists in the United States. Today, CRNAs are directly involved in delivering 30 million anesthetics given to patients each year in the United States. CRNA services include administering the anesthetic, monitoring the patient's vital signs, staying with the patient throughout the surgery, and providing acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases, and in some States are the sole anesthesia providers in almost 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, and trauma stabilization, and pain management capabilities. CRNAs work in every setting in which anesthesia is delivered, including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management units, and the offices of dentists, podiatrists and plastic surgeons.

Nurse anesthetists are experienced and highly trained anesthesia professionals whose record of patient safety in the field of anesthesia was bolstered by the Institute of Medicine report in 2000, which found that anesthesia is 50 times safer than 20 years previous. (Kohn L, Corrigan J, Donaldson M, Ed. To Err is Human. Institute of Medicine, National Academy Press, Washington DC, 2000.) Nurse anesthetists continue to set for themselves the most rigorous continuing education and re-certification requirements in the field of anesthesia. Relative anesthesia patient safety outcomes are comparable among nurse anesthetists and anesthesiologists, with Pine having concluded, "the type of anesthesia provider does not affect inpatient surgical mortality." (Pine, Michael MD et al. "Surgical mortality and type of anesthesia provider." Journal of American Association of Nurse Anesthetists. Vol. 71, No. 2, p. 109–116. April 2003.)

Even more recently, a study published in Nursing Research indicates that obstetrical anesthesia, whether provided by Certified Registered Nurse Anesthetists (CRNAs) or anesthesiologists, is extremely safe, and there is no difference in safety between hospitals that use only CRNAs compared with those that use only anesthesiologists. (Simonson, Daniel C et al. "Anesthesia Staffing and Anesthetic Complications During Cesarean Delivery: A Retrospective Analysis." Nursing Research, Vol. 56, No. 1, pp. 9–17. January/February 2007). In addition, a recent AANA workforce study showed that CRNAs and anesthesiologists are substitutes in the production of surgeries, and it is important to note that through continual improvements in research, education, and practice, nurse anesthetists are vigilant in their efforts to ensure patient safety.

CRNAs provide the lion's share of anesthesia care required by our U.S. Armed Forces through active duty and the reserves. In May 2003 at the beginning of "Operation Iraqi Freedom," 364 CRNAs were deployed to the Middle East to ensure military medical readiness capabilities. For decades, CRNAs have staffed ships, remote U.S. military bases, and forward surgical teams without physician anesthesiologist support. In addition, CRNAs predominate in rural and medically underserved areas and areas where more Medicare patients live. A recent analysis of the nurse anesthesia workforce, indicates that in 2006, 38 percent of nurse anesthesia graduates went to work in a Medically Underserved Area or for a Medically Underserved Population.

IMPORTANCE OF TITLE VIII NURSE ANESTHESIA EDUCATION FUNDING

The nurse anesthesia profession's chief request of the subcommittee is for $4 million to be reserved for nurse anesthesia education and $79.55 million for advanced education nursing from the title VIII program. We feel that this funding request is well justified, as we are seeing a vacancy rate of nurse anesthetists in the United States that is impacting the public's access to healthcare. The title VIII program, which has been strongly supported by members of this subcommittee in the past, is an effective means to help address the nurse anesthesia workforce demand.

Increasing funding for advanced education nursing from $64.44 million to $79.55 million is necessary to meet the continuing demand for nursing faculty and other advanced education nursing services throughout the United States. The program provides for competitive grants that help enhance advanced nursing education and practice and traineeships for individuals in advanced nursing education programs. This funding is critical to meet the nursing workforce needs of Americans who require healthcare. In fact, this funding not only seeks to increase the number of providers in rural and underserved America but also prepares providers at the master's and doctoral levels, increasing the number of clinicians who are eligible to serve as faculty.

The CRNA workforce is seeing a shortage in the clinical and educational setting. In 2007, an AANA nurse anesthesia workforce study found a 12.6 percent vacancy rate in hospitals for CRNAs, and a 12.5 percent faculty vacancy rate. The supply of clinical providers has increased in recent years, stimulated by increases in the number of CRNAs trained. Between 2000–2008, the number of nurse anesthesia educational program graduates doubled, with the Council on Certification of Nurse Anesthetists (CCNA) reporting 1,075 graduates in 2000 and 2,158 graduates in 2008. This growth is expected to continue. However, it is important to note that even though the number of graduates has doubled in 8 years, the nurse anesthetist vacancy rate remained steady at around 12 percent, which is likely due to increased demand for anesthesia services as the population ages, growth in the number of clinical sites requiring anesthesia services, and CRNA retirements.

The problem is not that our 108 accredited programs of nurse anesthesia are failing to attract qualified applicants. It is that they have to turn them away by the hundreds. The capacity of nurse anesthesia educational programs to educate qualified applicants is limited by the number of faculty, the number and characteristics of clinical practice educational sites, and other factors. A qualified applicant to a CRNA program is a bachelor's educated registered nurse who has spent at least 1 year serving in an acute care healthcare practice environment. Nurse anesthesia educational programs are located all across the country, including Alabama, Arkansas, Iowa, Illinois, Louisiana, Pennsylvania, Rhode Island, Tennessee, Texas, Washington, and Wisconsin.

Recognizing the important role nurse anesthetists play in providing quality healthcare, the AANA has been working with the 108 accredited nurse anesthesia educational programs to increase the number of qualified graduates. In addition, the AANA has worked with nursing and allied health deans to develop new CRNA programs.

To truly meet the nurse anesthesia workforce challenge, the capacity and number of CRNA schools must continue to grow. With the help of competitively awarded grants supported by title VIII funding, the nurse anesthesia profession is making significant progress, expanding both the number of clinical practice sites and the number of graduates.

The AANA is pleased to report that this progress is extremely cost-effective from the standpoint of Federal funding. Anesthesia can be provided by nurse anesthetists, physician anesthesiologists, or by CRNAs and anesthesiologists working together. As mentioned earlier, the study by Pine et al confirms, "the type of anesthesia provider does not affect inpatient surgical mortality." Yet, for what it costs to educate one anesthesiologist, several CRNAs may be educated to provide the same service with the same optimum level of safety. Nurse anesthesia education represents a significant educational cost-benefit for supporting CRNA educational programs with Federal dollars vs. supporting other, more costly, models of anesthesia education.

To further demonstrate the effectiveness of the title VIII investment in nurse anesthesia education, the AANA surveyed its CRNA program directors in 2003 to gauge the impact of the title VIII funding. Of the 11 schools that had reported receiving competitive Title VIII Nurse Education and Practice Grants funding from 1998 to 2003, the programs indicated an average increase of at least 15 CRNAs graduated per year. They also reported on average more than doubling their number

of graduates. Moreover, they reported producing additional CRNAs that went to serve in rural or medically underserved areas.

We believe it is important for the subcommittee to allocate $4 million for nurse anesthesia education for several reasons. First, as this testimony has documented, the funding is cost-effective and needed. Second, the title VIII authorization previously providing such a reserve expired in September 2002. Third, this particular funding is important because nurse anesthesia for rural and medically underserved America is not affected by increases in the budget for the National Health Service Corps and community health centers, since those initiatives are for delivering primary and not surgical healthcare. Lastly, this funding meets an overall objective to increase access to quality healthcare in medically underserved America.

TITLE VIII FUNDING FOR STRENGTHENING THE NURSING WORKFORCE

The AANA joins a growing coalition of nursing organizations, including the Americans for Nursing Shortage Relief (ANSR) Alliance and representatives of the nursing community, and others in support of the subcommittee providing a total of $263 million in fiscal year 2010 for nursing shortage relief through title VIII. This amount is the same as the President's request for 2010. However, AANA asks that of the $263 million, $79.55 million go to Advanced Education Nursing to help increase clinicians in underserved communities and those eligible to serve as faculty. The AANA appreciates the support for nurse education funding in fiscal year 2009 and past fiscal years from this subcommittee and from the Congress.

In the interest of patients past and present, particularly those in rural and medically underserved parts of this country, we ask Congress to invest in CRNA and nursing educational funding programs and to provide these programs the sustained increases required to help ensure Americans get the healthcare that they need and deserve. Quality anesthesia care provided by CRNAs saves lives, promotes quality of life, and makes fiscal sense. This Federal support for title VIII and advanced education nurses will improve patient access to quality services and strengthen the Nation's healthcare delivery system.

SAFE INJECTION PRACTICES

Last, as a leader in patient safety, the AANA has been playing a vigorous role in the development and projects of the Safe Injection Practices Coalition, intended to reduce and eventually eliminate the incidence of healthcare facility acquired infections. In the interest of promoting safe injection practice, and reducing the incidence of healthcare facility acquired infections, we recommend the subcommittee provide the following appropriations for fiscal year 2010:

—*Centers for Disease Control and Prevention.*—$9 million for provider education and patient awareness activities; $8 million to promote private-sector healthcare solutions to injection safety and infection control problems; $9 million for detection and tracking in order to enable States to investigate outbreaks of hepatitis and other potential pathogens related to injection safety.

—*Agency for Healthcare Research and Quality (AHRQ).*—$10 million in general patient safety funds for the AHRQ's Ambulatory Patient Safety Program.

—*Department of Health and Human Services.*—$1 million to expand its current focus for reducing HAIs from hospitals to all healthcare settings, including outpatient facilities.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

EXECUTIVE SUMMARY

The American Academy of Ophthalmology (AAO) requests a fiscal year 2010 National Institutes of Health (NIH) funding increase of at least 7 percent, to a level of $32.4 billion, which represents a modest 3 percent increase plus the biomedical inflation rate, estimated at 3.8 percent in fiscal year 2009. This increase is necessary to keep pace with inflation and rebuild the base, since NIH has lost 14 percent of its purchasing power during the past six funding cycles. AAO commends the congressional leadership's actions in fiscal year 2008 and 2009 to increase NIH funding, including the $150 million in the fiscal year 2008 supplemental dedicated to investigator-initiated grants, the $10.4 billion in 2-year stimulus NIH funding within the American Recovery and Reinvestment Act (ARRA), and the final fiscal year 2009 appropriations inflationary increase of 3.2 percent. However, NIH needs sustained and predictable funding to rebuild its base and support multi-year, investigator-initiated research, which is the cornerstone of the biomedical enterprise. Annual increases of at least 7 percent put NIH on a pathway to budget-doubling within

the next 10 years. Secure and consistent funding for biomedical research is integral to the Nation's economic and global competitiveness. NIH is a world-leading institution that must be adequately funded so that its research can reduce healthcare costs, increase productivity, and save and improve the quality of lives.

AAO requests that Congress make vision health a top priority by increasing National Eye Institute (NEI) funding by at least 7 percent, to a level of $736 million, in this year that NEI celebrates its 40th anniversary. Over the past 6 funding cycles, NEI lost 18 percent of its purchasing power. Despite funding challenges, NEI has maintained its impressive record of breakthroughs in basic and clinical research that have resulted in treatments and therapies to save and restore vision and prevent eye disease. NEI will be challenged further, as 2010 begins the decade in which more than half of the 78 million Baby Boomers will turn 65 and be at greatest risk for aging eye disease. Adequately funding the NEI is a cost-effective investment in our Nation's health, as it can delay, save, and prevent expenditures, especially to the Medicare and Medicaid programs.

Fiscal year 2010 funding at $736 million enables NEI to expand its impressive record of basic and clinical collaborative research that has resulted in treatments and therapies to save and restore vision.

NEI continues to be a leader in basic research—especially that which elucidates the genetic basis of ocular disease—and in translational research, as those gene discoveries can lead to development of diagnostics and treatments. NEI Director Paul Sieving, M.D., Ph.D., has reported that one-quarter of all genes identified to date through NEI's collaboration with the National Human Genome Research Institute (NHGRI) are associated with eye disease/visual impairment. Recent examples include:

—In 2005, NEI reported that gene variants of Complement Factor H (CFH), the protein product of which is engaged in the control of the body's immune response, are associated with increased risk of developing age-related macular degeneration (AMD), the leading cause of vision loss. NEI-funded researchers are now working on potential therapies, including the manufacture and use of a protective version of the CFH protein in an augmentation strategy similar to that of treating diabetes with insulin. This therapy is under development and expected to enter Phase I clinical safety trials in summer 2009.

—In March 2008, NEI-funded researchers announced that damage from both AMD and diabetic retinopathy was prevented and even reversed when the protein Robo4 was activated in mouse models that simulate the two diseases. Robo4 treated and prevented the diseases by inhibiting abnormal blood vessel growth and by stabilizing blood vessels to prevent leakage. Since this research into the "Robo4 Pathway" used animal models associated with these diseases that are already used in drug development, the time required to test this approach in humans could be shortened, expediting approvals for new therapies

—In late April 2008, researchers funded by the NEI and private funding organization Foundation Fighting Blindness reported on their use of gene therapy to restore vision in young adults who were virtually blind from a severe form of the neurodegenerative disease Retinitis Pigmentosa, known as Leber Congenital Amaurosis (LCA). Seven years earlier, the researchers shared on Capitol Hill results of a preclinical study of the same gene therapy, which at the time was successfully giving vision to dogs born blind with LCA. The subsequent human gene therapy trial validated the process of putting genes in the body to restore vision. Although the primary goal of the Phase I study was to ensure patient safety, the researchers reported through both objective and subjective testing that the patients were able to read several additional lines on an eye chart, had better peripheral vision, and better eyesight in dimly lit settings. In further research, the investigators will treat LCA patients as young as 8 years old, since they believe the most dramatic results will be seen in young children.

—In late 2008, NEI initiated its new NEI Glaucoma Human genetics collaBORation, known as NEIGHBOR, through which seven U.S. research teams will lead genetic studies of the disease. Glaucoma is called the "stealth robber of vision" as it often has no symptoms until vision is lost, and anywhere from 50–75 percent of individuals with it are undiagnosed. It is also the leading cause of preventable vision loss in African American and Hispanic populations, which emphasizes the vital nature of determining the genetic basis of this disease.

Fiscal year 2010 funding at $736 million enables NEI to fully fund new initiatives that more fully characterize eye disease.

NEI has been a leader in collaborative research, the use of networks to study diagnostics and treatments and their use in clinical settings, and in ocular epidemiology to characterize the nature and frequency of eye disease in diverse populations to better manage public health. In fiscal year 2008, NEI reported on/launched the

initial phase of three important new programs to characterize eye disease requiring adequate future funding.

—In early 2009, the NEI and the National Aeronautics and Space Administration (NASA) reported on the use of a compact fiber optic probe developed for the space program that has proven valuable as the first non-invasive early detection device for cataracts, the leading cause of vision loss worldwide. Using a laser light technique called dynamic light scattering (DLS), which was developed to analyze the growth of protein crystals in a zero-gravity environment, the probe measures the amount of light scattering by an anti-cataract protein called alpha-crystallin. The probe senses protein damage due to oxidative stress, a key process involved in many medical conditions including age-related cataract and diabetes, as well as Alzheimer's and Parkinson's disease.

—In late 2008, NEI launched a new research network, the Neuro-Ophthalmology Research Disease Investigator Consortium, or NORDIC. It will initially lead multi-site observational and treatment trials, involving nearly 200 community and academic practitioners, to address the risks, diagnosis, and treatment of two "rare" diseases: idiopathic intracranial hypertension (visual dysfunction due to increased intracranial pressure) and thyroid eye disease (also called Graves' disease, in which muscles of the eye enlarge and cause bulging of the eyes, retraction of the lids, double vision, decreased vision, and irritation). The NEI and NORDIC's Principal Investigator have already begun coordinating with the Department of Defense's (DOD) newly established Vision Center of Excellence (VCE) about the applicability of NORDIC research to combat-related eye injuries, especially those associated with Traumatic Brain Injury (TBI).

—There is currently almost no information on the prevalence, risk factors, and genetic determinants in Asian Americans—one of the fastest growing racial groups in the United States. Studies from East Asia have suggested that Asians have a spectrum of eye diseases different from that of White Americans, African Americans, and Hispanics. In late 2008, NEI launched the Chinese American Eye Study to characterize the extent of eye disease in Chinese Americans, the largest Asian subgroup in the United States. Participants 50 years and older will be evaluated for blindness, visual impairment, and eye disease. These results will add to the expanding body of knowledge about vision health disparities already characterized by NEI in the African-American and Hispanic populations.

Vision impairment/eye disease is a major public health problem that increases healthcare costs, reduces productivity, and diminishes quality of life.

The NEI estimates that more than 38 million Americans age 40 and older experience blindness, low vision, or an age-related eye disease such as AMD, glaucoma, diabetic retinopathy, or cataracts. This is expected to grow to more than 50 million Americans by year 2020. The economic and societal impact of eye disease is increasing not only due to the aging population, but to its disproportionate incidence in minority populations and as a co-morbid condition of chronic disease, such as diabetes.

Although the NEI estimates that the current annual cost of vision impairment and eye disease to the United States is $68 billion, this number does not fully quantify the impact of direct healthcare costs, lost productivity, reduced independence, diminished quality of life, increased depression, and accelerated mortality. The continuum of vision loss presents a major public health problem and financial challenge to the public and private sectors.

—In public opinion polls over the past 40 years, Americans have consistently identified fear of vision loss as second only to fear of cancer. As recently as March 2008, the NEI's Survey of Public Knowledge, Attitudes, and Practices Related to Eye Health and Disease reported that 71 percent of respondents indicated that a loss of their eyesight would rate as a "10" on a scale of 1 to 10, meaning that it would have the greatest impact on their day-to-day life.

In 2009, the NEI will celebrate its 40th anniversary as the NIH Institute that leads the Nation's commitment to save and restore vision. During the next decade, more than half of the 78 million Baby Boomers will celebrate their 65th birthday and be at greatest risk for developing aging eye disease. As a result, sustained, adequate Federal funding for the NEI is an especially vital investment in the health, and vision health, of our Nation as the treatments and therapies emerging from research can preserve and restore vision. Adequately funding the NEI can also delay, save, and prevent health expenditures, especially those associated with the Medicare and Medicaid programs, and is, therefore, a cost-effective investment.

AAO urges fiscal year 2010 NIH and NEI funding at $32.4 billion and $736 million, respectively, reflecting an at-least 7 percent increase more than fiscal year 2009.

ABOUT AAO

The American Academy of Ophthalmology is a 501c(6) educational membership association. AAO is the largest national membership association of eye M.D.s with more than 27,000 members, more than 17,000 of which are in active practice in the United States. Eye M.D.s are ophthalmologists, medical, and osteopathic doctors who provide comprehensive eye care, including medical, surgical and optical care. More than 90 percent of practicing U.S. eye M.D.s are AAO members.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

On behalf of the more than 75,000 clinically practicing physician assistants in the United States, the American Academy of Physician Assistants is pleased to submit comments on fiscal year 2010 appropriations for Physician Assistant (PA) educational programs that are authorized through title VII of the Public Health Service Act.

A member of the Health Professions and Nursing Education Coalition (HPNEC), the Academy supports the HPNEC recommendation to provide at least $300 million for title VII programs in fiscal year 2010, including a minimum of $7 million to support PA educational programs. This would fund the programs at the 2005 funding level, not accounting for inflation.

AAPA recommends that Congress provide additional support to grow the PA primary care workforce through healthcare reform initiatives. A reformed healthcare system will require a much-expanded primary healthcare workforce, both in the private and public healthcare markets. For example, the National Association of Community Health Centers' March 2009 report, Primary Care Access: An Essential Building Block of Health Reform, predicts that in order to reach 30 million patients by 2015, health centers will need at least an additional 15,585 primary care providers, just more than one-third of whom are nonphysician primary care professionals.

The Academy believes that the recommended restoration in funding for title VII health professions programs is well justified.

A review of PA graduates from 1990–2006 demonstrates that PAs who have graduated from PA educational programs supported by title VII are 59 percent more likely to be from underrepresented minority populations and 46 percent more likely to work in a rural health clinic than graduates of programs that were not supported by title VII.

A study by the UCSF Center for California Health Workforce Studies found a strong association between physician assistants exposed to title VII during their PA educational preparation and those who ever reported working in a federally qualified health center or other community health center.

Title VII safety net programs are essential to the development and training of primary healthcare professionals and, in turn, provide increased access to care by promoting healthcare delivery in medically underserved communities. Title VII funding is especially important for PA programs as it is the only Federal funding available on a competitive application basis to these programs.

The AAPA is very appreciative of the recent funding increases, for the title VII Health Professions Programs, in the fiscal year 2009 omnibus appropriations bill (Public Law 111–8), which appropriated $221.7 million, a 14.3 percent increase, more than fiscal year 2008 and the American Recovery and Reinvestment Act (Public Law 111–5), which invested $200 million in expanding title VII Health Professions Programs. However, the AAPA believes that these recent investments only begin to rectify the chronic underfunding of these programs and address existing and looming shortages of health professionals, especially physician assistants. According to HRSA, an additional 30,000 health practitioners are needed to alleviate existing health professional shortages.

We wish to thank the members of this subcommittee for your historical role in supporting funding for the health professions programs, and we hope that we can count on your support to restore funding to these important programs in fiscal year 2010 to the fiscal year 2005 funding level.

OVERVIEW OF PHYSICIAN ASSISTANT EDUCATION

Physician assistant programs train students to practice medicine with physician supervision. PA programs are located within schools of medicine or health sciences, universities, teaching hospitals, and the Armed Services. All PA educational programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant.

The typical PA program consists of 26 months of instruction, and the typical student has a bachelor's degree and about 4 years of prior healthcare experience. The first phase of the program consists of intensive classroom and laboratory study. More than 400 hours in classroom and laboratory instruction are devoted to the basic sciences, with more than 75 hours in pharmacology, approximately 175 hours in behavioral sciences, and almost 580 hours of clinical medicine.

The second year of PA education consists of clinical rotations. On average, students devote more than 2,000 hours, or 50–55 weeks, to clinical education, divided between primary care medicine—family medicine, internal medicine, pediatrics, and obstetrics and gynecology—and various specialties, including surgery and surgical specialties, internal medicine subspecialties, emergency medicine, and psychiatry. During clinical rotations, PA students work directly under the supervision of physician preceptors, participating in the full range of patient care activities, including patient assessment and diagnosis, development of treatment plans, patient education, and counseling.

After graduation from an accredited PA program, physician assistants must pass a national certifying examination developed by the National Commission on Certification of Physician Assistants. To maintain certification, PAs must log 100 continuing medical education hours every 2 years, and they must take a recertification exam every 6 years.

PHYSICIAN ASSISTANT PRACTICE

Physician assistants are licensed healthcare professionals educated to practice medicine as delegated by and with the supervision of a physician. In all States, physicians may delegate to PAs those medical duties that are allowed by law and are within the physician's scope of practice and the PA's training and experience. All States, the District of Columbia, and Guam authorize physicians to delegate prescriptive privileges to the PAs they supervise. Nineteen percent of all PAs practice in nonmetropolitan areas where they may be the only full-time providers of care (State laws stipulate the conditions for remote supervision by a physician). Approximately 41 percent of PAs work in urban and inner city areas. Approximately 40 percent of PAs are in primary care. Roughly 80 percent of PAs practice in outpatient settings.

AAPA estimates that in 2008, more than 257 million patient visits were made to PAs and approximately 332 million medications were written by PAs.

CRITICAL ROLE OF TITLE VII PUBLIC HEALTH SERVICE ACT PROGRAMS

Title VII programs promote access to healthcare in rural and urban underserved communities by supporting educational programs that train health professionals in fields experiencing shortages, improve the geographic distribution of health professionals, increase access to care in underserved communities, and increase minority representation in the healthcare workforce.

Title VII programs are the only Federal educational programs that are designed to address the supply and distribution imbalances in the health professions. Since the establishment of Medicare, the costs of physician residencies, nurse training, and some allied health professions training have been paid through Graduate Medical Education (GME) funding. However, GME has never been available to support PA education. More importantly, GME was not intended to generate a supply of providers who are willing to work in the Nation's medically underserved communities—the purpose of title VII.

Furthermore, title VII programs seek to recruit students who are from underserved minority and disadvantaged populations, which is a critical step towards reducing persistent health disparities among certain racial and ethnic U.S. populations. Studies have found that health professionals from disadvantaged regions of the country are 3 to 5 times more likely to return to underserved areas to provide care.

It is also important to note that a December 2008 Institute of Medicine report characterized HRSA's health professions programs as "an undervalued asset."

TITLE VII SUPPORT OF PA EDUCATIONAL PROGRAMS

Targeted Federal support for PA educational programs is authorized through section 747 of the Public Health Service Act. The program was reauthorized in the 105th Congress through the Health Professions Education Partnerships Act of 1998, Public Law 105–392, which streamlined and consolidated the Federal health professions education programs. Support for PA education is now considered within the broader context of training in primary care medicine and dentistry.

Public Law 105–392 reauthorized awards and grants to schools of medicine and osteopathic medicine, as well as colleges and universities, to plan, develop, and operate accredited programs for the education of physician assistants, with priority given to training individuals from disadvantaged communities. The funds ensure that PA students from all backgrounds have continued access to an affordable education and encourage PAs, upon graduation, to practice in underserved communities. These goals are accomplished by funding PA educational programs that have a demonstrated track record of: (1) placing PA students in health professional shortage areas; (2) exposing PA students to medically underserved communities during the clinical rotation portion of their training; and (3) recruiting and retaining students who are indigenous to communities with unmet healthcare needs.

The PA programs' success in recruiting and retaining underrepresented minority and disadvantaged students is linked to their ability to creatively use title VII funds to enhance existing educational programs. For example, PA programs in Texas use title VII funds to create new clinical rotation sites in rural and underserved areas, including new sites in border communities, and to establish nonclinical rural rotations to help students understand the challenges faced by rural communities. One Texas program uses title VII funds for the development of Web based and distant learning technology and methodologies so students can remain at clinical practice sites. In New York, a PA program with a 90 percent ethnic minority student population uses title VII funding to focus on primary care training for underserved urban populations by linking with community health centers, which expands the pool of qualified minority role models that engage in clinical teaching, mentoring, and preceptorship for PA students. Several other PA programs have been able to use title VII grants to leverage additional resources to assist students with the added costs of housing and travel that occur during relocation to rural areas for clinical training.

Without title VII funding, many of these special PA training initiatives would not be possible. Institutional budgets and student tuition fees simply do not provide sufficient funding to meet the needs of medically underserved areas or disadvantaged students. The need is very real, and title VII is critical in meeting that need.

NEED FOR INCREASED TITLE VII SUPPORT FOR PA EDUCATIONAL PROGRAMS

Increased title VII support for educating PAs to practice in underserved communities is particularly important given the market demand for physician assistants. Without title VII funding to expose students to underserved sites during their training, PA students are far more likely to practice in the communities where they were raised or attended school. Title VII funding is a critical link in addressing the natural geographic maldistribution of healthcare providers by exposing students to underserved sites during their training, where they frequently choose to practice following graduation. Currently, 36 percent of PAs met their first clinical employer through their clinical rotations.

Changes in the healthcare marketplace reflect a growing reliance on PAs as part of the healthcare team. Currently, the supply of physician assistants is inadequate to meet the needs of society, and the demand for PAs is expected to increase. A 2006 article in the Journal of the American Medical Association (JAMA) concluded that the Federal Government should augment the use of physician assistants as physician substitutes, particularly in urban CHCs where the proportional use of physicians is higher. The article suggested that this could be accomplished by adequately funding title VII programs. Additionally, the Bureau of Labor Statistics projects that the number of available PA jobs will increase 49 percent between 2004 and 2014. Title VII funding has provided a crucial pipeline of trained PAs to underserved areas. One way to assure an adequate supply of physician assistants practicing in underserved areas is to continue offering financial incentives to PA programs that emphasize recruitment and placement of PAs interested in primary care in medically underserved communities.

Despite the increased demand for PAs, funding has not proportionately increased for title VII programs that educate and place physician assistants in underserved communities. Nor has title VII support for PA education kept pace with increases in the cost of educating PAs. A review of PA program budgets from 1984 through 2004 indicates an average annual increase of 7 percent, a total increase of 256 percent over the past 20 years, as Federal support has decreased.

RECOMMENDATIONS ON FISCAL YEAR 2010 FUNDING

The American Academy of Physician Assistants urges members of the Appropriations Committee to consider the inter-dependency of all public health agencies and programs when determining funding for fiscal year 2010. For instance, while it is critical, now more than ever, to fund clinical research at the National Institutes of

Health (NIH) and to have an infrastructure at the Centers for Disease Control and Prevention (CDC) that ensures a prompt response to an infectious disease outbreak or bioterrorist attack, the good work of both of these agencies will go unrealized if the Health Resources and Services Administration (HRSA) is inadequately funded. HRSA administers the "people" programs, such as title VII, that bring the results of cutting edge research at NIH to patients through providers such as PAs who have been educated in title VII-funded programs. Likewise, CDC is heavily dependent upon an adequate supply of healthcare providers to be sure that disease outbreaks are reported, tracked, and contained.

The Academy respectfully requests that title VII health professions programs receive $300 million in funding for fiscal year 2010, including a minimum of $7 million to support PA educational programs. Thank you for the opportunity to present the American Academy of Physician Assistants' views on fiscal year 2010 appropriations.

PREPARED STATEMENT OF THE ALLIANCE FOR AGING RESEARCH

Chairman Harkin and members of the subcommittee, for more than two decades the not-for-profit Alliance for Aging Research has advocated for research to improve the experience of aging for all Americans. Our efforts have included supporting Federal funding of aging research by the National Institutes of Health (NIH), through the National Institute on Aging (NIA) and other Institutes and Centers that work with the NIA on cross-cutting initiatives. To this end, the Alliance appreciates the opportunity to submit testimony highlighting the important role that the NIH plays in facilitating aging research activities and the ever more urgent need for increased appropriations to advance scientific discoveries to keep individuals healthier longer.

Many challenges will arise as Americans age in increasing numbers. There are approximately 36 million Americans aged 65 and older. That group is expected to double in size within the next 20 years, at which time at least 20 percent of the U.S. population will be older than 65. Of particular concern is the dramatic growth that is anticipated among those aged 85 and older. By 2050, 19.4 million Americans will be older than the age of 85.

Late-in-life diseases such as type 2 diabetes, cancer, neurological diseases, heart disease, and osteoporosis are increasingly driving the need for healthcare services in this country. If rapid discoveries are not made now to reduce the prevalence of age-related diseases and conditions like these, the costs associated with caring for the oldest and sickest Americans will place an unmanageable burden on patients, their families, and our healthcare system. The Alliance strongly believes that with a relatively modest investment, further advances in the area of longevity science could yield tremendous health and economic benefits by shortening the period during which humans suffer from costly, debilitating diseases.

Within the NIH, the NIA leads research efforts to better understand the nature of aging and to maintain the health and independence of Americans as they grow older. The NIA supports a range of genetic, biological, clinical, social, and economic research related to aging and the diseases of the elderly. Through the Division of Aging Biology, the NIA funds research focused on understanding and exploiting the mechanisms underlying the aging process. Research supported by the Division of Aging Biology program is critically important in that much of it is centered around how changes in function considered to be "normal aging" become risk factors for many age-associated infirmities. Other noteworthy NIA-supported projects focus on increasing healthspan. These include studies to assess the beneficial effects of reducing caloric intake in animals, as well as those to test compounds that mimic this process in subjects with the potential to extend the years of disease-free life. Both approaches have produced promising results that may lead to insights into human applications. By capitalizing on these and other successful studies to identify genes that influence longevity, investigators hope to delay the onset of disease and disability associated with human aging in the future.

The NIA also participates in multi-Institute collaborations on disease-specific research aimed at preventing, diagnosing, and more effectively treating age-related illnesses. Action to Control Cardiovascular Disease, led by the National, Heart, Lung, and Blood Institute in partnership with the NIA and three other NIH Institutes, is a large clinical trial of adults with type 2 diabetes who are at high risk for cardiovascular disease. The trial involves the aggressive testing of interventions to reduce the burden of cardiovascular disease in high-risk patients, many of whom are elderly. Major cardiovascular disease events result in death for 65 percent of diabetic patients and no effective preventative strategies currently exist for this vulnerable population. The Alzheimer's Disease Neuroimaging Initiative (ADNI) is a major

public-private partnership led by the NIA to evaluate imaging technologies, biological markers, and other tests to improve knowledge surrounding the progression of Alzheimer's disease. ADNI has produced a wealth of data that is accessible to researchers worldwide. It is believed that ADNI findings could lead to shorter and less costly trials for Alzheimer's therapies. As many as 5.3 million people have Alzheimer's disease and it drains more than $148 billion from the Nation's economy each year. Streamlined clinical trials could accelerate the development and approval of more effective AD treatments to the benefit of those who are yet to be diagnosed. The Diabetes Prevention Program, which was an NIH-supported clinical trial involving the NIA, continues to reveal information about diabetes onset, prevention an outcomes. It was initially intended to examine the effects of multiple interventions for adults at risk of type 2 diabetes. While it succeeded in identifying lifestyle changes that were particularly effective in the 60 and older population, it is the analysis of the long-term effects of these interventions on diabetes onset that could have the most impact on the 57 million adults who are at risk for developing the disease.

In general, the NIH is the primary funder of biomedical research in this country. Eighty percent of all the nonprofit medical research in the United States is funded by the NIH. But the unfortunate reality is that shrinking budgets have impeded progress. In part the scarcity of resources has resulted in a decline of the overall success rate for NIH research grant applications. At its lowest point only 1 in 4 research proposals could be funded by the NIH. The effect of this has been reluctance on behalf of new investigators to submit truly ground-breaking research proposals for consideration. While we recognize that there is enormous competition for congressional appropriations each year, a lack of sustained funding for the NIH will have a devastating impact on the rate of basic discovery and the development of interventions that could have the significant public health benefits for our aging population.

Until recent actions taken by Congress and the President to provide a short-term resource infusion through passage of the American Reinvestment and Recovery Act, funding for the NIH had been on a downward trajectory. In the 6 years through 2008, a series of nominal increases and cuts has amounted to flat funding for the NIH, and as a result it has lost as much as 17 percent of its purchasing power. Aging in particular is a field of research that had been hampered by this stagnant funding. To operate in this environment the NIA and other Institutes involved in aging-related research have not been able to fund increasing numbers of high-quality research grants each year.

The Alliance for Aging Research applauds Congress and the Obama administration's renewed focus on the importance of medical research in improving the overall health of the country. In order to demonstrate a strong commitment to bolstering science, we would recommend an increase in funding for the NIH of at least 7 percent in fiscal year 2010. This increase would begin to restore the NIH's ability to pursue new basic, translational, and clinical research opportunities. A $32.4 billion budget for the NIH in fiscal year 2010 would allow the NIA specifically to increase support of new and existing investigator initiated research projects and better facilitate the acceleration of discoveries for a wide range debilitating age-related diseases and conditions among our growing population of older Americans.

Mr. Chairman, the Alliance for Aging Research thanks you for the opportunity to outline the challenges posed by the aging population that lie ahead as you consider the fiscal year 2010 appropriations for the NIH and we would be happy to furnish additional information upon request.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists (ACOG), representing 53,000 physicians and partners in women's healthcare, is pleased to offer this statement to the Senate Committee on Appropriations, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies. We thank Chairman Harkin, and the entire subcommittee for their leadership to continually address women's health research at the National Institutes of Health (NIH). The Nation has made important strides to improve women's health over the past several years, and ACOG is grateful to this subcommittee for its commitment to ensure that vital research continues to eliminate disease and to ensure valuable new treatment discoveries are implemented.

The American Recovery and Reinvestment Act (ARRA) made a sizeable down payment on healthcare programs that have been underfunded in recent years. The

$10.4 billion for the National Institutes of Health (NIH) and the commitment to comparative effectiveness research will help to foster innovation and convey best practices to physicians. While ACOG is thankful for the generous funding from the stimulus package, funds for NIH must be used within 2 years, limiting the ability of programs to be carried out to their completion.

An increase in funds through the regular appropriations process will help supplement programs supported by the stimulus package beyond the 2-year mark. The President's budget provides a modest increase of 1.4 percent, not enough to sustain the 19,000 grant applications that have been submitted in the wake of the stimulus, which will result in lower pay lines. Therefore, we urge the subcommittee to support an appropriation of at least $32.4 billion for NIH, a $2.1 billion increase (7 percent) for fiscal year 2010.

WOMEN'S HEALTH RESEARCH AT THE NIH

NIH Institutes work collaboratively to conduct women's health research. The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) conducts the majority of women's health research, and has made critical accomplishments in preterm birth, contraceptive research, and infertility. The National Cancer Institute (NCI) has made monumental discoveries on gynecologic cancers, and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) works with the NICHD to discover treatments for urinary incontinence. The Office of Research on Women's Health (ORWH) in the NIH Office of the Director coordinates women's health research projects and manages mentoring programs for new investigators.

Despite the NIH's critical advancements, reduced funding levels have made it difficult for research to continue, largely due to the lack of new investigators. The NIH advanced women's health research during the congressional doubling between fiscal year 1998 and fiscal year 2003, but funding increases have been so low since fiscal year 2003, the NIH budget is almost the same as it was before the doubling.

OFFICE OF THE DIRECTOR—OFFICE OF RESEARCH ON WOMEN'S HEALTH (ORWH)

Coordinating and Promoting Women's Health Research Throughout NIH

Established in September 1990, the Office of Research on Women's Health (ORWH) is a focal point for women's health research at the NIH.

The Building Interdisciplinary Research Careers in Women's Health (BIRCWH) is operated by the ORWH, and the Women's Reproductive Health Research (WRHR) Career Development Program at the NICHD. BIRCWH programs are expanding women's health research through career development, increasing diversity in the field of women's health, promoting interdisciplinary research training and developing independent researchers with backgrounds in high-priority women's health research areas. These programs attract new researchers, but low pay lines make it difficult for the NIH to maintain them.

The ORWH recently launched the NIH Women's Health Fellowships in Intramural Women's Health Research. This intramural program is funded through the Foundation of the NIH, which was established by Congress to maximize the resources at the NIH and support medical research through public-private partnerships. The fellowships are supported by donations from Battelle and AstraZeneca.

An ob-gyn resident at Loyola University, Chicago, Illinois, is one of the first recipients of the fellowship. She is studying the difference in severity and prevalence of fibroids in African American and white women. The Women's Health Fellowship helps new investigators enhance their research skills, and mentor women to senior positions in science.

ACOG urges Congress to increase funding for the ORWH to help prepare the next generation of women's health researchers and to maintain a high level of research innovation and excellence, in turn reducing the incidence of maternal morbidity and mortality and discovering cures for other chronic conditions.

NICHD

ACOG supports a $90.6 million increase (7 percent) in funds more than fiscal year 2009 for NICHD at NIH. These funds will assist research into the following areas:

Expanding Maternal Health Research

The Maternal Fetal Medicine Units (MFMU) Network investigates clinical questions in maternal fetal medicine and obstetrics, with a focus on preterm birth, and has advanced women's health research by making several monumental discoveries including using progesterone treatments to reduce preterm birth. The MFMU is

working at 14 sites across the United States to reduce the risks of preterm birth, cerebral palsy, and pre-eclampsia (high blood pressure).

Reducing the Prevalence of Premature Births

NICHD is helping our Nation understand how adverse conditions and health disparities increase the risks of premature birth in high-risk racial groups, and how to reduce these risks. Prematurity rates have increased almost 35 percent since 1981, accounting for 12.5 percent of all births, yet the causes are unknown in 25 percent of cases. Preterm births cost the Nation $26 billion annually, $51,600 for every infant born prematurely. Direct healthcare costs to employers for a premature baby average $41,610, 15 times higher than the $2,830 for a healthy, full-term delivery.

The 2008 Surgeon General's Conference on the prevention of preterm birth brought together experts from the public and private sectors to discuss key research findings and to develop an agenda to mitigate the problem of prematurity. The conference concluded by calling on the surgeon general to make the prevention of preterm birth a national public health priority. ACOG supports this effort and urges Congress to recognize the importance of new research to identify the causes and effective interventions for preterm births.

Improving Contraceptive Research

The United States has one of the highest unintended pregnancy rates of the industrialized nations. Of the approximately 6 million pregnancies each year, an estimated one-half is unintended. Contraceptive use saves as much as $19 billion in healthcare costs annually. Research has found that oral contraceptives are less effective in overweight and obese women, yet the causes are unknown. It is critical that Congress continue to invest in contraceptive research, ensuring that women have access to safe and effective contraceptives to help them time and space their pregnancies. The NICHD's research on male and female contraceptives can help reduce the number of unintended pregnancies and abortions, and improve women's health.

National Cancer Institute (NCI)

Developing Gynecologic Cancer Research, Prevention, and Education

—*Effects of Cervical Procedure on Pregnancy*.—At the Washington University School of Medicine, St. Louis, Missouri, researchers are studying the impact of the Loop Electrosurgical Excision Procedure (LEEP), which is a common treatment for abnormal cells on the cervix, on subsequent pregnancy. This study may determine whether LEEP increases the risk of preterm birth and other adverse pregnancy outcomes.

—*Stress and Ovarian Cancer*.—At the University of Texas, MD Anderson Cancer Center, Houston, Texas, researchers are examining the effects of chronic stress on growth and progression of ovarian cancer along with underlying mechanisms. Based on these results, researchers hope to gain a better understanding of the adverse effects of chronic stress and discover new strategies for blocking its harmful effects on cancer patients.

—*Pediatric Cancer Survivor Fertility*.—There are currently more than 250,000 childhood cancer survivors in the United States, and while cancer therapies improve long-term survival, such treatments may impair fertility potential and cause premature ovarian failure. Research at the University of Pennsylvania—Philadelphia, Philadelphia, will provide preliminary data for the establishment of a long-term study of pediatric cancer survivors and their pregnancy rates, pregnancy outcomes and the occurrence of premature menopause.

Expanding Ovarian Cancer Research

Despite the women's health research advancements at the NCI, much more needs to be done. According to the NCI, there will be 22,430 new cases of ovarian cancer and 15,280 deaths from ovarian cancer in the United States in 2007. With more ovarian cancer biomarker research, we may reduce ovarian cancer. ACOG urges Congress to pass the Ovarian Cancer Biomarker Act, S. 2569/H.R. 3689, which would increase funding for research and clinical centers at the NCI for risk stratification, early detection, and screening of ovarian cancer.

INCREASING GYNECOLOGIC CANCER EDUCATION

Public and provider education on gynecologic cancers is critical to early detection. When women and their doctors understand the symptoms and risk factors of gynecologic cancers they can find appropriate medical help quickly, increasing the potential for earlier detection. ACOG urges Congress to fully fund Johanna's Law,

Public Law 109–475, at $10 million in fiscal year 2009, which would increase provider and public education on gynecologic cancers, saving thousands of lives.

NIDDK

Exploring Treatments for Urinary Incontinence

The Urinary Incontinence Treatment Network (UITN) at the NIDDK and the NICHD, researches urinary incontinence treatments. The UITN clinical trials compare the outcomes of commonly used surgical procedures, drug therapies, and behavioral treatments for incontinence.

—*The Trial of Mid-urethral Slings*.—Researches the outcomes of surgical procedures to treat stress urinary incontinence. Although these surgical procedures are approved by the Food and Drug Administration, researchers are investigating which are more effective.

—*The Stress Incontinence Surgical Treatment Efficacy Trial*.—Studies the long-term outcomes of commonly performed stress urinary incontinence treatment surgeries. The Burch procedure and the sling produce have estimated cure rates of 60 percent –90 percent, and researchers are determining which produces the best long-term outcome.

—*The Behavior Enhances Drug Reduction of Incontinence*.—Studies whether adding behavioral treatment to drug therapy makes it possible to discontinue drug treatment, and still maintain a reduced number of incontinence accidents.

ACOG urges Congress to increase funding for critical women's health research at the NIDDK.

Again, we would like to thank the subcommittee for its continued support of programs to improve women's health, and urge Congress to increase funding for the NIH and its Institutes 7 percent more than fiscal year 2009 levels in fiscal year 2010.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS

Chairman Harkin and Ranking Member Cochran, thank you for allowing the American College of Physicians (ACP) to share our views on the Department of Health and Human Services budget for fiscal year 2010.

ACP represents 126,000 internal medicine physicians, residents, and medical students. ACP is also the Nation's largest medical specialty society and its second largest physician membership organization.

Today, ACP is urging the following funding levels:

—Title VII and title VIII programs, under the Public Health Service Act, $550 million;

—National Health Service Corps (NHSC), $235 million;

—Agency for Healthcare Research and Quality (AHRQ), $405 million; and

—National Institutes of Health (NIH), at minimum a 7 percent increase more than the fiscal year 2009 baseline.

PRIMARY CARE WORKFORCE

We are experiencing a primary care shortage in this country, the likes of which we have not seen. The expected demand for primary care in the United States continues to grow exponentially while the Nation's supply of primary care physicians dwindles and interest by U.S. medical graduates in primary care specialties steadily declines. The reasons behind this decline in primary care physician supply are multi-faceted and complex. Key factors include the rapid rise in medical education debt, decreased income potential for primary care physicians, failed payment policies, and increased burdens associated with the practice of primary care.

A strong primary care infrastructure is an essential part of any high-functioning healthcare system. In this country, primary care physicians provide 52 percent of all ambulatory care visits, 80 percent of patient visits for hypertension, and 69 percent of visits for both chronic obstructive pulmonary disease and diabetes, yet they comprise only one-third of the U.S. physician workforce. Those numbers are compelling, considering the fact that primary care is known to improve health outcomes, increase quality, and reduce healthcare costs.

There are many regions of the country that are currently experiencing shortages in primary care physicians. The Institute of Medicine reports that it would take 16,261 additional primary care physicians to meet the need in currently underserved areas alone. To help alleviate the shortage of primary care physicians, we believe sufficient funding should be provided for title VII and title VIII programs, as well as NHSC.

TITLE VII AND TITLE VIII PROGRAMS

The health professions education programs, authorized under titles VII and VIII of the Public Health Service Act and administered through the Health Resources and Services Administration, support the training and education of healthcare providers to enhance the supply, diversity, and distribution of the healthcare workforce, filling the gaps in the supply of health professionals not met by traditional market forces. ACP was pleased that the American Recovery and Reinvestment Act (ARRA, Public Law 111–5) provided a down payment of $200 million for title VII and title VIII programs.

NHSC, along with the Health Professions and Nursing Education Coalition, is recommending that these programs require at least $550 million to adequately educate and train a healthcare workforce that meets the public's healthcare needs. This amount includes restoration of title VII to at least the fiscal year 2005 level (close to $300 million).

Lower funding or elimination of title VII programs will have an immediate impact on the training and recruitment of health professions students and the educational infrastructures developed and supported by title VII. It is important to note that these programs are unique in that they are the only federal investment in interdisciplinary training, which is vitally important as care is often provided in interdisciplinary settings. These programs are also designed to enhance minority representation in the healthcare workforce, which is essential when it comes to providing access to care as minority providers are more likely than others to care for underserved populations and help reduce the shortages in these specific areas. Moreover, not only does this funding support essential training programs, it also facilitates the delivery of care to the underserved areas of the country through the Area Health Education Centers and Health Education and Training Centers.

As the Nation's healthcare delivery system undergoes rapid and dramatic changes, an appropriate supply and distribution of health professionals has never been more essential to the public's health. The title VII and title VIII programs are critical to help institutions and programs respond to these current and emerging challenges and ensure that all Americans have access to appropriate and timely health services.

NHSC

In conjunction with other stakeholders, ACP is recommending a combined appropriation of $235 million for NHSC. We are pleased the ARRA provided an additional $300 million, which will enable 4,200 more clinicians to access the scholarship and loan repayment programs.

The NHSC scholarship and loan repayment programs provide payment toward tuition/fees or student loans in exchange for service in an underserved area. The programs are available for primary medical, oral, dental, and mental and behavioral professionals. Participation in the NHSC for 4 years or more greatly increases the likelihood that a physician will continue to work in an underserved area after leaving the program. Over the years, the number of clinicians in those programs has grown from 180 to more than 4,000. In 2000, the NHSC conducted a large study of NHSC clinicians who had completed their service obligation up to 15 years before and found that 52 percent of those clinicians continued to serve the underserved in their practice. The programs under NHSC have proven to make an impact in meeting the healthcare needs of the underserved, and with more appropriations, they can do more.

The NHSC estimates that nearly 50 million Americans currently live in health professions shortage areas (HPSAs)—underserved communities which lack adequate access to primary care services—and that 27,000 primary care professionals are needed to adequately serve the people living in HPSAs. Currently, more than 4,000 NHSC clinicians are caring for nearly 4 million people. The outstanding need remains unmet.

Limited funding has reduced new NHSC awards from 1,570 in fiscal year 2003 to an estimated 947 in fiscal year 2008, a nearly 40 percent decrease. The NHSC scholarship program already receives 7 to 15 applicants for every award available. The National Advisory Council on the NHSC has recommended that Congress double the appropriations for the NHSC to more than double its field strength to 10,000 primary care clinicians in underserved areas.

AHRQ

AHRQ is the leading public health service agency focused on healthcare quality. AHRQ's research provides the evidence-based information needed by consumers,

providers, health plans, purchasers, and policymakers to make informed healthcare decisions.

ACP is dedicated to ensuring AHRQ's vital role in improving the quality of our Nation's health and supports a fiscal year 2010 budget allocation of $405 million for AHRQ. This amount will allow AHRQ to carry out its congressional mandate to improve healthcare quality and reduce costs by identifying which treatments work best and at what cost. ACP's request of an additional $32 million more than the fiscal year 2009 funding level would be designated for increased research in patient safety, health information technology, resources for research into the causes of and solutions to raising healthcare costs, chronic care management, and strategies to translate research into practice.

The additional $32 million will allow AHRQ to expand its investigator-initiated research program, a critically important element of our Nation's healthcare research effort. This funding stream provides for many clinical innovations—innovations that improve patient outcomes. It will also facilitate the translation of research into clinical practice and disease management strategies, and address the healthcare needs of vulnerable populations. Investment in AHRQ's investigator-initiated research is an investment in America's health. Additionally, investment in investigator-initiated research represents a cost-effective and efficient use of our Federal health research dollars. The relatively modest investment provided to clinical investigators in the form of grants often result in advancements with positive economic implications far outweighing the original investment.

ACP was pleased that the ARRA provided AHRQ with $300 million for comparative clinical effectiveness research. This funding, along with an additional $400 million for the Office of the Director of the NIH and $400 million to the Secretary of Health and Human Services, will stimulate the development of comparative effectiveness research and provide a good foundation for the establishment of the recommended, national comparative effectiveness entity. Furthermore, the act prohibits the Government from using the research for making any coverage or payment decisions or issuing clinical guidelines. The sole purpose is to develop this research and disseminate the results to all stakeholders.

NIH

Together, the fiscal year 2009 omnibus and the ARRA provided $38.5 billion to NIH, which will fund more than 16,000 new research grants for live-saving research into diseases such as cancer, diabetes, and Alzheimer's.

In his budget, the President envisions doubling our investment in basic research. Consistent with his proposal, we respectfully urge the subcommittee to increase funding for NIH by at least 7 percent more than the fiscal year 2009 baseline.

CONCLUSION

Mr. Chairman and Ranking Member Cochran, thank you for the opportunity to offer testimony on the importance of the Department of Health and Human Services budget for fiscal year 2010.

In conclusion, ACP would like to reiterate ACP's recommended funding levels:

—Title VII and title VIII programs, under the Public Health Service Act, $550 million;
—NHSC, $235 million;
—AHRQ, $405 million; and
—NIH, at minimum a 7 percent increase more than the fiscal year 2009 baseline.

The United States must invest in these programs in order to achieve a high-performance healthcare system. ACP greatly appreciates the support of the subcommittee on these issues and looks forward to working with Congress as you being to work on the fiscal year 2010 appropriations process.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE

Each year, 50,000 Americans die violent deaths. Homicide and suicide are, respectively, the third and fourth leading causes of death for people aged 1–39 years. An average of 80 people take their own lives every day.

Before the National Violent Death Reporting System (NVDRS) was created, Federal and State public health and law enforcement officials collected valuable information about violent deaths, but lacked the ability to combine it into one comprehensive reporting system. Instead, data was held in a variety of different systems, and policymakers lacked the clear picture necessary to develop effective violence prevention policies.

When it was created in 2002, NVDRS promised to capture data that is critical to identifying patterns and developing strategies to save lives. With a clearer picture of why violent deaths occurs, law enforcement and public health officials can work together more effectively to identify those at risk and provide effective preventive services.

Currently, NVDRS funding levels only allow the program to operate in the following 17 States: Alaska, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, and Wisconsin. Nine additional States, plus the District of Columbia were previously approved for participation in the NVDRS, but were unable to join due to funding shortfalls: Connecticut, Illinois, Maine, Michigan, Minnesota, New York, Ohio, and Texas. Several other States have expressed an interest in joining once new funding becomes available.

While NVDRS is beginning to strengthen violence and suicide prevention efforts in the 17 participating States, many other States have been forced to sit idle until additional funding is allocated. With the inclusion of $7.5 million for NVDRS in fiscal year 2010, NVDRS will be able to expand to additional States and continue its incremental growth toward national implementation.

NVDRS PROVIDES CRITICAL DATA FOR SUICIDE PREVENTION

Although it is preventable, more than 30,000 Americans die by suicide each year, and another 1.8 million Americans attempt it, costing more than $3.8 billion in hospital expenses and $13 billion in lost earnings.

In the United States today, there is no comprehensive national system to track suicides. However, because NVDRS includes information on all violent deaths—include deaths by suicide—information from the system can be used to develop effective suicide prevention plans at the community, State, and national level.

Among the ways NVDRS data is being used to inform suicide prevention programs: NVDRS data from 13 States uncovered significant racially and ethnically based differences in mental illness diagnoses and treatment among those who died by suicide. Specifically, whites were more likely to have been diagnosed with depression or bipolar disorder, while blacks were more likely than other groups to have been diagnosed with schizophrenia. Hispanics were less likely to have been diagnosed with a mental illness or to have received treatment at all, although the family reports of depression were comparable to other racial groups. Additionally, NVDRS data from all 17 States show that veterans accounted for 26 percent of males who died by suicide in 2004. While veterans also accounted for 26 percent of the male U.S. population, this finding points to the importance of veterans' services to potentially identify and treat at-risk individuals.

With such information available for the first time, officials in participating States are using NVDRS data in myriad ways. For example,

—With the sixth-highest rate of elder suicide in the Nation, Oregon tailored its NVDRS data to develop an epidemiological profile of victims and establish an elder suicide prevention plan. NVDRS data indicated that most victims of elder suicide in Oregon had been suffering from physical illness, and that 37 percent had visited a doctor in the 30 days prior to their death. As a result of this NVDRS data, the State developed an elder suicide prevention plan that calls for better integration of primary care and mental health services, so that potential suicide victims can be better identified and treated. The plan also calls for training primary healthcare providers, integrating mental healthcare into primary care, and educating family members about the risks of suicide and warning signs of depression.

—NVDRS data found that 1 in 4 of Virginia's suicide victims had served in the military. Among male victims older than 65, more than 60 percent were veterans. These findings indicate that the State's suicide prevention and education efforts must extend to veterans' hospitals and service providers.

—NVDRS data provides State health officials in South Carolina with vital information that indicates behavior patterns, enables health officials to identify individuals at risk, and to intervene early with appropriate preventive measures. After NVDRS data showed that more than 40 percent of suicide victims were currently or formerly receiving mental health treatment or tested positive for psychiatric medication, the State established its first ever suicide prevention plan, which also included the formation of a Suicide Prevention Task Force.

NVDRS PROVIDES CRITICAL DATA TO PROTECT CHILDREN AND ADOLESCENTS

Child abuse and other violence involving children and adolescents remains a problem in America, and it is only through a comprehensive understanding of its root

causes that many needless deaths can be prevented. Studies suggest that between 3.3 and 10 million children witness some form of domestic violence annually. Additionally, 1,387 children died as a result of abuse or neglect in 2004, according to the Federal Administration on Children, Youth, and Families, part of the Department of Health and Human Services.

Children are most vulnerable and most dependent on their caregivers during infancy and early childhood. Sadly, NVDRS data has shown that young children are at the greatest risk of homicide in their primary care environments. Combined NVDRS data from Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, and Virginia determined that African American children 4 years old and younger are more than four times more likely to be victims of homicide than Caucasian children, and that homicides of children 4 and under are most often committed by a parent or caregiver in the home. The data also shows that household items, or "weapons of opportunity," were most commonly used, suggesting that poor stress responses may be factors in these deaths. Knowing the demographics and methods of abusers can lead to more effective, targeted prevention programs.

Other examples of how NVDRS data is informing programs to protect children and adolescents from violence, include the following:

—Data from NVDRS pilot sites in Connecticut, Maine, Utah, Wisconsin, Pennsylvania, and California found that almost 30 percent of suicide victims age 17 and under told someone they felt suicidal. Many teen suicides also appear to be linked to recent events in their lives, with nearly one-third of suicides taking place on the same day as a crisis and almost half within the same week. This data underscores the importance of developing community-based programs to rapidly respond to the warning signs of suicide.

—With data generated by NVDRS, State health officials in Massachusetts have been able to monitor suicides and homicides more accurately among specific populations, such as foster children and youths in custody. The NVDRS data has been used to secure grants for violence prevention programs for these special populations, about whom data had previously been impossible to obtain.

NVDRS PROVIDES CRITICAL DATA TO PREVENT INTIMATE PARTNER VIOLENCE

While intimate partner violence has declined along with other trends in crime over the past decade, thousands of Americans still fall victim to it every year. Women are much more likely than men to be killed by an intimate partner. Intimate partner homicides accounted for 33.5 percent of the murders of women and less than four percent of the murders of men in 2000, according to the Bureau of Justice Statistics.

Although the program is still in its early stages, NVDRS is providing critical information that is helping law enforcement and health and human service officials allocate resources and develop programs in ways that target those most at risk for intimate partner violence, thereby preventing needless deaths. For example, NVDRS data shows that while occurrences are rare, most murder-suicide victims are current or former intimate partners of the suspect, and a substantial number of victims were the suspect's children. In addition, NVDRS indicates that women are about seven times more likely than men to be killed by a spouse, ex-spouse, lover, or former lover, and the majority of these incidents occurred in the women's homes

Examples of how State officials are using NVDRS data to better understand and prevent intimate partner violence include:

—Based on an analysis of NVDRS data, the Kentucky Injury Prevention Research Center concluded that among women killed by an intimate partner, only 39 percent had had filed for a restraining order or been seen by or reported to Adult Protective Services. This finding underscored a perceived need in the community to improve outreach linking potential victims to local protective services.

—Working with the State's NVDRS program, the Alaska Department of Law and Public Safety found there is a high risk for intimate partner violence, both homicide and suicide, when one partner is attempting to leave the relationship. Findings such as this one are molding the State's strategy for domestic violence prevention.

STRENGTHENING AND EXPANDING NVDRS IN FISCAL YEAR 2010

At an estimated annual cost of $20 million for full implentation, NVDRS is a relatively low-cost program that yields high-quality results. While State-specific information provides enormous value to local public health and law enforcement officials, national data from all 50 States, the U.S. territories and the District of Columbia must be obtained to complete the picture and establish effective national violence prevention policies and programs.

That is why the National Violence Prevention Network, a coalition of national organizations who advocate for health and welfare, violence and suicide prevention, and law enforcement, is calling on Congress to provide no less than $7.5 million for NVDRS for fiscal year 2010. The cost of not implementing the program is much greater: without national participation in the program, thousands of American lives remain at risk.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE

RECOMMENDATION

The American College of Preventive Medicine (ACPM) urges the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee to reaffirm its support for training preventive medicine physicians and other public health professionals by providing $10.1 million in fiscal year 2010 for preventive medicine residency training under the public health, dentistry, and preventive medicine line item in title VII of the Public Health Service Act. ACPM also supports the recommendation of the Health Professions and Nursing Education Coalition that $550 million be appropriated in fiscal year 2010 to support all health professions and nursing education and training programs authorized under titles VII and VIII of the Public Health Service Act.

THE NEED FOR PREVENTIVE MEDICINE IS GROWING

In today's healthcare environment, the tools and expertise provided by preventive medicine physicians are integral to the effective functioning of our Nation's public health system. These tools and skills include the ability to deliver evidence-based clinical preventive services, expertise in population-based health sciences, and knowledge of the social and behavioral aspects of health and disease. These are the tools employed by preventive medicine physicians who practice in public health agencies and in other healthcare settings where improving the health of populations, enhancing access to quality care, and reducing the costs of medical care are paramount. As the body of evidence supporting the effectiveness of clinical and population-based interventions continues to expand, so does the need for specialists trained in preventive medicine.[1 2 3]

Organizations across the spectrum have recognized the growing demand for public health and preventive medicine professionals. The Institute of Medicine released a report in 2007 calling for an expansion of preventive medicine training programs by an "additional 400 residents per year".[15] The Health Resources and Services Administration's (HRSA) Bureau of Health Professions, using data extracted from the Department of Labor, reports that the demand for public health professionals will grow at twice the rate of all occupations between 2000 and 2010.[4] The Council on Graduate Medical Education recommends increased funding for training physicians in preventive medicine.[5] In addition, the Nation's medical schools are devoting more time and effort to population health topics.[6] These are just a few of the examples demonstrating the growing demand for preventive medicine.

In fact, preventive medicine is the only 1 of the 24 medical specialties recognized by the American Board of Medical Specialties that requires and provides training in both clinical medicine and public health. Preventive medicine physicians possess critical knowledge in population and community health issues, disease and injury prevention, disease surveillance and outbreak investigation, and public health research. Preventive medicine physicians are employed in hospitals, State and local health departments, Health Maintenance Organizations (HMOs), community and

---

[1] Berrino, F. Role of Prevention: Cost Effectiveness of Prevention. *Annals of Oncology* 2004; 15:iv245–iv248.

[2] Eikjemans G, Takala J. Moving Knowledge of Global Burden into Preventive Action. *American Journal of Industrial Medicine* 2005; 48:395–399.

[3] Ortegon M, Redekop W, Niesen L. Cost-Effectiveness of Prevention and Treatment of the Diabetic Foot. *Diabetes Care* 2004; 27:901–907.

[15] Training Physicians for Public Health Careers. Institute of Medicine. National Academies Press, June 2007.

[4] Biviano M. Public Health and Preventive Medicine: What the Data Shows. Presented at the 9th Annual Preventive Medicine Residency Program Directors Workshop, San Antonio, Texas. HRSA. 2002.

[5] Glass JK. Physicians in the Public Health Workforce. In Update on the Physician Workforce. Council on Graduate Medical Education. 2000.

[6] Sabharwal R. Trends in Medical School Graduates' Perceptions of Instruction in Population-Based Medicine. In Analysis in Brief. American Association of Medical Colleges. Vol. 2, No. 1. January 2002.

migrant health centers, industrial sites, occupational health centers, academic centers, private practice, the military, and Federal Government agencies.

The recent focus on emergency preparedness is also driving the demand for these skills. Unfortunately, many experts have expressed concerns about the preparedness level of our public heath workforce and its ability to respond to emergencies. The nonpartisan, not-for-profit Trust for America's Health has published annual reports assessing America's pubic health emergency response capabilities. The most recent report, released in December 2008, found that neither State nor Federal Governments are adequately prepared to manage a public health emergency. One reason for this is a significant shortfall in funding needed to improve the Nation's public health systems.[7] Furthermore, the Centers for Disease Control and Prevention recently affirmed that there are significant holes in U.S. hospital emergency planning efforts for bioterrorism and mass casualty management.[8] These include varying levels of training among hospital staff for treating exposures to chemical, biological or radiological agents; lack of memoranda of understanding with supporting local healthcare facilities; and lack of preparedness training for explosive incidents.

THE SUPPLY OF PREVENTIVE MEDICINE SPECIALISTS IS SHRINKING

According to HRSA and health workforce experts, there are personnel shortages in many public health occupations, including among others, preventive medicine physicians, epidemiologists, biostatisticians, and environmental health workers.[9]

Exacerbating these shortages is a shrinking supply of physicians trained in preventive medicine:

—In 2002, only 6,893 physicians self-designated as specialists in preventive medicine in the United States, down from 7,734 in 1970. The percentage of total U.S. physicians self-designating as preventive medicine physicians decreased from 2.3 percent to 0.8 percent over that time period.[10]

—Between 1999 and 2006, the number of residents enrolled in preventive medicine training programs declined nearly 20 percent.[11]

—The number of preventive medicine residency programs decreased from 90 in 1999 to 71 in 2008–2009.[12]

ACPM is deeply concerned about the shortage of preventive medicine-trained physicians and the ominous trend of even fewer training opportunities. The decline in numbers is dramatic considering the existing critical shortage of physicians trained to carry out core public health activities. This deficiency will lead to major gaps in the expertise needed to deliver clinical prevention and community public health. The impact on the health of those populations served by HRSA may be profound.

FUNDING FOR RESIDENCY TRAINING IS ERODING

Physicians training in the specialty of preventive medicine, despite being recognized as an underdeveloped national resource and in shortage for many years, are the only medical residents whose graduate medical education (GME) costs are not supported by Medicare, Medicaid or other third-party insurers. Training occurs outside hospital-based settings and therefore is not financed by GME payments to hospitals. Both training programs and residency graduates are rapidly declining at a time of unprecedented national, State, and community need for properly trained physicians in public health and disaster preparedness, prevention-oriented practices, quality improvement and patient safety. Both the Council on Graduate Medical Education and Institute of Medicine have called for enhanced training support.

Currently, residency programs scramble to patch together funding packages for their residents. Limited stipend support has made it difficult for programs to attract and retain high-quality applicants; faculty and tuition support has been almost non-

---

[7] Hearne S, Chrissie J, Segal L, Stephens T, Earls M. Ready or Not? Protecting the Public's Health from Diseases, Disasters, and Bioterrorism 2008; Trust for America's Health. www.healthyamericans.org.

[8] Niska R, Burt C. Bioterrorism and mass casualty preparedness in hospitals: United States, 2003. Advance data from vital and health statistics; no 364. Hyattsville, MD: National Center for Health Statistics. 2005.

[9] Health Professions and Nursing Education Coalition. Recommendation for Fiscal Year 2007. March 2006.

[10] American Medical Association (AMA). Physician Characteristics and Distribution in the U.S. 2004, Table 5.2, p. 323.

[11] AMA. Graduate Medical Education Database. Copyright 1994–2005, Chicago, IL.

[12] Magee JH. Analysis of Program Data for Preventive Medicine Residencies in the United States: Report to the Bureau of Health Resources & Services Administration. Washington, DC: American College of Preventive Medicine, 1997.

existent.[12] Directors of residency programs note that they receive many inquiries about and applications for training in preventive medicine; however, training slots often are not available for those highly qualified physicians who are not directly sponsored by an outside agency (such as the Armed Services) or who do not have specific interests in areas for which limited stipends are available (such as research in cancer prevention).

HRSA—as authorized in title VII of the Public Health Service Act—is a critical funding source for several preventive medicine residency programs. HRSA funding ($1.1 million in fiscal year 2008) currently supports only about 20 physicians in 5 preventive medicine training programs,[13] yet it represents the largest Federal funding source for public health and general preventive medicine (PH/GPM) programs. Funding is in steady decline; in fiscal year 2002 the level was $1.9 million.

These programs directly support the mission of the HRSA health professions programs by facilitating practice in underserved communities and promoting training opportunities for underrepresented minorities:

—Forty percent of HRSA-supported preventive medicine graduates practice in medically underserved communities, a rate four times the average for all health professionals.[4] These physicians are meeting a critical need in these underserved communities.

—One-third of preventive medicine residents funded through HRSA programs are under-represented minorities, which is three times the average of minority representation among all health professionals.[4] Increased representation of minorities is critical because (1) under-represented minorities tend to practice in medically underserved areas at a higher rate than nonminority physicians, and (2) a higher proportion of minorities contributes to high-quality, culturally competent care.

—Fourteen percent of all preventive medicine residents are under-represented minorities, the largest proportion of any medical specialty.[16]

THE BOTTOM LINE: A STRONG, PREPARED, PUBLIC HEALTH SYSTEM REQUIRES A STRONG PREVENTIVE MEDICINE WORKFORCE

The growing threats of a flu pandemic, disasters, and terrorism has thrust public health into the forefront of the Nation's consciousness. ACPM applauds recent investments in disaster planning, information technology, laboratory capacity, and drug and vaccine stockpiles. However, any efforts to strengthen the public health infrastructure and disaster response capability must include measures to strengthen the existing training programs that help produce public health leaders.

Many of the public health leaders who guide the Nation's public health response in the aftermath of the September 11 attacks and the recent hurricane disasters were physicians trained in preventive medicine. According to William L. Roper, MD, MPH, Dean of the School of Public Health, The University of North Carolina at Chapel Hill, "Investing in public health preparedness and response without supporting public health and preventive medicine training programs is like building a sophisticated fleet of fighter jets without training the pilots to fly them."

PREPARED STATEMENT OF THE ASSOCIATION FOR CLINICAL RESEARCH TRAINING

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2010

Works towards fully funding the emerging Clinical and Translational Science Awards (CTSA) program by a providing $532 million of support. Continued support for the NIH K-awards for the training of research scientists. Continued emphasis on the importance of Comparative Effectiveness Research (CER).

Association for Clinical Research Training (ACRT) is committed to improving the Nation's health by increasing the amount and quality of clinical research through the expansion and improvement of clinical research training. This training is funded

[12] Magee JH. Analysis of Program Data for Preventive Medicine Residencies in the United States: Report to the Bureau of Health Resources & Services Administration. Washington, DC: American College of Preventive Medicine, 1997.

[13] http://bhpr.hrsa.gov/publichealth/preventive/index.htm. Preventive Medicine Residency Training Grants.

[4] Biviano M. Public Health and Preventive Medicine: What the Data Shows. Presented at the 9th Annual Preventive Medicine Residency Program Directors Workshop, San Antonio, Texas. HRSA. 2002.

[16] Percentage of ACGME Residents/Fellows Who are Black, Native American or Native Hawaiian by Speciality. AAMC/AMA National GME census, October 2008.

by both the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ).

The National Alliance of Socieities for Clinical Research Resources (NASCRR) is comprised of the national organizations that provide leadership in the field of clinical and translational medical research. NASCRR coalesces around areas of common concern for the entire community and works in support of the mission of the National Center for Research Resources (NCRR).

Let me begin by thanking the subcommittee for showing a strong commitment to improving public health through the recently passed fiscal year 2009 omnibus appropriations package. The legislation included $938 million for NIH; the first meaningful funding increase to the agency's baseline budget in many years. ACRT applauds the subcommittee for its role in securing this funding, and we hope that significant funding increases for NIH and other public health programs will continue in subsequent fiscal years.

Clinical research is an increasingly important component of medical research. A large, well-trained workforce is required to ensure that breakthroughs in bioscience are translated into improved treatment options for patients. Currently, the field of clinical research is facing the same work-force shortage and retention issues felt throughout the medical research community. Additionally, clinical investigators undertake comparative effectiveness research activities and as investment in this area is increased, it stands to reason that the present pressures on the clinical research community will be exacerbated. Commitments to increase funding for clinical research training activities and programs must be made to ensure that in the future, the workforce is robust and capable of improving the public health in an effective and expeditious manner.

THE IMPORTANCE OF FULLY FUNDING THE CTSA PROGRAM.

The CTSA program is a critical effort to modernize this Nation's clinical and translational research infrastructure, and bring the entire field of medical research into the 21st century. To accomplish this task, the program has identified four important goals; improving the way biomedical research is conducted across the country, reducing the time it takes for laboratory discoveries to become treatments for patients, engaging communities in clinical research efforts, and training the next generation of clinical and translational researchers.

The CTSA program is intended to assist institutions in creating a home for clinical and translational science. The program started with 12 academic health centers located throughout the Nation, and the NIH's plan for the CTSAs will ultimately link 60 institutions together to energize the discipline of clinical and translational science. Currently, there are 38 CTSA sites.

Recent years of near-level funding for NIH have hampered NCRR's budget and drained the pool of resources that could be committed to supporting the growing CTSA network.

NCRR has to reduce the size of awards by about half in some instances. NCRR does not have the funds necessary to support 60 sites.

When applying to be part of the CTSA network, institutions had to identify the types of programs and research they would be conducting. The proposals that were deemed meritorious were subsequently funded, but in most cases at a reduced level.

While we applaud the funding for NCRR that was provided through the economic stimulus package, this additional money has created a frustrating situation for CTSA-recipients. Presently, NCRR and other NIH Institutes, Centers, and Offices are holding competitions and accepting proposals to allocate the stimulus funds. Many of the research activities which are being proposed are very similar to activities the CTSA's already outlined in their initial peer-reviewed applications, but have been unable to undertake due to a lack of funding. In fact, many CTSA's are simply peeling off the programs which have been approved, but unfunded and redundantly competing for stimulus funds. Trying to fully fund CTSA activities in this manner is overly complicated and inefficient.

The CTSA program is currently funded at just under $475 million. You will note from the attached professional judgment provided by NCRR that to facilitate appropriate implementation, the program requires a funding level of $532 million in fiscal year 2010. Additionally, this document states that to fully implement the program and support a network of 60 centers by 2011, a funding level of $669 million is required.

It is our recommendation that the subcommittee work towards full implementation of the CTSA program by providing $532 million in support for fiscal year 2010.

THE IMPORTANCE OF CONTINUING TO SUPPORT THE K-AWARDS PROGRAM.

As the CTSA program is rolled out, it is meant to subsume the activities of other NCRR programs, such as the K–30 Clinical Research Curriculum Awards (CRCA). However, while flat budgets slowed implementation of the CTSA network, the phasing out of K–30 awards continued on unimpeded. Last year the subcommittee showed strong leadership and urged NCRR to continue the CRCA program for those institutions that had not yet received a CTSA. I am pleased to inform you that the NCRR has complied with this request, and recently the Center issued the K–30 recompetition notice. Thank you for taking an interest in clinical research training and please continue to do so moving forward.

K–30 awards remain an exceedingly cost-effective approach to improving the quality of training in clinical research. This efficiency is seen throughout the larger K-award program which has many mechanisms that go beyond the scope of the K–30's to provide support for career development for individual researchers. Highly trained clinical researchers are needed in order to capitalize on the many profound developments and discoveries in basic science and to translate them to clinical settings at all research institutions.

While the K–30 awards are primarily funded by NCRR, these individualized K-awards, like the K–23 Mentored Patient-Oriented Research Career Development Awards and the K–24 Midcareer Investigator Awards in Patient-Oriented Research are administered by many NIH Institutes and Centers. K–23 awards support the career development of investigators who have made a commitment to focus their research endeavors on patient-oriented research. The purpose of K–24 awards is to provide support to mid-career health-professional doctorates that are typically at the Associate Professor level for protected time to devote to patient-oriented research and to act as research mentors primarily for clinical residents, clinical fellows and/or junior clinical faculty.

The universe of K-awards is vast and also includes K–01 Mentored Research Scientist Development Awards and K–08 Mentored Clinical Scientist Development Awards, amongst others. All of these awards mechanism fill a critical research training niche. As the role of the clinical investigator gains prominence, it is important to begin raising awareness of these mechanisms and to bolstering their support.

We ask the subcommittee to emphasize its interest in the K-award programs and to urge NIH to continue to provide adequate support for K-awards moving forward.

THE IMPORTANCE OF CONTINUING TO SUPPORT CER

The American Recovery and Reinvestment Act of 2009 contained $1.1 billion for CER activities at NIH and AHRQ. NIH has been conducting critical CER for some time and we are pleased that Congress is beginning to appreciate the importance of these activities.

Within the $1.1 billion allocation for CER, $400 million was provided to NIH. CTSA program recipients should compete well for a portion of these funds as many sites consider CER a crucial component of clinical and translational research. Additionally, the CTSA network is intended to be a collaborative endeavor capable of leveraging great resources to maximize productivity. As CER gains prominence, we hope the Subcommittee will recognize the CTSA network as an ideal home for comparative effectiveness research activities.

CER is just one example of how the role of the clinical investigator is becoming more critical in a modern healthcare system. However, without bolstering clinical research training opportunities we will not be able to properly prepare the next generation of clinical researchers. This will slow hinder our Nation's capability to stay on the cutting edge of medical research and slow the development of new treatment options for patients.

We ask the subcommittee to continue to appreciate and support CER activities at NIH and AHRQ. We also ask that concurrently the subcommittee express its interest in expanding clinical research training opportunities at both NIH and AHRQ.

Thank you for this opportunity to present the views and recommendations of the clinical research training community.

ADDENDUM

National Institutes of Health—National Center for Research Resources (NCRR)

CTSA/GCRC ESTIMATE PER CURRENT MODEL

[Dollars in millions]

Cohort	No.	Fiscal year 2009	Fiscal year 2010	Fiscal year 2011
Fiscal year 2006 Grants [1]	12	$140	$140	$116
Fiscal year 2007 Grants [1]	12	120	121	121
Fiscal year 2008 Grants [1]	14	107	107	107
Fiscal year 2009 Grants [1]	5	36	36	36
Fiscal year 2010 Grants [1]	2		14	14
Fiscal year 2011 Grants [1]	15			100
Total, CTSA Grants	60	403	418	494
CTSA Support Contract		3	3	3
K30 Recompetition			5	1
Total, CTSAs		406	426	497
GCRCs		69	41	3
Total, CTSAs/IGCRCs		475	467	500

[1] UL1, KL2, TL1 awards.

CTSAI/GCRC ESTIMATE IF REQUESTED AMOUNT AWARDED

[Dollars in millions]

Cohort	No.	Fiscal year 2009	Fiscal year 2010	Fiscal year 2011
Fiscal year 2006 Grants [1]	12	$140	$140	$140
Fiscal year 2007 Grants [1]	12	158	158	158
Fiscal year 2008 Grants [1]	14	155	155	155
Fiscal year 2009 Grants [1]	5	50	50	50
Fiscal year 2010 Grants [1]	2		21	21
Fiscal year 2011 Grants [1]	15			142
Total, CTSA Grants	60	503	524	[2] 666
CTSA Support Contract		3	3	3
K30 Recompetition			5	1
Total, CTSAs		506	532	669
GCRCs		69	41	3
Total, CTSAs/IGCRCs		575	573	672

[1] UL1, KL2, TL1 awards.
[2] It would cost $666 million to fund 60 CTSAs at the amounts requested by the institutions, which is $166 million more than the $500 million budget.

DIFFERENCE

[Dollars in millions]

Cohort	No.	Fiscal year 2009	Fiscal year 2010	Fiscal year 2011
Fiscal year 2006 Grants [1]	12			[2] $24
Fiscal year 2007 Grants [1]	12	38	$37	37
Fiscal year 2009 Grants [1]	14	$48	48	48
Fiscal year 2009 Grants [1]	5	14	14	14
Fiscal year 2010 Grants [1]	2		7	7
Fiscal year 2011 Grants [1]	15			42
Total, CTSA Grants	60	100	106	172
CTSA Support Contract				

DIFFERENCE—Continued

[Dollars in millions]

Cohort	No.	Fiscal year 2009	Fiscal year 2010	Fiscal year 2011
K30 Recompetition				
Total, CTSAs		100	106	172
GCRCs				
Total, CTSAs/IGCDCs		100	106	172

[1] UL1, KL2, TL1 awards.

[2] It would cost an additional $100 million in fiscal year 2009, $106 million in fiscal year 2010, and $172 million in fiscal year 2011 to fund the CTSAs at the amounts requested by the institutions.

PREPARED STATEMENT OF THE AMERICAN HEART ASSOCIATION

Despite considerable progress, heart disease, stroke, and other forms of cardiovascular disease remain major causes of permanent disability and our Nation's No. 1 and most costly killer, with a death every 37 seconds. Cardiovascular disease will cost our country a projected $475 billion in medical costs and lost productivity this year. Heart disease, alone, is our leading cause of death and stroke is our No. 3 killer.

In the face of these staggering statistics, heart disease and stroke research, treatment and prevention programs remain woefully underfunded. For example, National Institutes of Health (NIH) invests only 4 percent of its budget on heart research and a mere 1 percent on stroke research. This level of funding is not commensurate with scientific opportunities, the number afflicted and the economic toll exacted on our Nation.

Cardiovascular disease remains the No. 1 killer in every State and many preventable and treatable risk factors continue to escalate. Unfortunately, the Centers for Disease Control and Prevention (CDC) has been able to provide basic implementation awards to only 14 States through its Heart Disease and Stroke Prevention Program and only 20 States are funded for CDC's WISEWOMAN, a heart disease and stroke screening program for low-income uninsured and underinsured females. Moreover, where you live could affect whether you survive a particularly deadly form of heart disease, sudden cardiac arrest. At present, only 12 States receive funding for the Health Resources and Services Administration's (HRSA) Rural and Community Access to Emergency Devices Program designed to save lives from sudden cardiac death.

The American Heart Association (AHA) appreciates Congress providing hope to the 1 in 3 adults in the United States who live with the consequences of cardiovascular disease, with the enactment of the American Recovery and Reinvestment Act (ARRA) and the fiscal year 2009 Omnibus Appropriations Act. The Association commends Congress for including $10 billion for the NIH and $1 billion for a Prevention and Wellness Fund in the ARRA. These are wise and prudent investments that will provide both a much needed boost to our Nation's economy and enhance health. Yet these funds represent a one-time infusion of resources. Stable and sustained funding is imperative to boost heart disease and stroke prevention and treatment.

FUNDING RECOMMENDATIONS: INVESTING IN THE HEALTH OF OUR NATION

With numerous new and promising research opportunities on the horizon and with cardiovascular disease risk factors on the rise, now is the time to make a wise enhanced investment to prevent and treat America's No. 1 and most costly killer. If Congress fails to capitalize on progress against cardiovascular disease now, Americans will pay more in the future in lost lives and higher healthcare costs. Our recommendations listed below address these issues in a comprehensive but fiscally responsible way follow.

FUNDING GAP FOR THE NIH

NIH research has revolutionized patient care and holds the key to finding new ways to prevent, treat, and cure cardiovascular disease, resulting in longer, healthier lives and reduced healthcare costs. NIH invests resources in every State and in 90 percent of congressional districts.

The AHA Recommends.—AHA supports the President's campaign pledge to double the NIH budget over the next decade. We advocate for a fiscal year 2010 appropriation of $32.4 billion for NIH, a 7 percent increase over the fiscal year 2009 appropriation, representing the first installment to double the NIH budget by fiscal year 2020. Stable and sustained funding is needed to help secure a solid return on Congress' investment that has saved millions of lives. NIH supported research prevents and cures disease and generates economic growth, creates jobs and preserves the U.S. role as the world leader in pharmaceuticals and biotechnology. Each NIH grant is associated with approximately seven jobs.

ENHANCE FUNDING FOR NIH HEART AND STROKE RESEARCH: A PROVEN AND WISE INVESTMENT

Death rates from coronary heart disease and stroke have each fallen by almost 30 percent since 1999. This decline is directly related to NIH heart and stroke research, with scientists on the verge of new and exciting discoveries that could lead to innovative treatments and even cures for heart disease and stroke. For instance, recent NIH research has shown that postmenopausal hormone therapy does not prevent heart disease and stroke, has defined the genetic basis of dangerous responses to vital blood-thinners, and funded early work of the 2007 Nobel Prize winners in Physiology or Medicine for development of gene targeting technology.

In addition to saving lives, NIH-supported research can cut healthcare costs. For example, the original NIH tPA drug trial resulted in a 10-year net $6.47 billion reduction in stroke healthcare costs. The Stroke Prevention in Atrial Fibrillation Trial 1 produced a 10-year net saving of $1.27 billion. But, despite such concrete returns on investments and other successes, NIH heart and stroke research continues to be disproportionately underfunded, with NIH spending only 4 percent of its budget on heart research, and a mere 1 percent on stroke research. NIH funding for these diseases are not commensurate with scientific opportunities, the number afflicted, the increasing prevalence, and the economic toll exacted on our Nation.

CARDIOVASCULAR DISEASE RESEARCH: NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI)

Cardiovascular disease research funding fails to keep pace with medical research inflation and cannot sufficiently support existing studies or permit investment in promising research opportunities. The sustained loss of purchasing power has reduced NHLBI's ability to support investigator-initiated research and has forced cuts in Institute programs. Cutbacks will limit the implementation of both the NHLBI general and cardiovascular-specific strategic plans. Studies that could be scaled back include, the translation of basic research on human behavior into real world ways to reduce obesity and promote cardiovascular health; research on genetic susceptibility to heart disease in the Framingham population followed for three generations, and additional research into the best methods for saving lives of sudden cardiac arrest sufferers.

STROKE RESEARCH: NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE (NINDS)

An estimated 795,000 Americans will suffer a stroke this year, and more than 137,000 will die. Many of the 6.5 million stroke survivors face physical and mental disabilities, emotional distress and huge costs—a projected $69 billion in medical expenses and lost productivity in 2009.

The NINDS-sponsored Stroke Progress Review Group has issued a long-term, stroke research strategic plan. A variety of research initiatives have since been undertaken, but more funding is needed to fully implement the plan. The fiscal year 2009 estimate for NINDS stroke research falls about 60 percent short of the plan's target and additional funding is needed for programs such as:

—*Stroke Translational Research*.—Translational studies are essential to providing cutting-edge stroke treatment, patient care and prevention. However, due to budget shortfalls, NINDS has been forced to scale back by 30 percent its Specialized Programs of Translational Research in Acute Stroke from a planned 10 centers to only 7.

—*Genetic Repository*.—NINDS could better understand genetic risk factors associated with stroke by helping more researchers contribute data and findings to an NIH-funded genetic repository and to study available samples.

—*Neurological Emergencies Treatment Trials Network*.—NINDS has established a clinical research network of emergency medicine physicians, neurologists and neurosurgeons to develop more and improved treatments for acute neurological

emergencies, such as strokes. However, the number of trials will be limited by available funding.

The AHA Recommends.—AHA supports an fiscal year 2010 appropriation of $3.227 billion for the NHLBI; and $1.705 billion for the NINDS. These represent a 7 percent increase more than fiscal year 2009—comparable to the Association's recommended percentage increase for the NIH.

INCREASE FUNDING FOR THE CDC

Prevention is the best way to protect the health of Americans and reduce the economic burden of heart disease and stroke. However, effective prevention strategies and programs are not being implemented due to insufficient Federal resources.

For example, despite the fact that cardiovascular disease remains the No. 1 killer in every State, CDC's Division for Heart Disease and Stroke Prevention funds only 14 States to implement programs to reduce risk factors for heart disease and stroke, improve emergency response and quality care, and end treatment disparities. Another 27 States receive funds for capacity building (planning); but, there are no funds for actual implementation and many of these States have been stalled in the planning phase for years—some for a decade.

This division also administers the WISEWOMAN program that screens uninsured and underinsured low-income women ages 40 to 64 in 20 States for heart disease and stroke risk. They receive counseling, education, referral, and followup as needed. Since January 2000, more than 84,000 women have been screened and more than 210,000 lifestyle interventions have been conducted. An estimated 94 percent of these women were found to have at least one risk factor or pre-condition for heart disease, stroke, or other forms of cardiovascular disease. This program should be expanded to the other 30 States and to screen more eligible women in currently funded States.

The AHA Recommends.—AHA joins with the CDC Coalition in support of an appropriation of $8.6 billion for CDC core programs, including increases for the Heart Disease and Stroke Prevention and WISEWOMAN programs. Within that total, we recommend $74 million for the Heart Disease and Stroke Prevention Program, allowing CDC to: (1) add the nine unfunded States; (2) elevate up to 18 States with capacity building awards to basic program implementation; (3) continue to support the remaining funded States; (4) maintain the Paul Coverdell National Acute Stroke Registry; (5) increase the capacity for heart disease and stroke surveillance; and (6) provide additional support for prevention research and program evaluation. We advocates $37 million to expand WISEWOMAN to more States. During last year's national competition, 10 States received approved applications but were denied funding due to insufficient resources. And, we join with the Friends of the NCHS in recommending $137.5 million for NCHS and one-time funding of $15 million to modernize the vital statistics system.

RESTORE FUNDING FOR RURAL AND COMMUNITY ACCESS TO EMERGENCY DEVICES (AED) PROGRAM

About 92 percent of cardiac arrest victims die outside of a hospital. Receiving immediate CPR and the use of an AED can more than double your chance of survival. Communities with comprehensive AED programs have achieved survival rates of 40 percent or higher. The Rural and Community AED Program provides grants to States to buy and place AEDs and train lay rescuers and first responders to use them. During its first year, 6,400 AEDs were purchased, and placed and 38,800 individuals were trained. Due to budget cuts, only 12 States receive resources for this program.

The AHA Recommends.—For fiscal year 2010, AHA advocates restoring the Rural and Community AED Program to its fiscal year 2005 level of $8.927 million.

INCREASE FUNDING FOR THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

AHRQ develops scientific evidence to improve health and healthcare. Through its Effective Health Care Program, AHRQ supports research focused on outcomes, comparative effectiveness, and the appropriateness of pharmaceuticals, devices and healthcare services for conditions such as heart disease, stroke, and high blood pressure.

On another front, AHRQ's health information technology (HIT) plan will help bring healthcare into the 21st century through more than $260 million invested in more than 200 projects and demonstrations since 2004. AHRQ and its partners identify challenges to HIT adoption and use; develop solutions and best practices; and produce tools that help hospitals and clinicians successfully integrate HIT. This work must continue as a key component to health reform.

The AHA Recommends.—AHA joins with Friends of AHRQ in advocating for a $405 million in base funding for AHRQ. It will preserve AHRQ's current initiatives and get the agency on track to a base budget of $500 million by 2013.

CONCLUSION

Cardiovascular disease continues to impose a deadly, disabling and costly burden on Americans. However, a robust funding increase for NIH, CDC and HRSA research, treatment, and prevention programs will continue to save lives and reduce rising healthcare costs. The AHA urges Congress to give serious consideration to our recommendations during the fiscal year 2010 congressional appropriations process. They are a wise investment for our Nation and the health and well-being of all Americans now and in future generations.

PREPARED STATEMENT OF ADVOCATE HEALTH CARE

INTRODUCTION AND OVERVIEW

Advocate Health Care (Advocate)—the largest integrated healthcare provider in Illinois—very much appreciates the opportunity to submit written testimony for the record regarding Federal funding for the title VII and title VIII programs of the Public Health Service Act. Advocate serves 3.1 million patients annually and has a presence in virtually every Illinois congressional district through the operation of more than 200 sites of care. Specifically, 9 acute care hospitals, 2 children's hospitals, 4 Level I trauma centers (the State's highest designation in trauma care), a home healthcare company, and the region's largest medical group—in Illinois' 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 13th and 14th Congressional Districts. Advocate also serves patients from—and employs people in the 11th and 16th Congressional Districts of Illinois. As the second largest employer in the Chicagoland area, Advocate employs 28,000 individuals, including 7,000 nurses. More than 5,000 physicians are also affiliated with Advocate.

Advocate maintains a long-standing commitment to supporting the nurses who work within the Advocate system and to increasing resources at the State and Federal level to bolster and expand Illinois' and the Nation's nursing workforce. High-quality, compassionate health professionals are critical to the delivery of care in the Advocate system. Without our 7,000 nurses—who work hard every day on behalf of patients and their families, our standard of care could not be achieved for the millions of people we serve throughout Illinois each year.

Advocate joins with Members of Congress, national nursing organizations, health professional societies and coalitions, and the general public in being deeply concerned about the current and anticipated national shortages of nurses and other health professionals and their potential adverse impact on patient access to quality care. To that end, Advocate respectfully urges the House Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee to provide $550 million in fiscal year 2010 funding for the title VII and title VIII programs of the Public Health Service Act to support and expand diversity within the Nation's healthcare workforce, and ensure that the Nation has the nurses and other health professionals it needs to provide quality care to the patients of today and tomorrow.

THE NURSING SHORTAGE AND THE NEED FOR TITLE VIII FUNDING

According to an April 13, 2009 Wall Street Journal article, last summer, the nation was short approximately 125,000 nurses. The nurse faculty shortage is of serious concern, since it is widely recognized as a principal cause of the nursing shortage. The American Association of Colleges of Nursing reports that in 2008, nearly 50,000 qualified applicants were not able to matriculate in nursing school, "due primarily to a shortage of faculty shortage and resource constraints." Although the recent economic downturn has prompted some nurses, who were retired or otherwise not working, to return to the workforce, many communities across the nation still do not have enough nurses to work in their hospitals and nursing homes, or to provide care in home or ambulatory settings.

The Health Resources and Services Administration (HRSA) estimates that, due to a combination of increased demand and the anticipated insufficient supply of registered nurses, the Nation will face a growing shortage in the years ahead. Specifically, the Nation will be short an estimated 275,215 nurses in 2015—a deficit that will grow to approximately 808,416 by 2020. Within Illinois, HRSA predicts that the State will be short an estimated 9,300 nurses in 2010 and 31,900 in 2020. Since nearly 60 percent of all nurses are employed by hospitals, the national and State

level nursing shortages will have a significant and disproportionate impact on hospitals and hospital systems, including Advocate.

The Title VIII Nursing Workforce Development Programs, housed at HRSA, provide resources to support the education and training for entry-level and advanced practice nurses. Specifically, title VIII programs offer loans, scholarships, traineeships, and other support to tens of thousands of individuals each year. According to the Health Professions and Nursing Education Coalition (HPNEC), more than 50,000 nursing students and nurses received support from title VIII in fiscal year 2008. However, it is important to note that the demand for such financial support far exceeds current resources. In fiscal year 2008, HRSA received 6,078 applications for the Nurse Education Loan Repayment Program, but only had the funds to award 435 of those applications. Also, in fiscal year 2008, HRSA received 4,894 applications for the Nursing Scholarship Program, but only had funding to support 172 awards. As such, to ensure that the nation can educate, train, and deploy enough nurses to the communities most in need, Advocate urges the subcommittee to provide a significant increase to title VIII programs in fiscal year 2010.

PHYSICIAN SHORTAGES AND THE NEED FOR TITLE VII FUNDING

The title VII health professions programs, housed within HRSA, provide: loans, loan guarantees and repayments, and scholarships to students; and contracts and grants to nonprofit organizations and entities, as well as academic institutions. Program funding supports: (1) health professional training—with a focus on increasing minority representation in the healthcare workforce, and (2) myriad community-based programs, which seek to increase access to care for underserved individuals and communities in Illinois and across the nation. As the nation currently faces shortages of primary care and specialty physicians—shortfalls that are expected to worsen in the coming years—these programs play a critical role in bolstering the nation's health workforce and helping to ensure its diversity.

Advocate is proud that from fiscal year 2003 to fiscal year 2006, Advocate Illinois Masonic Medical Center (AIMMC)—an urban, Level I trauma center serving primarily high-risk populations in medically underserved and ethnically diverse Chicago northside communities—received a total of more than $600,000 in funding from HRSA for its two residency programs—in family practice and dentistry. HRSA funding helped support the training of 23 primary care/family practice residents, approximately 40 percent of whom were ethnic minorities. This Federal funding of the AIMMC residency program helped develop dozens of physicians who chose to practice in primary care, many of whom specifically work in underserved communities. For example, graduates of the AIMMC family residency program have gone on to practice in rural health clinics, Federally Qualified Health Centers, Federal and State Health Professional Shortage Areas, the Indian Health Service, and HIV/AIDS primary care clinics. In addition, past HRSA funding also supported the AIMMC dental residency program, allowing the staffing of a mobile dental van that provides care to approximately 600 individuals—primarily uninsured—who have limited access to dental providers and care.

As you know, funding for the title VII programs was reduced by more than 50 percent from fiscal year 2005 to fiscal year 2006, and funding for the title VIII program was decreased by nearly 34 percent during the same period. Due to these significant cuts—coupled with modest increases in the subsequent years—there have not been adequate resources to continue to fund Advocate's residency programs. The lack of title VII and title VIII funding has had a significant impact on our—and other hospitals'—ability to train the next generation of physicians and dentists. Moreover, we are concerned that the Nation is not investing adequately in health professionals who have an interest in—and commitment to—working in underserved communities. Increased fiscal year 2010 funding for title VII will help ensure that our nation is making the investment necessary to have the educated, well-trained, and diverse health professional workforce to care for a growing population in need.

FISCAL YEAR 2010 FUNDING REQUEST AND CONCLUSION

As the Congress works to increase access to healthcare for all Americans—a critical action we support—the number of individuals seeking care is anticipated to grow significantly. At the exact same time that demand for healthcare likely will rise, the Nation is facing a significant shortage of nurses, physicians, and other health professionals. Therefore, we urge the subcommittee to provide $550 million to the title VII and title VIII programs of the Public Health Service Act to bolster the Nation's health workforce and ensure access to care for all in need. We thank the subcommittee for its consideration of our views and stand ready to be a resource to you on health workforce and other matters.

PREPARED STATEMENT OF THE AD HOC GROUP FOR MEDICAL RESEARCH

The Ad Hoc Group for Medical Research, which is a coalition of more than 300 patient and voluntary health groups, medical and scientific societies, academic and research organizations, and industry, thanks and commends Congress for including the extraordinary investment in medical research through the National Institutes of Health (NIH) that was included as part of in the American Recovery and Reinvestment Act (ARRA, Public Law 111–5) as well as the $938 million increase in NIH funding in the Omnibus Appropriations Act for fiscal year 2009 (Public Law 111–8). In particular, we are deeply grateful to the subcommittee for its long-standing support of NIH. These are difficult times for our Nation and for people all around the globe, but the affirmation of science is the key to a better future is a strategic step forward.

The partnership between NIH and America's scientists, medical schools, teaching hospitals, universities, and research institutions continues to serve as the driving force in this Nation's search for ever-greater understanding of the mechanisms of human health and disease, from which arise new diagnostics and treatments, and cures, and better ways to improve the health and quality of life for all Americans. These advances also contribute to the Nation's economic strength by creating skilled, high-paying jobs; new products and industries; and improved technologies.

The recent history of the NIH budget has hindered scientific discovery and limited the capacity of a key engine for today's innovation-based economy. The additional funding in the ARRA and the fiscal year 2009 omnibus are critical first steps to returning the NIH to a course for even greater discovery. These investments give patients, their families and researchers renewed hope for the future, and will help ensure the success of America's medical research enterprise and leadership.

The funding increases in the ARRA and the fiscal year 2009 omnibus will provide an immediate infusion of funds into the Nation's proven and highly competitive medical research enterprise to sustain the pursuit of improved diagnostics, better prevention strategies, and new treatments for many devastating and costly diseases as well as support innovative research ideas, state-of-the-art scientific facilities and instrumentation, and the scientists, technicians, laboratory personnel, and administrators necessary to maintain the enterprise. More importantly, these funds will reinvigorate this Nation's ability to produce the human and intellectual capital that will continue to drive scientific discovery, transform health, and improve the quality of life for all Americans.

Moreover, we see this as the first step in renewing a national commitment to sustained, predictable growth in NIH funding, which we believe is an essential element in restoring and sustaining both national and local economic growth and vitality as well as maintaining this Nation's prominence as the world leader in medical research.

President Obama has committed to increase Federal support for research, technology, and innovation so that America can lead the world in creating new advanced jobs and products. A key element of his strategy is to double Federal funding for basic research to "foster home-grown innovation, help ensure the competitiveness of U.S. technology-based businesses, and ensure that 21st century jobs can and will grow in America." If America is to succeed in the information-based, innovation driven world-wide economy of the 21st century, we must recommit to long-term sustained and predictable growth in medical research funding.

As a result of this subcommittee's prior investment in NIH, we have made critical advances in several key areas including:

—*Stem Cells*.—Reprogramming skin cells from a patient with Parkinson's Disease into normal neurons that could be used to fight this degenerative disease.

—*Infectious Diseases*.—Developing more effective antibodies, and ultimately vaccines, to fight lethal flu viruses before they become pandemic.

—*Cancer*.—Launching the Cancer Genome Atlas as a partnership between the National Cancer Institute and the National Human Genome Research Institute to discover the genetic basis for various cancers.

In addition, as a consequence of the investment over the past two decades in the human genome project and other areas of genetics, we are now entering an era of personalized medicine, which has the potential to transform healthcare through earlier diagnosis, more effective prevention and treatment of disease, and avoidance of drug side effects. For example, the same medication can help one patient and be ineffective for, or toxic to, another. By applying our greater understanding of how an individual's genetic make-up affects a response to specific drugs, we will increasingly know which patients will likely benefit from treatment and which will not benefit, or worse, be harmed. Cancer chemotherapy and the use of the anticoagulant Coumadin are good examples of how this might be applied.

However, the discovery process—while it produces tremendous value—often takes a lengthy and unpredictable path. The talent base and infrastructure that we are creating needs to be maintained. Large fluctuations in funding will be disruptive to training, to careers, long range projects and ultimately to progress. The research engine needs a predictable, sustained investment in science to maximize our return.

We must ensure that after the stimulus money is spent we do not have to dismantle our newly built capacity and terminate valuable, on-going research. In 2011 and beyond we need to be able to continue to advance the new directions initiated with ARRA support.

The fiscal year 2009 omnibus and the ARRA provided $38.5 billion for NIH to provide more than 16,000 new research grants for live-saving research into diseases such as cancer, diabetes, and Alzheimer's. Keeping up with the rising cost of medical research in the 2010 appropriations will help NIH begin to prepare for the "post-stimulus" era. In 2011 and beyond we need to make sure that the total funding available to NIH does not decline and that we can resume a steady, sustainable growth that will enable us to achieve the President's goal of doubling our investment in basic research. Consistent with the President's vision, we respectfully urge this subcommittee to increase funding for NIH in fiscal year 2010 by at least 7 percent.

The ravages of disease are many, and the opportunities for progress across all fields of medical science to address these needs are profound. The community appreciates that this subcommittee has always recognized that science is unpredictable and that it is difficult to know exactly which discoveries gained through basic research will foster the next medical advancement. There are many examples of areas where important therapies for one disease have resulted from investments in unrelated areas of research. Investing broadly in biomedical research is the key to ensuring the future of America's medical research enterprise and the health of her citizens.

Thank you again for your leadership in improving the health and quality of life for all Americans.

PREPARED STATEMENT OF THE AIDS INSTITUTE

Dear Chairman Harkin and members of the subcommittee: The AIDS Institute, a national public policy research, advocacy, and education organization, is pleased to comment in support of critical HIV/AIDS and Hepatitis programs as part of the fiscal year 2010 Labor, Health and Human Services, and Education, and Related Agencies appropriation measure. We thank you for your support of these programs over the years, and trust you will do your best to adequately fund them in the future in order to provide for and protect the health of the Nation.

HIV/AIDS

HIV/AIDS remains one of the world's worst health pandemics in history. Worldwide, some 33 million people are infected with this incurable infectious disease, and 7,400 new infections occur each day. Tragically, AIDS has already claimed the lives of more than 25 million. In the United States 583,298 people have died of AIDS. Last year, the CDC announced that its estimate of new infections per year is now 56,300, which is 40 percent higher than previous estimates. That translates into a new infection every 9½ minutes. At the end of 2007, an estimated 1.1 million people in the United States were living with HIV/AIDS.

Persons of minority races and ethnicities are disproportionately affected by HIV/AIDS. African Americans, who make up 12 percent of the U.S. population, account for half of the HIV/AIDS cases. HIV/AIDS also disproportionately affects the poor, and about 70 percent of those infected rely on public healthcare financing.

The U.S. Government has played a leading role in fighting HIV/AIDS, both here and abroad. The vast majority of the discretionary programs supporting HIV/AIDS efforts domestically are funded through your subcommittee. The AIDS Institute, working in coalition with other AIDS organizations, has developed funding request numbers for each of these domestic AIDS programs. We ask that you do your best to adequately fund them at the requested level.

Below are the program requests and supporting explanation:

CENTERS FOR DISEASE CONTROL AND PREVENTION—HIV PREVENTION AND SURVEILLANCE

[In millions of dollars]

	Amount
Fiscal year 2009	692
Fiscal year 2010 President's budget request	745
Fiscal year 2010 community request	1,570

As stated above, the Centers for Disease Control and Prevention (CDC) has increased the estimate of people infected each year by 40 percent. New infections are particularly occurring in certain populations, such as the poor, African-Americans, men who have sex with men, Latinos, substance users, and the incarcerated. In order to address the specific needs of these populations and the increased number of people infected, CDC is going to need additional funding.

The CDC has developed a professional judgment budget outlining what funding is necessary to improve HIV prevention efforts and reduce HIV transmission in the United States. The professional judgment budget called for an additional $877 million in funding over the next 5 years. With the additional funding the CDC estimates that by 2020 it could decrease the HIV transmission rate by 50 percent, reduce the number of people who do not know their status by 50 percent, and halve the disparities in the Black and Hispanic communities.

This additional funding would be targeted toward: (1) Increasing HIV testing and the number of people who are reached by effective prevention programs; (2) developing new tools to fight HIV with scientifically proven interventions; and (3) improving systems to monitor HIV and related risk behaviors, and to evaluate prevention programs.

Investing in prevention today will save money tomorrow. Every case of HIV that is prevented saves, on average, $1 million of lifetime treatment costs for HIV. The CDC estimates that the cost of treating the estimated 56,300 new HIV infections in 2006 will translate into $9.5 billion in annual future medical costs.

RYAN WHITE HIV/AIDS PROGRAMS

[In millions of dollars]

	Amount
Fiscal year 2009	2,238
President's budget request	2,292
Community request	2,816

The centerpiece of the Government's response to caring and treating low-income people with HIV/AIDS is the Ryan White HIV/AIDS Program. Ryan White currently serves more than half and million low-income, uninsured, and underinsured people each year.

In fiscal year 2009, the Program received an increase of $72 million, or just 3.3 percent. This increase does not even cover the rate of inflation. In his fiscal year 2010 budget the President is proposing an increase of $54 million, or just 2.2 percent. This includes a $20 million increase, or only 2.5 percent, to the AIDS Drug Assistance Program. The AIDS Institute urges you to provide substantial funding increases to all parts of the Ryan White Program. Consider the following:

—*Caseload Levels are Increasing*.—People are living longer due to lifesaving medications; there are more than 56,000 new infections each year; and increased testing programs, according to the CDC, will identify 12,000 to 20,000 new people infected with HIV each year. With rising unemployment, people are losing their employer-sponsored health coverage. All of this will necessitate the need for more Ryan White services and medications.

—The price of healthcare, including medications, is increasing and State and local budgets are experiencing cutbacks due to the economic downturn. A recent survey by the National Alliance of State and Territorial AIDS Directors found that 50 percent of ADAP programs have experienced or will experience State funding decreases in fiscal year 2009.

—There are significant numbers of people in the United States who are not receiving life-saving AIDS medications. An IOM report concluded that 233,069 people in the United States who know their HIV status do not have continuous access to Highly Active Antiretroviral Therapy.

Specifically, The AIDS Institute requests the following funding levels for each part of the Program:

—Part A provides medical care and vital support services for persons living with HIV/AIDS in the metropolitan areas most affected by HIV/AIDS. We request an increase of $103 million, for a total of $766.1 million.

—Part B base provides essential services including diagnostic, viral load testing, and viral resistance monitoring and HIV care to all 50 States, DC, Puerto Rico, and the territories. We are requesting a $105.4 million increase, for a total of $514.2 million.

The AIDS Drug Assistance Program (ADAP) provides life-saving HIV drug treatment to more than 140,000 people. Due to a lack of funding, States have not been able to include all necessary drugs on their formularies, have limited eligibility and capped enrollment. In order to address the 8,472 new ADAP clients and drug cost increases, we are requesting an increase of $268.6 million for a total of $1,083.6 million.

—Part C provides early medical intervention and other supportive services to more than 248,000 people at more than 380 directly funded clinics. We are requesting a $66.4 million increase, for a total of $268.3 million.

—Part D provides care to more than 84,000 women, children, youth, and families living with and affected by HIV/AIDS. This family-centered care promotes better health, prevents mother-to-child transmission, and brings hard-to-reach youth into care. We are requesting a $57.7 million increase, for a total of $134.6 million.

—Part F includes the AIDS Education and Training Centers (AETCs) program and the Dental Reimbursement program. We are requesting a $15.6 million increase for the AETC program, for a total of $50 million, and a $5.6 million increase for the Dental program, for a total of $19 million.

The AIDS Institute supports increased funding for the Minority AIDS Initiative (MAI). MAI funds services nationwide that address the disproportionate impact that HIV has on communities of color. We are requesting a $200.5 million increase across these programs, for a total of $610 million.

NATIONAL INSTITUTES OF HEALTH—AIDS RESEARCH

[In billions of dollars]

	Amount
Fiscal year 2009	3.01
President's budget request	3.06
Community request	3.5

Through the National Institutes of Health (NIH), research is conducted to understand HIV and its complicated mutations, discover new drug treatments, develop a vaccine and other prevention programs such as microbicides, and ultimately develop a cure. Much of this work at the NIH is done in cooperation with private funding. The critically important work performed by the NIH not only benefits those in the United States, but the entire world.

This research has already helped in the development of many highly effective new drug treatments, prolonging the lives of millions of people. As neither a cure nor a vaccine exists, and patients continue to build resistance to existing medications, additional research must continue. NIH also conducts the necessary behavioral research to learn how HIV can be prevented best in various affected communities. We ask the subcommittee to fund critical AIDS research at the community requested level of $3.5 billion.

COMPREHENSIVE SEX EDUCATION

The President's proposed budget eliminates appropriated funding for abstinence-only until marriage programs and instead creates a Teen Pregnancy Prevention Program primarily for interventions that have gone through a rigorous evaluation to delay sexual activity, reduce teen pregnancy, or increase contraceptive use. We fully support the zeroing-out of Community Based Abstinence Education programs. However, we hope these new programs will be used to fund efforts to protect teen sexual health beyond the prevention of teen pregnancy. Messages to prevent teen pregnancy may not speak to all youth, particularly gay youth, who are at a high risk of HIV infection. We request that the $110 million in discretionary funds in the President's budget for the Teen Pregnancy Prevention Initiative be maintained and that the language be broadened to include HIV and STD prevention.

SYRINGE EXCHANGE PROGRAMS

At least one-quarter of all reported AIDS cases in our country are attributed to injection drug use through the sharing of needles and syringes. Federal scientific studies have repeatedly demonstrated that syringe exchange programs reduce the transmission of HIV and other infectious diseases without increasing or encouraging the use of illicit drugs, and may even help reduce drug use by creating a point of entry for addiction treatment. Today, there are nearly 200 such programs operating in 38 States, DC, and Puerto Rico. Despite their proven effectiveness, there is a ban on the use of Federal funds for these programs. We urge you to lift the Federal funding ban on syringe exchange programs in fiscal year 2010.

VIRAL HEPATITIS

Viral Hepatitis, whether A, B, or C, is an infectious disease that also deserves increased attention by the Federal Government. According to the CDC, there are an estimated 800,000 to 1.4 million Americans chronically infected with Hepatitis B, and 46,000 new infections each year. An estimated 1.6 percent of Americans have been infected with Hepatitis C, of whom 3.2 million are chronically infected. It is believed that one quarter of those infected with HIV are co-infected with Hepatitis C.

Given these numbers, we are disappointed the program is currently funded at a level that is substantially less than what it was funded in fiscal year 2003 and falls far short of what is needed. In the President's budget, funding for Hepatitis Prevention at the CDC is slated to receive a negligible increase of $51,000. Funds are needed to establish a program to lower the incidence of Hepatitis through education, outreach, and surveillance. We are requesting an increase of $31.7 million for the program, for a total of $50 million.

The AIDS Institute asks that you give weight to our testimony as you consider the fiscal year 2010 appropriation bill.

PREPARED STATEMENT OF THE AMERICAN INDIAN HIGHER EDUCATION CONSORTIUM

Summary of Requests.—Summarized below are the fiscal year 2010 recommendations for the Nation's 36 Tribal Colleges and Universities (TCUs), covering three areas within the Department of Education and one in the Department of Health and Human Services (HHS), Administration for Children and Families' (ACF) Head Start Program.

DEPARTMENT OF EDUCATION PROGRAMS

Higher Education Act (HEA) Programs

Strengthening Developing Institutions.—Section 316 of title III–A, specifically supports TCUs through two separate grant programs: (a) formula funded development grants, and (b) competitive facilities/construction grants designed to address the critical facilities needs at TCUs. The TCUs request that the Subcommittee appropriate $32 million to support these two vital programs.

Pell Grants.—TCUs urge the subcommittee to fund the Pell Grant Program at the highest possible level.

Perkins Career and Technical Education Programs

The TCUs urge the Subcommittee to appropriate $8.5 million for section 117 of the Carl D. Perkins Career and Technical Education Improvement Act, which supports our two Tribally Controlled Postsecondary Vocational Institutions: United Tribes Technical College and Navajo Technical College. Additionally, TCUs strongly support the Native American Career and Technical Education Program (NACTEP) authorized under section 116 of the act.

Relevant Title IX Elementary and Secondary Education Act (ESEA) Programs

Adult and Basic Education.—Although Federal funding for tribal adult education was eliminated in fiscal year 1996, TCUs continue to offer much needed adult education, GED, remediation and literacy services for American Indians, yet their efforts cannot meet the demand. The TCUs request that the subcommittee direct $5 million of the Adult Education State Grants appropriated funds to make awards to TCUs to support their ongoing and essential adult and basic education programs.

American Indian Teacher and Administrator Corps.—The American Indian Teacher Corps and the American Indian Administrator Corps offer professional development grants designed to increase the number of American Indian teachers and ad-

ministrators serving their reservation communities. The TCUs request that the subcommittee support these programs at $10 million and $5 million, respectively.

HHS PROGRAM

TCUs Head Start Partnership Program (DHHS–ACF)

TCUs are ideal partners to help achieve the goals of Head Start in Indian country. The TCUs are working to meet the mandate that Head Start teachers earn degrees in Early Childhood Development or a related discipline. The TCUs request that $5 million be designated for the TCU-Head Start Partnership program, to ensure the continuation of current programs and the resources needed to support additional TCU-Head Start Partnership programs.

BACKGROUND ON TCUS

TCUs are accredited by independent, regional accreditation agencies and like all institutions of higher education, must undergo stringent performance reviews on a periodic basis to retain their accreditation status. In addition to college level programming, TCUs provide essential high school completion (GED), basic remediation, job training, college preparatory courses, and adult education programs. TCUs fulfill additional roles within their respective reservation communities functioning as community centers, libraries, tribal archives, career and business centers, economic development centers, public meeting places, and child and elder care centers. Each TCU is committed to improving the lives of its students through higher education and to moving American Indians toward self-sufficiency.

TCUs provide access to higher education for American Indians and others living in some of the Nation's most rural and economically depressed areas. According to 2000 Decennial Census data, the annual per capita income of the U.S. population was $21,587. In contrast, the annual per capita income of Native Americans was $12,893 or about 40 percent less. In addition to serving their student populations, TCUs offer a variety of much needed community outreach programs.

These institutions, chartered by their respective tribal governments, were established in response to the recognition by tribal leaders that local, culturally-based institutions are best suited to help American Indians succeed in higher education. TCUs effectively blend traditional teachings with conventional postsecondary curricula. They have developed innovative ways to address the needs of tribal populations and are overcoming long-standing barriers to success in higher education for American Indians. Since the first TCU was established on the Navajo Nation just 40 years ago, these vital institutions have come to represent the most significant development in the history of American Indian higher education, providing access to, and promoting achievement among, students who may otherwise never have known postsecondary education success.

JUSTIFICATIONS FOR FISCAL YEAR 2010 APPROPRIATIONS REQUESTS FOR TCUS

HEA

The Higher Education Act Amendments Act of 1998 created a separate section (§316) within title III–A specifically for the Nation's TCUs. Programs under titles III and V of the act support institutions that enroll large proportions of financially disadvantaged students and that have low per-student expenditures. Tribal colleges, which are truly developing institutions, are providing access to quality higher education opportunities to some of the most rural, impoverished, and historically underserved areas of the country. A clear goal of HEA title III programs is "to improve the academic quality, institutional management and fiscal stability of eligible institutions, in order to increase their self-sufficiency and strengthen their capacity to make a substantial contribution to the higher education resources of the Nation." The TCU title III program is specifically designed to address the critical, unmet needs of their American Indian students and communities, in order to effectively prepare them to succeed in a global, competitive workforce. The TCUs urge the subcommittee to appropriate $32 million in fiscal year 2010 for title III–A section 316, an increase of $8.8 million more than fiscal year 2009. These funds will afford these developing institutions the resources necessary to continue their ongoing grant programs and address the needs of their historically underserved students and communities.

The importance of Pell Grants to TCU students cannot be overstated. U.S. Department of Education figures show that the majority of TCU students receive Pell Grants, primarily because student income levels are so low and our students have far less access to other sources of financial aid than students at State-funded and other mainstream institutions. Within the TCU system, Pell Grants are doing ex-

actly what they were intended to do—they are serving the needs of the lowest income students by helping them gain access to quality higher education, an essential step toward becoming active, productive members of the workforce. The TCUs urge the subcommittee to fund this critical program at the highest possible level.

CARL D. PERKINS CAREER AND TECHNICAL EDUCATION ACT

Tribally-controlled Postsecondary Vocational Institutions.—Section 117 of the Perkins Act provides operating funds for two of our member institutions: United Tribes Technical College in Bismarck, North Dakota, and Navajo Technical College in Crownpoint, New Mexico. The TCUs urge the subcommittee to appropriate $8.5 million for section 117 of the act.

Native American Career and Technical Education Program.—The Native American Career and Technical Education Program (NACTEP) under section 116 of the Act reserves 1.25 percent of appropriated funding to support Indian vocational programs. The TCUs strongly urge the subcommittee to continue to support NACTEP, which is vital to the continuation of much needed career and technical education programs being offered at TCUs.

GREATER SUPPORT OF INDIAN EDUCATION PROGRAMS

American Indian Adult and Basic Education (Office of Vocational and Adult Education).—This program supports adult basic education programs for American Indians offered by TCUs, State and local education agencies, Indian tribes, institutions, and agencies. Despite a lack of funding, TCUs must find a way to continue to provide basic adult education classes for those American Indians that the present K–12 Indian education system has failed. Before many individuals can even begin the course work needed to learn a productive skill, they first must earn a GED or, in some cases, even learn to read. The number of students in need of remedial education before embarking on their degree programs is considerable at TCUs. There is a broad need for basic adult educational programs and TCUs need adequate funding to support these essential activities. TCUs respectfully request that the subcommittee direct $5 million of the Adult Education State Grants appropriated funds to make awards to TCUs to help meet the ever increasing demand for basic adult education and remediation program services that exists on their respective reservations.

American Indian Teacher/Administrator Corps (Special Programs for Indian Children).—American Indians are severely underrepresented in the teaching and school administrator ranks nationally. These competitive programs are designed to produce new American Indian teachers and school administrators for schools serving American Indian students. These grants support recruitment, training, and in-service professional development programs for Indians to become effective teachers and school administrators and in doing so become excellent role models for Indian children. We believe that the TCUs are ideal catalysts for these two initiatives because of their current work in this area and the existing articulation agreements they hold with 4-year degree awarding institutions. The TCUs request that the subcommittee support these two programs at $10 million and $5 million, respectively, to increase the number of qualified American Indian teachers and school administrators in Indian Country.

HHS/ACF/HEAD START

TCUs Head Start Partnership Program.—The TCU-Head Start Partnership has made a lasting investment in our Indian communities by creating and enhancing associate degree programs in Early Childhood Development and related fields. Graduates of these programs help meet the degree mandate for all Head Start program teachers. More importantly, this program has afforded American Indian children Head Start programs of the highest quality. A clear impediment to the ongoing success of this partnership program is the erratic availability of discretionary funds made available for the TCU-Head Start Partnership. In fiscal year 1999, the first year of the program, some colleges were awarded 3-year grants, others 5-year grants. In fiscal year 2002, no new grants were awarded. In fiscal year 2003, funding for eight new TCU grants was made available, but in fiscal year 2004, only two new awards could be made because of the lack of adequate funds. The President's February 26, 2009 budget summary includes an additional $1 billion to improve and expand Head Start. The TCUs request that the subcommittee direct the Head Start Bureau to designate $5 million, of the more than $7.2 billion included in the President's budget, to fund the TCU-Head Start Partnership program, to ensure that this critical program can continue and expand so that all TCUs have the opportunity to participate in the TCU-Head Start Partnership program.

CONCLUSION

TCUs are providing access to higher education opportunities to many thousands of American Indians and essential community services and programs to many more. The modest Federal investment in TCUs has already paid great dividends in terms of employment, education, and economic development, and continuation of this investment makes sound moral and fiscal sense. TCUs need your help if they are to sustain and grow their programs and achieve their missions to serve their students and communities.

Thank you again for this opportunity to present our funding recommendations. We respectfully ask the members of the subcommittee for their continued support of the Nation's TCUs and full consideration of our fiscal year 2010 appropriations needs and recommendations.

PREPARED STATEMENT OF THE ASSOCIATION OF INDEPENDENT RESEARCH INSTITUTES

The Association of Independent Research Institutes (AIRI) respectfully submits this written testimony for the record to the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. AIRI appreciates the commitment that the members of this subcommittee have made to biomedical research through your strong support for the National Institutes of Health (NIH), and recommends that you maintain this support for NIH in fiscal year 2010 by providing the agency with at least a 7 percent increase more than fiscal year 2009.

AIRI is a national organization of 90 independent, nonprofit research institutes that perform basic and clinical research in the biological and behavioral sciences. AIRI institutes vary in size, with budgets ranging from a few million to hundreds of millions of dollars. In addition, each AIRI member institution is governed by its own independent board of directors, which allows our members to focus on discovery based research while remaining structurally nimble and capable of adjusting their research programs to emerging areas of inquiry. Researchers at independent research institutes consistently exceed the success rates of the overall NIH grantee pool, and receive about 10 percent of NIH's peer-reviewed, competitively awarded extramural grants. On average, AIRI member institutes receive a total of $1.6 billion in extramural grants from NIH in any given year.

Through passage of the American Recovery and Reinvestment Act (ARRA) and the Omnibus Appropriations Act for fiscal year 2009, the administration and Congress have taken critical steps to jump start the Nation's economy. Simultaneously, Congress is advancing and accelerating the biomedical research agenda in this country by focusing on scientific opportunities to address public health challenges. NIH now has the ability to fund a record number of research grants, with special emphasis on groundbreaking projects in areas that show the greatest potential for improving health, including genetic medicine, clinical research, and health disparities. In addition, NIH is also funding construction projects and providing support for equipment and instrumentation.

NIH is responding to its charge of stimulating the economy through job creation by supporting new scientists, construction workers, and suppliers. NIH is also supporting the next generation of biomedical research through cross-cutting, interdisciplinary initiatives such as those supported in the NIH Roadmap, the NIH Neuroscience Blueprint, the Clinical and Translational Science Award program, and the Genes, Environment and Health Initiative. Independent research institutes are involved extensively in these initiatives and will be beneficiaries of ARRA funds, making them an important and vital component of the overall U.S. medical research enterprise. Therefore, independent research institutes are positioned to help Congress achieve its goal of improving the quality of life for all Americans.

However, the discovery process—while it produces tremendous value—often takes a lengthy and unpredictable path. The infrastructure that we are creating needs to be maintained. Large fluctuations in funding will be disruptive to training, to careers, long-range projects and ultimately to progress. The research engine needs a predictable, sustained investment in science to maximize our return.

We must ensure that after the stimulus money is spent we do not have to dismantle our newly built capacity and terminate valuable, on-going research. In 2011 and beyond we need to be able to continue to advance the new directions charted with the ARRA support.

Keeping up with the rising cost of medical research in the 2010 appropriations will help NIH begin to prepare for the "post-stimulus" era. In 2011 and beyond we need to make sure that the total funding available to NIH does not decline and that we can resume a steady, sustainable growth that will enable us to complete the

President's vision of doubling our investment in basic research, which is why we are respectfully urging this subcommittee to increase funding for NIH in fiscal year 2010 by at least 7 percent.

AIRI'S COMMITMENT

Pursuing New Knowledge

The United States model for conducting biomedical research, which involves supporting scientists at universities, medical centers, and independent research institutes, provides an effective approach to making fundamental discoveries in the laboratory and translating them into medical advances that save lives. AIRI member institutes are private, stand-alone research centers that set their sights on the vast frontiers of medical science, specifically focused on pursuing knowledge about the biology and behavior of living systems and to apply that knowledge to extend healthy life and reduce the burdens of illness and disability.

Providing Efficiency and Flexibility

AIRI member institutes' smaller size and greater flexibility provide an environment that is particularly conducive to creativity and innovation. In addition, independent research institutes possess a unique versatility/culture that encourages them to share expertise, information, and equipment across their institutes and elsewhere, which helps to minimize bureaucracy and increase efficiency when compared to larger degree-granting academic universities.

Supporting Young Researchers

While the primary function of AIRI institutes is research, most are strongly involved in training the next generation of biomedical researchers and ensuring that a pipeline of promising researchers are prepared to make significant and potentially transformative discoveries in a variety of areas.

AIRI would like to thank the subcommittee for its important work to ensure the health of the Nation, and we appreciate this opportunity to present funding recommendations concerning NIH in the fiscal year 2010 appropriations bill. AIRI looks forward to working with Congress to carry out the research that will lead to improving the health and quality of life for all Americans.

PREPARED STATEMENT OF THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

Chairman Harkin and distinguished subcommittee members: I am grateful for this opportunity to submit written testimony on behalf of the Association of Maternal & Child Health Programs (AMCHP), our members, and the millions of women and children that are served by the title V Maternal and Child Health Services Block Grant. My name is Dr. Phyllis Sloyer and I am the current president of AMCHP, as well a Division Director at the Florida Department of Health. I am asking the subcommittee to support full funding for the title V Maternal and Child Health Services Block Grant at its authorized level of $850 million for Federal fiscal year 2010.

To help illustrate the importance of title V MCH funding, I want to begin by sharing the story of a girl from Iowa who was helped by title V services.

Cora is a girl who was born 34 weeks prematurely. She was first seen at a Child Health Specialty Clinic when she was only 3 weeks of age. While at the clinic, she was diagnosed with, plagiocephaly also sometimes referred to a "flat head syndrome". This problem occurs when a portion of an infant's skull becomes flattened due to pressure from outside forces and is not uncommon in premature infants. Workers at the clinic provided the new family with vital information on the disorder and what to expect. Cora was able to be seen by a pediatrician via telemedicine and was able to obtain a referral to see specialists in the treatment of plagiocephal. Cora is now 20 months old and likes to go to the local park and ride the merry-go-round. This same clinic that helped Cora and her family is supported by the Title V MCH Block Grant and would not be able to remain open without the funds and support that title V funds offer. It is a great thing that families can come to a clinic close to their home, or be seen using health technology and be provided a complete physical, neurological, developmental evaluation for their kids.

This is just one example of the literally thousand of children—children with special healthcare needs and pregnant women that are served by title V programs in Chairman Harkin's State alone. The MCH Block Grant supports a similar network in my home State of Florida, and none of this could happen without the Title V MCH Block Grant funding.

Title V of the Social Security Act was created during the Great Depression to "improve the health of all women and children." The MCH Block Grant is a celebrated example of an effective Federal and State partnership with a common goal of improving the health of all mothers and children, including those children with special healthcare needs. It is also at the forefront of promoting family-centered care in all of its work. But we are losing ground fast and we believe it is time to go back to the roots of title V and recommit ourselves to truly improving the health of our Nation's women and children by fully investing in the MCH Block Grant.

Despite major advances in medicine, technology, and our healthcare system, America still faces huge challenges to improving maternal and child health outcomes and addressing the needs of very vulnerable children.

Reductions in maternal and infant mortality have stalled in recent years and rates of preterm and low-birth-weight births have increased over the last decade. As we sit here today, the United States ranks 29th in infant mortality rates when compared to other nations. Every 18 minutes a baby in America dies before his or her first birthday. Each day in America we lose 12 babies due to a sudden unexpected infant death. There are places in this country where the African American infant mortality rate is double, and in some places even triple, the rate for whites. Preventable injuries remain the leading cause of death for all children, we are failing to adequately screen all young children for developmental concerns and childhood obesity has reached epidemic proportions, threatening to reverse a century of progress in extending life expectancy.

Sadly, there are gaps between what a family needs and actually receives for a child with a special need. Out of pocket healthcare costs are increasing and we are erasing gains we made in supporting effective services for children with special needs and their families. Currently, only 50 percent of these children receive comprehensive care within the context of a medical home and less than 20 percent of youth with special needs are able to find an adult healthcare provider who can appropriately care for them.

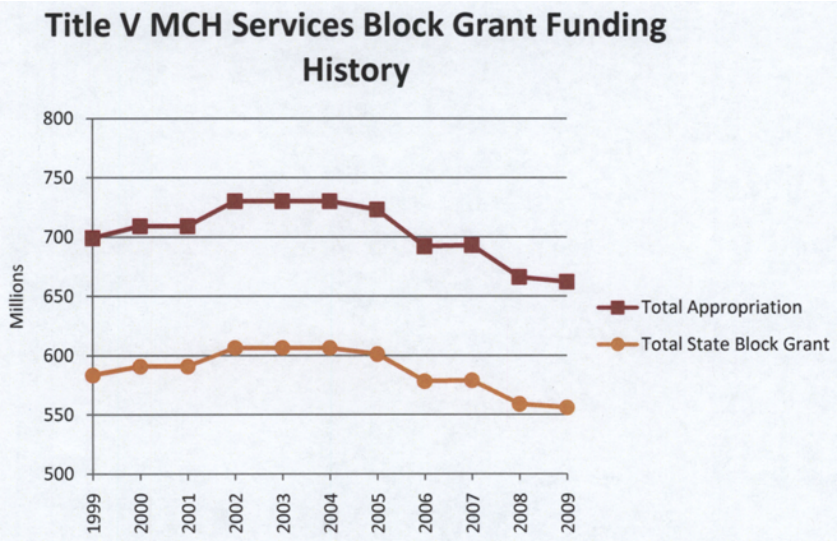
State programs, funded through MCH Block Grant dollars, are key to reversing this picture. Considering these and many other urgent health needs, AMCHP asks for your leadership in fully funding the MCH Block Grant at $850 million for fiscal year 2010.

AMCHP urges Congress to recognize the need to revitalize resources for States and their partners to reverse the trends and continue this critical work. We have a track record of demonstrating that we make a positive difference and are fully accountable for the funds that we receive. Fully funding the MCH Block Grant is an effective and efficient way to invest in our Nation's women, children, and families.

The Office of Management and Budget found that MCH Block Grant-funded programs deliver results and decrease the infant mortality rate, prevent disabling conditions, increase the number of children immunized, increase access to care for uninsured children, and improve the overall health of mothers and children. Close coordination with other health programs assures that funding is maximized and services are not duplicated.

Our results are available to the public through a national Web site known as the Title V Information System. Such a system is remarkably rare for a Federal program and we are proud of the progress we have made.

However, despite the increasing demand for maternal and child health services, reductions to the MCH Block Grant threaten the ability of programs to carry out their vital work. As States continue to face increasing economic hardship, more women and children will seek services through MCH Block Grant funded programs. Due to years of reduced investment, the MCH Block Grant is at its lowest funding level since 1993, $662 million, meaning States again are being asked to serve additional people with less.



Now, as economic troubles increase demand for health services, State MCH programs desperately need additional resources to:

—increase outreach and screening services to identify and link women and children to available healthcare services;

—assure coordination of those services and assist new parents through efforts such as expanded home visitation programs; and

—deliver essential prevention and health promotion services to make sure that every mom has a healthy pregnancy; every child has the opportunity for a healthy birth and strong start in life; and every child with special healthcare needs receives ongoing comprehensive care within a medical home.

Crucial MCH activities are also supported by title V under the Special Projects of Regional and National Significance (SPRANS) program, including MCH research, training, hemophilia diagnostic and treatment centers, and MCH improvement projects that develop and support a broad range of strategies. The SPRANS investment drives innovation for MCH programs and is an important part of the Title V MCH Block Grant.

Mr. Chairman and distinguished members, in closing I ask you to imagine with me an America in which every child in the United States has the opportunity to live until his or her first birthday; a Nation where our Federal and State partnership has effectively moved the needle on our most pressing maternal and child health issues. Imagine a day when we are celebrating significant reductions or even the total elimination of health disparities by creatively solving our most urgent maternal and child health challenges. The MCH Block Grant aims to do just that—using resources effectively to improve the health of all of America's women and children.

I want to close with one more story from a parent in my State that I think illustrates the personal impact of Title V MCH Block Grant funds.

My daughter Ashley continues to be at risk for a detached retina with myopia of the eye. Title V Children and Youth with Special Health Care Needs has been instrumental in providing medically necessary funding for the type of eyeglasses that she needs in order to be able to see and have some quality of life as an adolescent. There are medications that she needs to be able to control her executive functions, her impulses and her motor coordination in order to be able to function in school that I would not be able to afford as a parent. As a parent it would be devastating if she could not go to school which increases her chances of being able to transition into work and/or higher education.

PREPARED STATEMENT OF THE AMERICAN NURSES ASSOCIATION

The American Nurses Association (ANA) appreciates this opportunity to comment on fiscal year 2010 appropriations for nursing education, workforce development, and research programs. Founded in 1896, ANA is the only full-service national association representing registered nurses (RNs). Through our 51 constituent member associations, ANA represents RNs across the Nation in all practice settings.

The ANA gratefully acknowledges this subcommittee's history of support for nursing education and research. We appreciate your continued recognition of the important role nurses play in the delivery of quality healthcare services. This testimony will give you an update on the status of the nursing shortage, its impact on the Nation, and the outlook for the future.

THE NURSING SHORTAGE TODAY

The nursing shortage is far from solved. Here are a few quick facts:

—The American Hospital Association reported that hospitals needed 116,000 more RNs to fill immediate vacancies in July 2007. Hospitals report that this vacancy rate is hampering the ability to provide emergency care.

—The Bureau of Labor Statistics reports that registered nursing will have remarkable job growth in the time period spanning 2006–2016. During this time, the healthcare system will require more than 1 million new nurses.

—The Health Resources and Services Administration (HRSA) projects that the supply of nurses in America will fall 26 percent (more than 1 million nurses) below requirements by the year 2020. In year 2020, Wisconsin's demand for full-time RNs will outstrip the supply by 20 percent (a shortage of 10,200 RNs). New York's shortage will reach 39 percent (54,200 RNs) and Ohio will have a 30 percent shortage (34,000 RNs). California's demand will outstrip its supply by 45 percent (116,600 RNs).

This growing nursing shortage is having a detrimental impact on the entire healthcare system. Numerous studies have shown that nursing shortages contribute to medical errors, poor patient outcomes, and increased mortality rates. A study published in the January/February 2006 issue of Health Affairs showed that hospitals could avoid 6,700 deaths per year by increasing the amount of RN care provided to their patients. This study, "Nurse Staffing in Hospitals: Is There a Business Case for Quality?" by Jack Needleman, Peter Buerhaus, et al. also revealed that hospitals are currently providing 4 million days worth of inpatient care annually to treat avoidable patient complications associated with a shortage of RN care.

Research published in the October 23, 2002, Journal of the American Medical Association also demonstrated that more nurses at the bedside could save thousands of patient lives each year. In reviewing more than 232,000 surgical patients at 168 hospitals, researchers from the University of Pennsylvania concluded that a patient's overall risk of death rose roughly 7 percent for each additional patient above four added to a nurse's workload.

A Joint Commission on the Accreditation of Healthcare Organizations study published in 2002 shows that the shortage of nurses contributes to nearly a quarter of all unexpected incidents that kill or injure hospitalized patients.

NURSING WORKFORCE DEVELOPMENT PROGRAMS

Federal support for the Nursing Workforce Development Programs contained in title VIII of the Public Health Service Act is unduplicated and essential. The 107th Congress recognized the detrimental impact of the developing nursing shortage and passed the Nurse Reinvestment Act (Public Law 107–205). This law improved the title VIII Nursing Workforce Development programs to meet the unique characteristics of today's shortage. This achievement holds the promise of recruiting new nurses into the profession, promoting career advancement within nursing, and improving patient care delivery. However, this promise cannot be met without a significant investment. Prior to the release of President Obama's proposed budget for fiscal year 2010, ANA was strongly advocating Congress to increase funding for title VIII programs by at least $44 million to a total of $215 million. Now that President Obama is requesting $263 million for title VIII programs, we are urging the subcommittee to support this request and fund title VIII programs at $263 million.

Current funding levels are clearly failing to meet the need. In fiscal year 2008, the HRSA was forced to turn away 92.8 percent of the eligible applicants for the Nurse Education Loan Repayment Program (NELRP), and 53 percent of the eligible applicants for the Nursing Scholarship Program (NSP) due to a lack of adequate funding. These programs are used to direct RNs into areas with the greatest need—

including departments of public health, community health centers, and disproportionate share hospitals.

In 1973, Congress appropriated $160.61 million to title VIII programs. Inflated to today's dollars, this appropriation would equal $763.52 million, more than four times the fiscal year 2009 appropriation. Certainly, today's shortage is more dire and systemic than that of the 1970's; it deserves an equivalent response.

Title VIII includes the following program areas:

Nursing Education Loan Repayment Program and Scholarships (NELRP).—This line item is comprised of the NELRP and the NSP. In fiscal year 2009, the NELRP and the NSP received $37 million.

The NELRP repays up to 85 percent of a RN's student loans in return for full-time practice in a facility with a critical nursing shortage. The NELRP nurse is required to work for at least 2 years in a designated facility, during which time the NELRP repays 60 percent of the RN's student loan balance. If the nurse applies and is accepted for an optional third year, an additional 25 percent of the loan is repaid.

The NELRP boasts a proven track record of delivering nurses to facilities hardest hit by the nursing shortage. HRSA has given NELRP funding preference to RNs who work in departments of public health, disproportionate share hospitals, skilled nursing facilities, and federally designated health centers. However, lack of funding has hindered the full implementation of this program. In fiscal year 2008, 92.8 percent of applicants willing to immediately begin practicing in facilities hardest hit by the shortage were turned away from this program due to lack of funding.

The NSP offers funds to nursing students who, upon graduation, agree to work for at least 2 years in a healthcare facility with a critical shortage of nurses. Preference is given to students with the greatest financial need. Like the loan repayment program, the NSP has been stunted by a lack of funding. In fiscal year 2008, HRSA received 3,039 applications for the nursing scholarship. Due to lack of funding, a mere 177 scholarships were awarded. Therefore, 2,862 nursing students (94 percent) willing to work in facilities with a critical shortage were denied access to this program.

Nurse Faculty Loan Program.—This program establishes a loan repayment fund within schools of nursing to increase the number of qualified nurse faculty. Nurses may use these funds to pursue a master's or doctoral degree. They must agree to teach at a school of nursing in exchange for cancellation of up to 85 percent of their educational loans, plus interest, over a 4-year period. In fiscal year 2009, this program received $11.5 million.

This program is vital given the critical shortage of nursing faculty. America's schools of nursing can not increase their capacity without an influx of new teaching staff. Last year, schools of nursing were forced to turn away tens of thousands of qualified applicants due largely to the lack of faculty. In fiscal year 2008, HRSA funded 95 faculty loans.

Nurse Education, Practice, and Retention Grants.—This section is comprised of many programs designed to support entry-level nursing education and to enhance nursing practice. All together, the Nurse Education, Practice, and Retention Grants received $37.3 million in fiscal year 2009.

The education grants are designed to expand enrollments in baccalaureate nursing programs; develop internship and residency programs to enhance mentoring and specialty training, and; provide new technologies in education including distance learning.

Retention grant areas include career ladders and improved patient care delivery systems. The career ladders program supports education programs that assist individuals in obtaining the educational foundation required to enter the profession, and to promote career advancement within nursing. Enhancing patient care delivery system grants are designed to improve the nursing work environment. These grants help facilities to enhance collaboration and communication among nurses and other healthcare professionals, and to promote nurse involvement in the organizational and clinical decisionmaking processes of a healthcare facility. These best practices for nurse administration have been identified by the American Nurse Credentialing Center's Magnet Recognition Program. These practices have been shown to double nurse retention rates, increase nurse satisfaction, and improve patient care.

Nursing Workforce Diversity.—This program provides funds to enhance diversity in nursing education and practice. It supports projects to increase nursing education opportunities for individuals from disadvantaged backgrounds—including racial and ethnic minorities, as well as individuals who are economically disadvantaged. In fiscal year 2008, 85 applications were received for workforce diversity grants, 51 were funded. In fiscal year 2009, these programs received $16 million.

Advanced Nurse Education.—Advanced practice registered nurses (APRNs) are nurses who have attained advanced expertise in the clinical management of health

conditions. Typically, an APRN holds a master's degree with advanced didactic and clinical preparation beyond that of the RN. Most have practice experience as RNs prior to entering graduate school. Practice areas include, but are not limited to: anesthesiology, family medicine, gerontology, pediatrics, psychiatry, midwifery, neonatology, and women's and adult health. Title VIII grants have supported the development of virtually all initial State and regional outreach models using distance learning methodologies to provide advanced study opportunities for nurses in rural and remote areas. In fiscal year 2008, 7,650 advanced education nurses were supported through these programs. In fiscal year 2009, these programs received $64.4 million.

These grants also provide traineeships for masters and doctoral students. Title VIII funds more than 60 percent of U.S. nurse practitioner education programs and assists 83 percent of nurse midwifery programs. more than 45 percent of the nurse anesthesia graduates supported by this program go on to practice in medically underserved communities. A study published last year in the Journal of Rural Health showed that 80 percent of the nurse practitioners who attended a program supported by title VIII chose to work in a medically underserved or health profession shortage area after graduation.

Comprehensive Geriatric Education Grants.—This authority awards grants to train and educate nurses in providing healthcare to the elderly. Funds are used to train individuals who provide direct care for the elderly, to develop and disseminate geriatric nursing curriculum, to train faculty members in geriatrics, and to provide continuing education to nurses who provide geriatric care. In fiscal year 2009, these grants received 4.5 million.

The growing number of elderly Americans and the impending healthcare needs of the baby boom generation make this program critically important. In fiscal year 2006, HRSA continued 8 previously awarded grants and awarded 11 new ones.

NATIONAL INSTITUTE OF NURSING RESEARCH (NINR)

ANA also urges the subcommittee to increase funding for the NINR, one of the Institutes at the National Institutes of Health (NIH). The Institute's research focus transcends disciplines to address issues of health management, symptom management, and caregiving; health promotion and disease prevention; end-of-life care; technology integration; and research capacity development. This research is integral to improving the effectiveness of nursing care. Advances in nursing care arising from behavioral and biomedical research have shown excellent progress in reducing healthcare costs. Research programs supported by NINR address a number of critical public health and patient care questions. The cross-discipline research is driven by real and immediate problems currently facing patients and their families.

Recent NINR funded studies have shown that inadequate nurse staffing increases risks for patients; coping skills training improves teens' self-management of diabetes; a healthcare team helps reduce high blood pressure among inner-city black men; a community-based program improves self-management of arthritis among older Hispanics; home nursing visits benefit low-income mothers and their children; and transitional care improves outcomes for elders after leaving the hospital. NINR is leading the NIH research on end-of-life and palliative care. NINR is also the lowest-funded Institute at NIH. In fiscal year 2009, NINR received $141.88 million. ANA recommends $178 million, or a 25 percent increase more than fiscal year 2009, in fiscal year 2010 NINR funding.

CONCLUSION

While ANA appreciates the continued support of this subcommittee, we are concerned that title VIII funding levels have not been sufficient to address the growing nursing shortage. The nursing shortage will continue to worsen if significant investments are not made. Recent efforts have shown that aggressive and innovative recruitment efforts can help avert the impending nursing shortage—if they are adequately funded.

ANA asks you to meet today's shortage with a relatively modest investment of $263 million in title VIII programs. Additionally, an investment of $178 million in the NINR will help assure that nurses are equipped with the latest information and research needed to provide the best patient care possible.

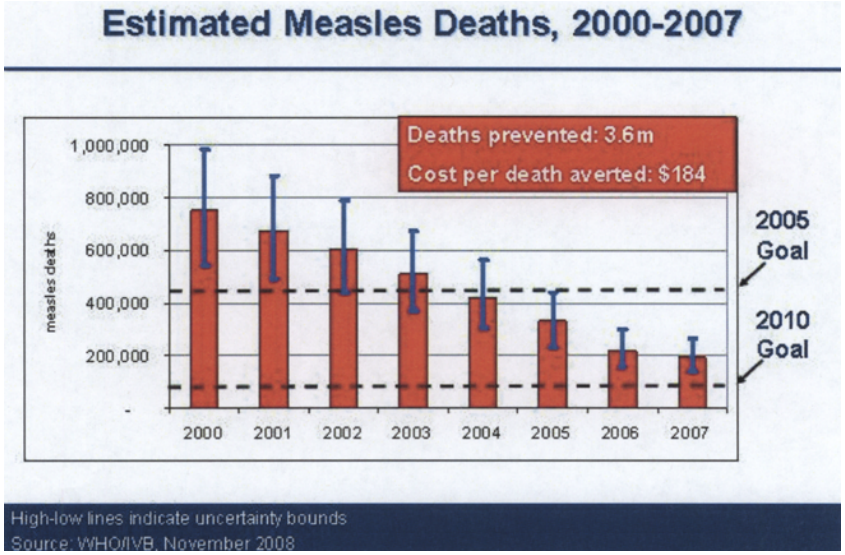
PREPARED STATEMENT OF THE AMERICAN NATIONAL RED CROSS

Chairman Tom Harkin, Ranking Member Thad Cochran, and members of the subcommittee, the American Red Cross and the United Nations Foundation appreciate

the opportunity to submit testimony in support of measles control activities of the U.S. Centers for Disease Control and Prevention (CDC). The American Red Cross and the United Nations Foundation recognize the leadership that Congress has shown in funding CDC for these essential activities. We sincerely hope that Congress will continue to support the CDC during this critical period in measles control.

In 2001, CDC—along with the American Red Cross, the United Nations Foundation, the World Health Organization (WHO), and UNICEF—became one of the spearheading partners of the Measles Initiative, a partnership committed to reducing measles deaths globally. The current U.N. goal is to reduce measles deaths by 90 percent by 2010 compared to 2000 estimates. The Measles Initiative is committed to reaching this goal by proving technical and financial support to governments and communities worldwide.

The Measles Initiative has achieved "spectacular"[1] results by supporting the vaccination of more than 600 million children. Largely due to the Measles Initiative, global measles mortality dropped 74 percent, from an estimated 750,000 deaths in 2000 to 197,000 in 2007. During this same period, measles deaths in Africa fell by 89 percent, from 395,000 to 45,000.



Working closely with host governments, the Measles Initiative has been the main international supporter of mass measles immunization campaigns since 2001. The Initiative mobilized more than $670 million and provided technical support in more than 60 developing countries on vaccination campaigns, surveillance, and improving routine immunization services. From 2000 to 2007, an estimated 3.6 million measles deaths were averted as a result of accelerated measles control activities (increased routine immunization coverage and mass immunization campaigns) at a donor cost of $184/death averted, making measles mortality reduction one of the most cost-effective public health interventions.

Nearly all the measles vaccination campaigns have been able to reach more than 90 percent of their target populations. Countries recognize the opportunities that measles vaccination campaigns provide in accessing mothers and young children, and "integrating" the campaigns with other life-saving health interventions has become the norm. In addition to measles vaccine, Vitamin A (crucial for preventing blindness in under nourished children), de-worming medicine, and insecticide-treated bed nets (ITNs) for malaria prevention are distributed during vaccination campaigns. The scale of these distributions is immense. For example, more than 37 million ITNs were distributed in vaccination campaigns in the last few years. The delivery of multiple child health interventions during a single campaign is far less expensive than delivering the interventions separately, and this strategy increases the potential positive impact on children's health from a single campaign.

[1] The Lancet, Volume 8, page 13 (January 2008).

Countries are well positioned to achieve the 2010 goal and to take a bold step toward achievement of the 2015 Millennium Development Goal #4 of reducing under 5 child mortality. However, achieving the 2010 goal will require:

—Accelerating activities, both campaigns and further efforts to improve routine measles coverage, in India since it is the greatest contributor to the global burden of measles.

—Sustaining the gains in reduced measles deaths, especially in Africa, by strengthening immunization programs to ensure that more than 90 percent of infants are vaccinated against measles through routine health services before their first birthday as well as conducting timely, high-quality follow-up campaigns.

—Securing sufficient funding for measles-control activities both globally and nationally. The Measles Initiative faces a funding shortfall of an estimated $100 million for 2010. Implementation of timely follow-up campaigns is increasingly dependent upon countries funding these activities locally. The decrease in donor funds available at global level to support activities to reduce measles mortality makes increased political commitment and country ownership of the activities critical for achieving and sustaining the goal of reducing measles mortality by 90 percent.

If these challenges are not addressed, the remarkable gains made since 2000 will be lost and a major resurgence in measles deaths will occur.

By controlling measles cases in other countries, U.S. children are also being protected from the disease. Measles can cause severe complications and death. A major resurgence of measles occurred in the United States between 1989 and 1991, with more than 55,000 cases reported. This resurgence was particularly severe, accounting for more than 11,000 hospitalizations and 123 deaths. Since then, measles control measures in the United States have been strengthened and endemic transmission of measles cases have been eliminated here since 2000. However, importations of measles cases into this country continue to occur each year. In 2008, the number of reported measles cases in the United States more than doubled and outbreaks are currently on-going in Virginia, Maryland, Washington, District of Columbia, Pennsylvania, California, and Missouri. These outbreaks cause needless suffering and accrue public health costs which in the United States are upwards of $150,000 to respond to each case.

THE ROLE OF CDC IN GLOBAL MEASLES MORTALITY REDUCTION

Since fiscal year 2001, Congress has provided approximately $42 million annually in funding to CDC for global measles control activities. These funds were used toward the purchase of approximately 415 million doses of measles vaccine for use in large-scale measles vaccination campaigns in more than 60 countries in Africa and Asia, and for the provision of technical support to Ministries of Health in those countries. Specifically, this technical support includes:

—Planning, monitoring, and evaluating large-scale measles vaccination campaigns;

—Conducting epidemiological investigations and laboratory surveillance of measles outbreaks; and

—Conducting operations research to guide cost-effective and high-quality measles control programs.

In addition, CDC epidemiologists and public health specialists have worked closely with the WHO, UNICEF, the United Nations Foundation, and the American Red Cross to strengthen measles control programs at global and regional levels.

While it is not possible to precisely quantify the impact of CDC's financial and technical support to the Measles Initiative, there is no doubt that CDC's support—made possible by the funding appropriated by Congress—was essential in helping achieve the sharp reduction in measles deaths in just 7 years.

The American Red Cross and the United Nations Foundation would like to acknowledge the leadership and work provided by CDC and recognize that CDC brings much more to the table than just financial resources. The Measles Initiative is fortunate in having a partner that provides critical personnel and technical support for vaccination campaigns and in response to disease outbreaks. CDC personnel have routinely demonstrated their ability to work well with other organizations and provide solutions to complex problems that help critical work get done faster and more efficiently.

In fiscal year 2009, Congress has appropriated approximately $41.8 million to fund CDC for global measles control activities. The American Red Cross and the United Nations Foundation thank Congress for the financial support that has been provided to CDC in the past and this year. We respectfully request a total of $51.8

million for fiscal year 2010 funding for CDC's measles control activities so that the gains made to date can continue and the 2010 goal of a 90 percent reduction in measles deaths can be achieved.

The additional funds we are seeking for CDC are critical for:

—Sustaining the great progress in measles mortality reduction in Africa by strengthening measles surveillance and strengthening the delivery of measles vaccine through routine immunization services to protect new birth cohorts;

—Conducting large-scale measles vaccination campaigns in South Asia, especially in India, thus protecting millions of children;

Your commitment has brought us unprecedented victories in reducing measles mortality around the world. In addition, your continued support for this initiative helps prevent children from suffering from this preventable disease both abroad and in the United States.

Thank you for the opportunity to submit testimony.

PREPARED STATEMENT OF THE AMERICANS FOR NURSING SHORTAGE ALLIANCE

The undersigned organizations of the ANSR Alliance greatly appreciate the opportunity to submit written testimony on fiscal year 2010 appropriations for Title VIII—Nursing Workforce Development Programs. The Alliance represents a diverse cross-section of health care and other related organizations, healthcare providers, and supporters of nursing issues that have united to address the national nursing shortage. We stand ready to work with the 111th Congress to advance programs and policies that will ensure that our Nation has a sufficient and adequately prepared nursing workforce to provide quality care to all well into the 21st century. The Alliance, therefore, urges Congress to:

—Appropriate $263.4 million in funding in fiscal year 2010 for the Nursing Workforce Development Programs under title VIII of the Public Health Service Act at the Health Resources and Services Administration (HRSA).

—Fund the Advanced Education Nursing program (section 811) at an increased level on par with the other title VIII programs.

THE EXTENT OF THE NURSING SHORTAGE

Nursing is the largest healthcare profession in the United States. According to the National Council of State Boards of Nursing, there were nearly 3.4 million licensed registered nurses (RNs) in 2006.[1] Nurses and advanced practice nurses (nurse practitioners, nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists) work in a variety of settings, including primary care, public health, long-term care, surgical care facilities, and hospitals. Approximately 59 percent of RN jobs are in hospitals.[2] A Federal report published in 2004 estimates that by 2020 the national nurse shortage will increase to more than 1 million full-time nurse positions. According to these projections, which are based on the current rate of nurses entering the profession, only 64 percent of projected demand will be met.[3] A study, published in March 2008, uses different assumptions to calculate an adjusted projected demand of 500,000 full-time equivalent registered nurses by 2025.[4] According to the U.S. Bureau of Labor Statistics, about 233,000 additional jobs for registered nurses will open each year through 2016, in addition to about 2.5 million existing positions. Based on these scenarios, the shortage presents an extremely serious challenge in the delivery of high-quality, cost-effective services, as the Nation looks to reform the current healthcare system. Even considering only the smaller projection of vacancies, this shortage still results in a critical gap in nursing service, essentially three times the 2001 nursing shortage.

---

[1] National Council of State Boards of Nursing. (2008). 2006 *Nurse Licensee Volume and NCLEX® Examination Statistics*. (Research Brief Vol. 31). On the Internet at: https://www.ncsbn.org/08__2006__LicExamRB__Vol31__21208__MW(1).pdf. (Accessed February 3, 2009).

[2] Bureau of Labor Statistics, U.S. Department of Labor. *Occupational Outlook Handbook, 2008–2009 Edition*, Registered Nurses. On the Internet at: http://www.bls.gov/oco/ocos083.htm (Accessed December 9, 2008).

[3] Health Resources and Services Administration, (2004) *What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?* On the Internet at: http://bhpr.hrsa.gov/healthworkforce/reports/behindrnprojections/4.htm. (Accessed December 9, 2008).

[4] Buerhaus, P., Staiger, D., Auerbach, D. (2008). *The Future of the Nursing Workforce in the United States: Data, Trends, and Implications*. Boston, MA: Jones & Bartlett.

BUILDING THE CAPACITY OF NURSING EDUCATION PROGRAMS

Nursing vacancies exist throughout the entire healthcare system, including long-term care, home care, and public health. Even the Department of Veterans Affairs, the largest sole employer of RNs in the United States, has a nursing vacancy rate of 10 percent. In 2006, the American Hospital Association reported that hospitals needed 116,000 more RNs to fill immediate vacancies, and that this 8.1 percent vacancy rate affects hospitals' ability to provide patient/client care.[5] Government estimates indicate that this situation only promises to worsen due to an insufficient supply of individuals matriculating in nursing schools, an aging existing workforce, and the inadequate availability of nursing faculty to educate and train the next generation of nurses. At the exact same time that the nursing shortage is expected to worsen, the baby boom generation is aging and the number of individuals with serious, life-threatening, and chronic conditions requiring nursing care will increase. Consequently, more must be done today by the Government to help ensure an adequate nursing workforce for the patients/clients of today and tomorrow.

A particular focus on securing and retaining adequate numbers of faculty is essential to ensure that all individuals interested in—and qualified for—nursing school can matriculate in the year they are accepted. In the 2006–2007 academic years, 99,000 qualified applications—or almost 40 percent of qualified applications submitted to prelicensure RN programs—were denied due to lack of capacity.[6] Aside from having a limited number of faculty, nursing programs struggle to provide space for clinical laboratories and to secure a sufficient number of clinical training sites at healthcare facilities.

ANSR supports the need for sustained attention on the efficacy and performance of existing and proposed programs to improve nursing practices and strengthen the nursing workforce. The support of research and evaluation studies that test models of nursing practice and workforce development is integral to advancing healthcare for all in America. Investments in research and evaluation studies have a direct effect on the caliber of nursing care. Our collective goal of improving the quality of patient/client care, reducing costs, and efficiently delivering appropriate healthcare to those in need is served best by aggressive nursing research and performance and impact evaluation at the program level.

THE IMPACT ON THE NATION'S PUBLIC HEALTH INFRASTRUCTURE

The National Center for Health Workforce Analysis reports that the nursing shortage challenges the healthcare sector to meet current service needs. Nurses make a difference in the lives of patients/clients from disease prevention and management to education to responding to emergencies. Chronic diseases, such as heart disease, stroke, cancer, and diabetes, are the most preventable of all health problems as well as the most costly. Nearly half of Americans suffer from one or more chronic conditions and chronic disease accounts for 70 percent of all deaths. In addition, increased rates of obesity and chronic disease are the primary cause of disability and diminished quality of life.

Even though America spends more than $2 trillion annually on healthcare—more than any other Nation in the world—tens of millions of Americans suffer every day from preventable diseases such as type 2 diabetes, heart disease, and some forms of cancer that rob them of their health and quality of life.[7] In addition, major vulnerabilities remain in our emergency preparedness to respond to natural, technological and manmade hazards. An October 2008 report issued by Trust for America's Health entitled "Blueprint for a Healthier America" found that the health and safety of Americans depends on the next generation of professionals in public health.[8] Further, existing efforts to recruit and retain the public health workforce are insufficient. New policies and incentives must be created to make public service careers

[5] American Hospital Association, (2007) *The State of America's Hospitals: Taking the Pulse, Findings from the 2007 AHA Survey of Hospital Leader*. On the Internet at: http://www.aha.org/aha/content/2007/PowerPoint/StateofHospitalsChartPack2007.ppt. (Accessed December 3, 2008).

[6] National League for Nursing, (2009) *Nursing Data Review 2006–2007: Baccalaureate, Associate Degree, and Diploma Programs*. On the Internet at: http://www.nln.org/research/slides/index.htm. (Accessed March 20, 2009).

[7] KaiserEDU.org. "U.S. Health Care Costs: Background Brief." Kaiser Family Foundation. On the Internet at: http://www.kaiseredu.org/topics__im.asp?imID=1&parentID=61&id=358 (Accessed November 24, 2008).

[8] Trust for America's Health. (2008) *Blueprint for a Healthier America: Modernizing the Federal Public Health System to Focus on Prevention and Preparedness*. On the Internet at: http://healthyamericans.org/report/55/blueprint-for-healthier-america (Accessed December 3, 2008).

in public health an attractive professional path, especially for the emerging workforce and those changing careers.

An Institute of Medicine report notes that nursing shortages in U.S. hospitals continue to disrupt hospitals operations and are detrimental to patient/client care and safety.[9] Hospitals and other healthcare facilities across the country are vulnerable to mass casualty incidents themselves and/or in emergency and disaster preparedness situations. As in the public health sector, a mass casualty incident occurs as a result of an event where sudden and high-patient/client volume exceeds the facilities/sites resources. Such events may include the more commonly realized multi-car pile-ups, train crashes, hazardous material exposure in a building or within a community, high-occupancy catastrophic fires, or the extraordinary events such as pandemics, weather-related disasters, and intentional catastrophic acts of violence.

Since 80 percent of disaster victims present at the emergency department, nurses as first receivers are an important aspect of the public health system as well as the healthcare system in general. The nursing shortage has a significant adverse impact on the ability of communities to respond to health emergencies, including natural, technological and manmade hazards.

SUMMARY

The link between healthcare and our Nation's economic security and global competitiveness is undeniable. Having a sufficient nursing workforce to meet the demands of a highly diverse and aging population is an essential component to reforming the healthcare system as well as improving the health status of the Nation and reducing healthcare costs. To mitigate the immediate effect of the nursing shortage and to address all of these policy areas, ANSR requests $263.4 million in funding for the Nursing Workforce Development Programs under title VIII of the Public Health Service Act at HRSA in fiscal year 2010. As part of this funding, the Advanced Education Nursing training program (section 811) should be funded at an increased level on par with the other title VIII programs.

UNDESIGNED ORAGNIZATIONS

Academy of Medical-Surgical Nurses; American Academy of Ambulatory Care Nursing; American Academy of Nurse Practitioners; American Academy of Nursing; American Association of Critical-Care Nurses; American Association of Nurse Anesthetists; American Association of Nurse Assessment Coordinators; American Association of Nurse Executives; American Association of Occupational Health Nurses; American College of Nurse Practitioners.

American Organization of Nurse Executives; American Psychiatric Nurses Association; American Society for Pain Management Nursing; American Society of PeriAnesthesia Nurses; American Society of Plastic Surgical Nurses; Association for Radiologic & Imaging Nursing; Association of Pediatric Hematology/Oncology Nurses; Association of periOperative Registered Nurses; Association of Rehabilitation Nurses; Association of State and Territorial Directors of Nursing.

Association of Women's Health, Obstetric & Neonatal Nurses; Developmental Disabilities Nurses Association; Emergency Nurses Association; Gerontological Advanced Practice Nurses Association; Infusion Nurses Society; International Society of Nurses in Genetics, Inc.; Legislative Coalition of Virginia Nurses; National Association of Clinical Nurse Specialists; National Association of Neonatal Nurses; National Association of Neonatal Nurse Practitioners.

National Association of Nurse Massage Therapists; National Association of Nurse Practitioners in Women's Health; National Association of Orthopaedic Nurses; National Association of Pediatric Nurse Practitioners; National Association of Registered Nurse First Assistants; National Black Nurses Association; National Council of State Boards of Nursing; National Gerontological Nursing Association; National League for Nursing; National Nursing Centers Consortium.

National Nursing Staff Development Organization; National Organization for Associate Degree Nursing; National Organization of Nurse Practitioner Faculties; National Student Nurses' Association, Inc.; Nurses Organization of Veterans Affairs; Oncology Nursing Society; Pediatric Endocrinology Nursing Society; RN First Assistants Policy & Advocacy Coalition; Society of Gastroenterology Nurses and Associates, Inc.; Society of Pediatric Nurses; Society of Trauma Nurses; Wound, Ostomy and Continence Nurses Society.

[9] Institute of Medicine, Committee on the Future of Emergency Care in the United States Health System. (2007) *Hospital-Based Emergency Care: At the Breaking Point*. On the Internet at: http://www.iom.edu/?id=48896. (Accessed December 3, 2008).

PREPARED STATEMENT OF THE AMERICANS FOR NURSING SHORTAGE RELIEF ALLIANCE

The Tri-Council for Nursing, a long-standing alliance focused on leadership and excellence in the nursing profession, is composed of the American Association of Colleges of Nursing, the American Nurses Association, the American Organization of Nurse Executives, and the National League for Nursing. The collaborative leadership of these four professional organizations impacts the breadth of nursing practice, including nurse executives, educators, researchers, and nurses providing direct patient care. The Tri-Council asks the subcommittee to provide $215 million in fiscal year 2010 for the Nursing Workforce Development Programs under title VIII of the Public Health Service Act, administered by the Health Resources and Services Administration (HRSA).

In light of the economic challenges facing our country today, the Tri-Council urges the subcommittee to focus on the larger context of building the capacity needed to meet the increasing health care demands of our Nation's population. Such public policy will require sustained investments aimed at refocusing the current health care system toward promoting health, while simultaneously improving value for our dollars. The title VIII Nursing Workforce Development Programs are proven policy instruments that help assure an adequately prepared nursing workforce. These programs—

—Increase access to healthcare in underserved areas through improved composition, diversity, and retention of the nursing workforce;
—Advance quality care by strengthening nursing education and practice; and
—Develop the identification and use of data, program performance measures, and outcomes to make informed decisions on nursing workforce matters.

The Tri-Council applauds the subcommittee for the emergency supplement provided across all the health professions programs via the American Recovery and Reinvestment Act (Public Law 111–5). We also value the enacted fiscal year 2009 omnibus appropriations bill (Public Law 111–8) providing $171.031 million specifically for the title VIII Nursing Workforce Development Programs. These investments are a critical component supporting our healthcare infrastructure.

Examining the broad context, the healthcare industry remains the largest industrial complex in the United States. Studies of the Nation's gross domestic product (GDP) show healthcare spending achieving a relatively high rate of real growth, with the portion of GDP devoted to healthcare growing from 8.8 percent in 1980 to 16.2 percent of GDP in 2007. While healthcare spending demands greater efficiencies, it also has helped to sustain our Nation's sagging economy.

Since 2001, healthcare is virtually the only sector that added jobs to the economy on a net basis. In March 2009, the U.S. Bureau of Labor Statistics (BLS) reported continued growth in the healthcare sector, despite our economy's freefall in a down cycle with unemployment reaching 8.1 percent in February 2009. With that month's job loss of 681,000 realized in nearly all major industries, BLS also reported the addition of 27,000 new jobs at hospitals, long-term care facilities, and other ambulatory care settings.

As the predominant occupation in the healthcare industry, the nurse workforce likely is filling most of the noted job openings. Nurses are the front line of healthcare delivery throughout the Nation, and the BLS numbers support that description showing the nurse workforce at well over four times the size of the medical workforce. Increased fiscal year 2010 investments in title VIII will help counterbalance the economic meltdown threatening nursing programs operating in congressional districts and serving communities by supporting nursing education—providing title VIII loans, scholarships, traineeships, and programmatic funding.

NURSING SHORTAGE OUTPACES CAPACITY-BUILDING

The Tri-Council contends that an episodic increased funding of title VIII will not fully fill the gap generated by an 11-year nursing shortage felt throughout the entire U.S. health system and projected to continue. The BLS projections estimate that RNs will have the greatest growth rate of all U.S. occupations in the period spanning 2006–2016, with more than 1 million new and replacement nurses needed by 2016. Despite this projected expansion in the profession, numerous other studies anticipate a growing national nurse workforce shortage to intensify as the baby boomer cohort ages, the current nurse workforce retires, and the demand for healthcare accrues.

Funding levels for the HRSA Title VIII Nursing Workforce Programs are failing to support the numerous qualified applicants seeking assistance from these programs. In the last 3 years, virtually flat title VIII funding, along with inflation and increased educational and administrative costs, has decreased purchasing power. According to HRSA statistics, in fiscal year 2006 the title VIII programs directly or

indirectly supported 91,189 nurses and nursing students. In fiscal year 2007, the number of grantees dropped by 21 percent and in 2008 the grantees dropped by 28 percent to support only 51,657 nurses and nursing students.

Additionally, schools of nursing continue to suffer from a growing shortage of faculty, a troubling infrastructure trend that exacerbates the nurse workforce demand-supply gap. According to a study conducted by the American Association of Colleges of Nursing (AACN) in 2008, schools of nursing turned away 49,948 qualified applicants to baccalaureate and graduate nursing programs. The top reasons cited for not accepting these potential students was a lack of qualified nurse faculty and resource constraints. Without faculty, nursing education programs are prevented from admitting many qualified students who are applying to their programs. (Data are Internet accessible at http://www.aacn.nche.edu/Media/NewsReleases/ 2009/ workforcedata.html.)

The AACN survey results are reinforced by the National League for Nursing's (NLN) study of all types of prelicensure RN programs, which prepare students to sit for the RN licensing exam (i.e., baccalaureate, associate, and diploma degree). The NLN statistics indicate more than 1,900 unfilled full-time faculty positions existed nationwide in 2007, affecting more than one-third (36 percent) of all schools of nursing. Significant recruitment challenges were found with 84 percent of nursing schools attempting to hire new faculty in 2007–2008, more than three-quarters (79 percent) reporting recruitment as "difficult" and almost 1 in 3 schools found it "very difficult." The two main difficulties cited were "not enough qualified candidates" (cited by 46 percent of schools), followed by inability to offer competitive salaries—cited by 38 percent. (Data are Internet accessible at www.nln.org/research/slides/ index.htm.)

THE FUNDING REALITY

If the United States is to reverse the eroding trends in the nurse and nurse faculty workforce, the Nation must make a significant investment in the title VIII programs, which are charged to favor institutions educating nurses for practice in rural and medically underserved communities. At adequate funding levels the title VIII programs supporting the education of registered nurses, advanced practice registered nurses, nurse faculty, and nurse researchers have demonstrated successful intervention strategies to solving past nursing shortages.

A brief examination of the HRSA title VIII illustrates the robust nature of these programs:

Section 811.—The Advanced Education Nursing (AEN) Program funds traineeships for individuals preparing to be nurse practitioners, nurse midwives, nurse administrators, public health nurses, and nurse educators, among other graduate-level education nursing roles. The AEN awards assisted nurse education programs to support 3,419 graduate nursing students in fiscal year 2008.

Section 821.—The Nursing Workforce Diversity Program funds grants and contracts to schools of nursing, nurse-managed health centers (NMCs), academic health centers, State and local governments, and nonprofit entities to increase nursing education opportunities for individuals from disadvantaged backgrounds and under-represented populations among RNs. This program—of proven intervention strategies—supported 18,741 students in fiscal year 2008, seeking to ensure a culturally diverse workforce to provide healthcare for a culturally diverse patient population.

Section 831.—The Nurse Education, Practice and Retention Program provides support for academic and continuing education projects designed to strengthen the nursing workforce. Several of this program's priorities apply to quality patient care including developing cultural competencies among nurses and providing direct support to establishing or expanding NMCs in noninstitutional settings to improve access to primary healthcare in medically underserved communities. The program also provides grants to improve retention of nurses and enhanced patient care. In fiscal year 2008, approximately 6,000 nurses and nursing students were supported.

Section 846.—The Nurse Loan Repayment and Scholarship Programs (NELRP) is divided into two primary elements. The NELRP assists individual RNs by repaying up to 85 percent of their qualified educational loans over 3 years in return for their commitment to work at health facilities with a critical shortage of nurses, such as departments of public health, community health centers, and disproportionate share hospitals. In fiscal year 2008, of the 5,875 applications reviewed by HRSA, only 435 students (7.4 percent) received NELRP awards. Similarly, the Nurse Scholarship Program (NSP) provides financial aid to individual nursing students in return for working a minimum of 2 years in a healthcare facility with a critical nursing shortage. In fiscal year 2008, NSP turned away most of the applicants owing to a lack of adequate funding, resulting in the distribution of only 169 student awards.

Section 846A.—The Nurse Faculty Loan Program (NFLP) supports the establishment and operation of a loan fund within participating schools of nursing to assist RNs to complete their education to become nursing faculty. The NFLP grants provide a cancellation provision in which 85 percent of the loan, plus interest, may be cancelled over 4 years in return for serving as full-time faculty in a school of nursing. NFLP granted 729 awards in fiscal year 2008.

Section 855.—The Comprehensive Geriatric Education Grant Program focuses on training, curriculum development, faculty development, and continuing education for nursing personnel caring for the elderly. In fiscal year 2008, 18 awards were made in this program.

While title VIII is the largest source of Federal funding for nursing, the current level of investment falls short of remedying a chronic underfunding of the Nursing Workforce Development Programs, compared to the existing and imminent shortages these programs address. The title VIII authorities are capable of providing flexible and effective support to assist students, schools of nursing, and health systems in their efforts to recruit, educate, and retain registered nurses. Recent efforts have shown that aggressive and innovative strategies can help avert the nurse and nurse faculty shortages. The Tri-Council for Nursing understands the competing priorities faced by this Congress, but we also maintain that title VIII Nursing Workforce Development Programs must be funded at an adequate level to begin to impact the shortage and to address the complex health needs of the Nation. The contributions of nurses in our healthcare system are multifaceted, and are impacted directly by the level of Federal funding that supports nursing programs.

PREPARED STATEMENT OF AMERICA'S PROMISE ALLIANCE

THE DROPOUT CRISIS: AMERICA'S NEW SILENT EPIDEMIC

Chairman Inouye, Vice Chairman Cochran, members of the subcommittee, thank you for the opportunity to testify on the most pressing issue facing our Nation: the high school dropout crisis. America's low graduation rate is our most pressing issue as a Nation and the culmination of years of failure. Everyone with a stake in the future of our children and the Nation—schools, parents, businesses, community, and faith-based organizations—have a role to play in the resolution of this crisis. We all must work together in new and unprecedented ways in support of our children.

In addition to its significant social implications, the potential economic impact of the dropout crisis shows why this issue is our most critical national challenge. Today, America is the only industrialized nation in the world where children are less likely to graduate from high school than their parents. A student drops out of high school every 26 seconds, with 1.2 million kids falling through the cracks each year. The national dropout crisis has resulted in 3 in 10 students failing to graduate with their class, a percentage that doubles for minority, urban, and low-income students.

When President Obama and Secretary Duncan say that a long-term, sustainable economic recovery is only possible if we strengthen our education system, they are precisely correct. The dropout crisis may not be as visible or swift as other important issues problems facing this Congress and our new administration, but its implications are just as severe and lasting. The dropout crisis, persisting without acknowledgment or resolution, has emerged as America's "silent epidemic." Although we are working diligently to raise public awareness of this issue, it has yet to permeate the national agenda. This makes it easier for our actions to be slow, inadequate, or even worse, nonexistent.

Strengthening our graduation rate will take historic focus, unprecedented collaboration, and significant resources. The required investments in our young people are the most cost-effective investments we can make. We must understand that our future is at stake, and we must resolve that failure is not an option.

MAGNITUDE OF THE DROPOUT CRISIS

Between 25 to 30 percent of high school students do not graduate on time. For young people of color, on-time graduation is a 50–50 proposition, the flip of a coin. A new report commissioned by America's Promise Alliance and developed by the Editorial Projects in Education Research Center found that only 53 percent of all young people in the Nation's 50 largest cities graduate on time. Despite some progress made by several of these cities between 1995 and 2005, the average graduation rate of the 50 largest cities is well below the national average of 71 percent,

and an 18 percentage point urban-suburban gap remains.[1] While the Nation's 50 largest school districts educate 1 out of 8 high school students; they produce one-quarter of the Nation's students who do not graduate on time.[2]

A significant graduation rate gap exists between urban and suburban school districts: 18 percentage points separate the metropolitan areas of the 50 largest cities from their suburban counterparts.[3] Fifty-nine percent of high school students in urban school districts graduate on time from high school versus 77 percent of their suburban counterparts. The urban-suburban gap is most prominent in the Northeast and Midwest, with Baltimore, Cleveland, Columbus, and Milwaukee experiencing the largest differentials.[4]

Economic Impact

The economic significance of the Nation's low graduation rate cannot be overstated, as countries that out-educate us today will out-compete us tomorrow. A report from McKinsey & Company estimated the economic impact in 2008 if the United States had closed the achievement gap 15 years after A Nation at Risk's 1983 release. Their findings amount to nothing less than a multibillion dollar lost opportunity and what they term as a "permanent national recession." Closing the international achievement, racial, and income gaps would have produced up to a 30 percent gain in GDP, or $4.2 trillion.

On an individual level, high school graduation is a determining factor of a student's future income. High school dropouts are less likely to be steadily employed and earn less income when they are employed compared with those who graduate from high school. Only 37 percent of high school dropouts nationwide are steadily employed and are more than twice as likely to live in poverty.[5]

High school dropouts account for 13 percent of the adult population, but earn less than 6 percent of all dollars earned in the United States. In the 50 largest cities, the median income for high school dropouts is $14,000, lower than the median income of $24,000 for high school graduates and $48,000 for college graduates. The Editorial Projects in Education Research Center estimates that earning a high school diploma would increase one's annual income by an average of 71 percent, or $10,000.[6]

CONTRIBUTORS TO THE CRISIS

There are two major influences in students' lives that impact their scholastic achievement: what happens inside the school building and what happens outside of it. A number of factors contribute to the high school dropout crisis, ranging from the quality of standards and rigor in our high schools to the issues impacting students before they ever step foot into the classroom.

In 1983, A Nation at Risk recommended that schools, colleges, and universities adopt more rigorous, measurable standards for academic performance and higher expectations for student conduct. Today, few disagree with the need to raise expectations of student performance. We must offer our students challenging curricula that are aligned with the expectations of college and the needs of our future workforce. We need stronger, internationally benchmarked standards, so that students, educators, and parents understand the effectiveness of the educational system in which they are part.

Equally important, though not duly recognized, is the importance of a student's living and learning environment in affecting how he or she performs in the classroom. Schools cannot shoulder the responsibility of educating our children and youth on their own. Every year, our students spend about 1,150 waking hours in school, and nearly five times that number (4,700 waking hours) in their families and communities.[7] Today's teachers have to act as mothers, fathers, social workers, and

---

[1] Christopher Swanson (2009). *Cities in Crisis 2009: Closing the Graduation Gap: Educational and Economic Conditions in America's Largest Cities*. Bethesda, Maryland: Editorial Projects in Education Research Center.

[2] The principal school districts of America's 50 largest cities collectively educate 1.7 million public high school students and produce 279,000 of the 1.2 million high school students who do not graduate on time (Ibid., p. 13).

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] David Berliner (2009). *Poverty and Potential: Out-of-School Factors and School Success*. Boulder and Tempe: Education and the Public Interest Center and Education Policy Research Unit. Retrieved May 6, 2009 from http://epicpolicy.org/publication/poverty-and-potential.

sometimes even police officers, in addition to the central task of educating our students.

In its recent report, Parsing the Achievement Gap II, the Educational Testing Service (ETS) outlined 16 factors that correlate with student achievement; more than half of these factors are present in a child's life before or beyond the classroom, including forced mobility, hunger and nutrition, and summer achievement gain and loss.[8] Today's educators must address the confluence of many of these factors at the same time, which are disproportionately concentrated in the Nation's poorest schools. Less than 4 percent of white students attend schools where 70–100 percent of the students are poor. However, 40 percent of black and Latino students attend such high-poverty schools.

It is important that we have a thorough understanding of the prevalence and importance of the larger environmental factors in a student's life that influence their academic success. Unless we address these foundational issues, not even the best teachers with the highest quality curriculum will be able to ensure that every student graduates ready for college.

THE SOLUTION: A COMPREHENSIVE APPROACH

The dropout crisis calls for a holistic solution, driven by national leadership and local action. Research demonstrates that young people need five core resources to be successful in life. We refer to them as the "five promises:" caring adults, safe places, a healthy start, effective education, and opportunities to serve. These promises provide a simple but powerful framework for a robust national strategy to end the dropout crisis, and they are at the heart of the Dropout Prevention Campaign launched by America's Promise Alliance in April 2008.

America's Promise Alliance Dropout Prevention Campaign

The campaign begins with high-level summits in all 50 States and the 55 cities with the largest dropout rates in order to raise the visibility of America's "silent epidemic." Within 60 days of each summit, States, and communities are required to develop action plans that include a cross section of stakeholders: educators, the business community, nonprofit organizations, and students. To date, 36 high-level summits have been held in cities nationwide—bringing together more than 14,000 mayors and Governors, business owners, child advocates, school administrators, students, and parents to develop workable solutions and action plans.

Already, cities and States that held summits last year have started implementing changes based on the discussions and early results are promising. Detroit has set a 10-year goal to graduate 80 percent of its youth from the 35 high schools with significant dropout rates and created the Greater Detroit Venture Fund, a $10 million effort to assist these efforts. Louisville set a 10-year goal to cut dropout rates in half, and Tulsa's summit resulted in an innovative career exploration program.

Grad Nation

The Dropout Summits and the action plans they produce are a critical first step, but communities also need tools and guidelines for sustainably raising their graduation rates. Grad Nation is a first-of-its-kind research-based toolkit for communities seeking to reduce their dropout rate and better support young people through high school graduation and beyond. Commissioned by the Alliance and authored by Robert Balfanz, Ph.D. and Joanna Honig Fox from the Everyone Graduates Center at Johns Hopkins University and John M. Bridgeland and Mary McNaught of Civic Enterprises, Grad Nation brings together—in one place—the Nation's best evidence-based practices for keeping young people in school. Grad Nation gives communities a comprehensive set of tools to rally collective support, develop effective action strategies, prepare youth for advanced learning, and build strong, lasting partnerships around ending the dropout crisis.

The Gallup Student Poll

The youth voice is often overlooked and not included in the national dialogue on dropout prevention. In order to determine effective solutions to the crisis, their voices must be heard. America's Promise Alliance (APA), along with Gallup and the American Association of School Administrators, recently launched the Gallup Student Poll, the largest-ever survey of students in grades 5–12. The poll measures

[8] Paul Barton and Richard Coley (2009). *Parsing the Achievement Gap II*. Princeton, New Jersey: Educational Testing Service. Note: This report uses the term "frequent school changes." I use the term "forced mobility" because it more accurately describes the living circumstances of our most at-risk students that, in turn, causes reductions in school performance. For additional information, see Duffield and Lovell (endnote 20).

three key metrics—hope, engagement, and well-being—that research has shown have a meaningful impact on educational outcomes and more importantly, can be improved through deliberate action by educators, school administrators, community leaders.

The March 2009 polling brought in nearly 71,000 responses from students in 18 States, 58 districts, and more than 330 schools. Half of those surveyed (50 percent) reported that they are not hopeful, with one-third (33 percent) indicating that they are stuck, while 17 percent feel discouraged. Just half (52 percent) said they were treated with respect all day. The findings from this and future Gallup Student Polls will highlight causes of the dropout crisis from the perspective of students themselves. The youth voice is a critical part of the ongoing dialogue about dropout prevention, and they can help us develop initiatives that sustainably change outcomes for our young people.

SERVICE AND ENGAGEMENT

The recently passed Edward M. Kennedy Serve America Act will boost the efforts of our Alliance's service initiatives through the most sweeping expansion of our country's service programs in 16 years. APA believes service is a bedrock strategy for tackling issues such as the high school dropout and college-readiness crises. By affirming the power of service to address some of the biggest challenges now facing the United States, this landmark piece of legislation will help reverse current dropout rates in communities across the country.

The Serve America Act will update and strengthen national service programs, including service-learning, a teaching method that combines volunteer service and a rigorous curriculum to engage young people in solving community problems. Research has shown that service-learning helps students achieve academically, develop civic and career-related skills, increase their self-confidence, and heighten their respect for diversity. Service-learning is a key component of our objective to help communities in this time of need and to ensure brighter futures for our children and youth.

Many students who ultimately drop out of school say they become disengaged during the middle-school years. The choices young people make at this age could set them on a course for active citizenship and engaged learning, or down a path of risky behavior and potential failure. Not enough opportunities currently exist for these children to engage in active learning through real-world experiences, such as school or community-based learning and career-centric activities.

Our national action strategy, "Ready for the Real World," brings together partners from professional societies and businesses looking for ways to connect with and prepare their future workforce. By designing "real-world" experiences relevant to them, the initiative exposes youth to service learning and career exploration, increasing their motivation to achieve in school, college, and life.

Through America's Promise, partners provide a range of resources and real-life experiences, such as job shadowing and mentoring programs. Ready for the Real World established innovative after-school and summer programs for youth, which are integrated into school curriculums afterwards. This type experiential learning has inspired at-risk youth to achieve academically, pursue higher goals, and contribute positively to their communities.

PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association (APA), the largest scientific and professional organization representing psychology in the United States and the world's largest association of psychologists, works to advance psychology as a science, as a profession and as a means of promoting human welfare. APA is grateful for the opportunity to submit written testimony on goals for the fiscal year 2010 appropriations bill. Below we enumerate recommendations for specific programs.

Bureau of Health Professions, Graduate Psychology Education Program.—The APA requests that the subcommittee include $7 million for the Graduate Psychology Education Program (GPE) within the Health Resources and Services Administration. This nationally competitive grant program provides integrated healthcare services to underserved communities—those individuals most in need of mental and behavioral health support with the least access to these services, including children, older adults, chronically ill persons, and victims of abuse or trauma.

Since 2002, GPE grants have provided interdisciplinary training for approximately 2,500 graduate students of psychology and other health professions to provide integrated healthcare services to underserved populations. There have been 70 grants in 30 States. Students benefiting from GPE grants have worked with more

than 30 different types of health professionals. GPE funding has allowed programs to double the number of students they are able to train: and more students trained means more impact on underserved populations. The GPE Program currently supports training grants at 18 academic institutions and training sites (e.g., children's and VA hospitals) throughout the Nation. All of the approximately 900 psychology graduate students who benefited from GPE funds are expected to work with underserved populations and 34–100 percent will be working in underserved areas immediately after completing the training.

Currently authorized under the Public Health Service Act (Public Law 105–392, section 755(b)(1)(J)) and funded under the "Allied Health and Other Disciplines" account in the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill, this program has proven effective for meeting the growing health needs of our Nation's least served communities. This year, specific authorizing legislation has been introduced in the U.S. Senate (S. 811) as well as in the U.S. House of Representatives (H.R. 2066).

The GPE program specifically seeks to support our Nation's aging and veteran populations. Twenty percent of people older than 55 suffer from a mental disorder (2005); mental disorders affect physical health and the ability to function (2008); and approximately 70 percent of all primary care visits by older adults are driven by psychological factors. In addition, older adults with chronic illnesses such as heart disease have higher rates of depression than those medically well, and depression lowers immunity and may compromise a person's ability to fight infection (2008). One in five military personnel returning from Iraq and Afghanistan report symptoms consistent with major depression, generalized anxiety or post-traumatic stress disorder (PTSD) (2008). According to the Pentagon the number of U.S. troops diagnosed by the military with PTSD jumped nearly 50 percent from 2006 to 2007 as more troops served lengthy and repeated tours in Iraq and Afghanistan (2008). Furthermore, the U.S. Army reported in May (2008) that more U.S. soldiers committed suicide in 2007 than at any time since the first Gulf War.

Providing $7 million in fiscal year 2010 would allow for 30 additional GPE grants including those that focus solely on the needs of older adults and returning military personnel and their families. There are approximately 900 eligible universities, professional schools and hospitals in every State nationwide.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

Garrett Lee Smith Memorial Act Programs—Campus Suicide Prevention Program

APA encourages the subcommittee to increase funding for the programs at SAMHSA authorized by the Garrett Lee Smith Memorial Act, especially the Campus Suicide Prevention program.

The Campus Suicide Prevention program is a small, but important program that seeks to assist college and universities raise awareness about mental and behavioral health to prevent suicides. By providing educational materials and outreach, the Campus Suicide Prevention program increases awareness about the signs of and risks of mental health problems and ensures greater success in college completion for those at risk of school failure because of concerns like stress, depression, eating disorders, risk behaviors, and suicidal thoughts.

There is a special need to increase funds for this program during the difficult economic times facing our Nation. A recent APA survey found that 18–29 year olds felt the economy added to their stress more than other concerns, like relationships or housing, a change from past years. The American College Counseling Association's 2008 Survey of College Counseling Center Directors found that "95 percent of directors report that the recent trend toward greater number of students with severe psychological problems continues to be true on their campuses." Addressing the mental and behavioral health needs of students in college and university settings can mean the difference between school failure or graduation on one hand, and life and death on the other.

Center for Mental Health Services, Minority Fellowship Program (MFP).—While minorities are projected to comprise 40 percent of the U.S. population by 2025, only 23 percent of recent doctorates in psychology, social work, and nursing were awarded to minorities. The MFP's mission is to address this need by increasing the number of minority mental health professionals and by training mental health professionals to become culturally competent. APA urges Congress to fund the Minority Fellowship Program at $7.5 million for fiscal year 2010.

Emergency Mental Health and Traumatic Stress Services Branch: Child Trauma.—SAMHSA has made tremendous efforts in this area through the outstanding National Child Traumatic Stress Network program. APA urges Congress to appropriate full funding for the National Child Traumatic Stress Initiative at the origi-

nally authorized level of $50 million for fiscal year 2010. To ensure continuity of leadership in this program, APA recommends the subcommittee encourage SAMHSA to expand the duration of NCTSI grant awards from 3 years to 6 years.

Center for Substance Abuse Prevention (CSAP): Substance Use and Mental Disorders of Persons with HIV.—According to recent reports, almost half of those with HIV/AIDS screened positive for illicit drug use or mental disorders. Unfortunately, healthcare providers fail to detect mental disorders and substance use problems in almost half of patients with HIV/AIDS. Several diagnostic screening tools are available for use by nonmental health staff. APA encourages SAMHSA and CDC to collaborate with HRSA to train healthcare providers to screen HIV/AIDS patients for mental health and substance use problems.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Lifespan Respite Program Family Caregivers.—Respite can provide family caregivers with relief necessary to maintain their own health, bolster family stability and well-being, and avoid or delay more costly nursing home or foster care placements. Under the Lifespan Respite Care Program, funds are available to improve access to respite for family caregivers. APA urges Congress to fund the Lifespan Respite Care Program at its authorized level of $71.1 million for fiscal year 2010.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

National Center for Injury Prevention and Control: Child Maltreatment Prevention at Community Health Centers (CHCs).—APA recommends the implementation of at least 10 demonstration projects of evidence-based preventative parenting programs through CHCs. Technical assistance to demonstration sites should be provided by organizations with expertise in parent-child relationships, parenting programs, prevention of child maltreatment, and the integration of behavioral health in primary and community health center settings. APA recommends evaluating the demonstration projects' implementation and outcomes, including health and mental health outcomes.

National Center for Health Statistics (NCHS): Eating Disorders.—Eating disorders may have serious, chronic effects on one's quality of life and often co-occur with significant physical and mental health problems. However, the impact of these disorders has not yet been appropriately investigated. APA urges the subcommittee to encourage CDC to increase support for surveillance and research efforts regarding the incidence, morbidity, and mortality rates of eating disorders, including anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorders not otherwise specified across age, ethnicity and gender subgroups.

Sexual and Gender Identity Inclusion in Health Data Collection.—The National Health Interview Survey (NHIS) is the most comprehensive and widely referenced Federal health statistics survey, yet currently does not include any question concerning sexual orientation and gender identity. APA recommends the allocation of an additional $2 million in funding for NHIS in the NCHS budget, to enable Government agencies to better understand and plan for the unique health needs of lesbian, gay, bisexual, and transgender individuals.

Administration for Children and Families.—Sexualization of Girls. Throughout U.S. culture, female children, adolescents, and adults are frequently depicted and treated in a sexualized manner that objectifies them. Research links sexualization with three of the most common mental health problems of female children, adolescents, and adults: eating disorders, depression or depressed mood, and low self-esteem. APA encourages HHS to fund media literacy and youth empowerment programs to prevent and counter the effects of the sexualization of female children, adolescents, and adults.

National Institutes of Health (NIH).—APA supports the request of the Ad Hoc Group and Coalition for Health Funding, urging an increase of at least 7 percent for the NIH. Years of sub-inflation budgets have stressed the NIH research enterprise, and made sharing of resources among programs more difficult. The fiscal year 2009 increase provided by Congress begins to ameliorate the budget difficulties, but scientific research will benefit from a smooth, steady and predictable rise in spending.

APA likewise supports an increase of 7 percent (to $28.61 million) for the NIH Office of Behavioral and Social Sciences Research in the Office of the Director. This small but important office coordinates behavioral and social science research initiatives across Institutes and Centers, and helps form partnerships to leverage the intellectual and monetary resources that make good science possible.

The behavioral and social sciences are leading proponents of cooperation and cost-sharing in cross-cutting NIH initiatives. APA supports NIH's decision to authorize

a Basic Behavioral and Social Sciences Research "Blueprint," to which several Institutes would contribute, to strengthen NIH funding of basic research in the behavioral and social sciences. This innovation will build creative cooperation and cost-sharing, and help plug gaps in NIH-supported basic research.

A key area of cooperation is in research on obesity. Given the role of obesity as a risk factor for the development of cardiovascular disease, diabetes, cancer, and arthritis, many of NIH's Institutes are collaborating with investigators and other Institutes to develop new ways to prevent and treat obesity and overweight as well as fostering the adoption of positive health behaviors.

For example, the Eunice Kennedy Shriver National Institute of Child Health and Human Development supports research into physical activity and eating behaviors and that examines the impact of family and peer support, developmental and social context, school-based interventions, which include the use of media and literacy, motivation, and use of various behavioral approaches to influence motivation in physical activity, food choices, and media use.

Alcohol and tobacco use are among the leading causes of death and disability in the United States, but NIH research funding to prevent, understand the etiology of, and treat tobacco and alcohol addiction is not commensurate with the public health burden of those diseases. APA suggests that as the NIH Scientific Management Review Board (SMRB) undertakes its review of the NIH organizational structure to optimize the research of substance use, abuse and addiction, that it also quantify the amount of NIH research funding dedicated to studies of alcohol, tobacco use and illicit substance use. Further, APA recommends that the SMRB evaluate the proportion of all substance use research funding at NIH compared to CDC estimates of the public health burden of disease (and costs to the criminal justice system) and consider a reapportionment of NIH funding to Institutes based on those findings.

DEPARTMENT OF EDUCATION

Office of the Director (OD).—Culturally and Linguistically Appropriate Education. Ethnically diverse children and American Indian/Alaska native children are performing at far lower levels than other students. APA urges the subcommittee to increase support for educational systems and the strengthening of programs that meet the unique cultural, linguistic and educational needs of ethnic minority and AI/AN students from pre-school to graduate-level education.

Office of Safe and Drug-free Schools: Bullying Prevention.—Bullying directly affects about one-third of American school children in a given semester. APA urges appropriate Federal funding to support the implementation of effective, research-based, and comprehensive bullying prevention programs.

National Institute on Disability and Rehabilitation Research: Disability Research.—APA recommends that NIDRR pursue mental health-related research proposals through its investigator-initiated and other grants programs, and sponsor studies on the impacts of socio-emotional, behavioral, and attitudinal aspects of disability.

ELEMENTARY AND SECONDARY SCHOOL COUNSELING PROGRAM

APA requests that the subcommittee increase funds for the Elementary and Secondary School Counseling program. Authorized by the Elementary and Secondary Education Act's Fund for the Improvement of Education, this program increases the range, availability, quantity, and quality of counseling services in the elementary and secondary schools across the country.

PREPARED STATEMENT OF THE AMERICAN PUBLIC POWER ASSOCIATION

The American Public Power Association (APPA) is the national service organization representing the interests of more than 2,000 municipal and other State and locally owned utilities throughout the United States (all but Hawaii). Collectively, public power utilities deliver electricity to 1 of every 7 electricity consumers (approximately 45 million people), serving some of the Nation's largest cities. However, the vast majority of APPA's members serve communities with populations of 10,000 people or less.

We appreciate the opportunity to submit this statement supporting funding for the Low-Income Home Energy Production Assistance Program (LIHEAP) for fiscal year 2010.

APPA has consistently supported an increase in the authorization level for LIHEAP. The administration's fiscal year 2010 budget requests $3.2 billion for LIHEAP. APPA supports a level of $5.1 billion for the program.

APPA is proud of the commitment that its members have made to their low-income customers. Many public power systems have low-income energy assistance programs based on community resources and needs. Our members realize the importance of having in place a well-designed, low-income customer assistance program combined with energy efficiency and weatherization programs in order to help consumers minimize their energy bills and lower their requirements for assistance. While highly successful, these local initiatives must be coupled with a strong LIHEAP program to meet the growing needs of low-income customers. In the last several years, volatile home-heating oil and natural gas prices, severe winters, high utility bills as a result of dysfunctional wholesale electricity markets and the effects of the economic downturn have all contributed to an increased reliance on LIHEAP funds.

Also when considering LIHEAP appropriations this year, we encourage the subcommittee to provide advanced funding for the program so that shortfalls do not occur in the winter months during the transition from one fiscal year to another. LIHEAP is one of the outstanding examples of a State-operated program with minimal requirements imposed by the Federal Government. Advanced funding for LIHEAP is critical to enabling States to optimally administer the program.

Thank you again for this opportunity to relay our support for increased LIHEAP funding for fiscal year 2010.

PREPARED STATEMENT OF THE ASSOCIATION FOR PSYCHOLOGICAL SCIENCE

SUMMARY OF RECOMMENDATIONS

—As a member of the Ad Hoc Group for Medical Research Funding, Association for Psychological Science (APS) recommends $32.4 billion for the National Institutes of Health (NIH) in fiscal year 2010.

—APS requests subcommittee support for behavioral and social science research and training as a core priority at NIH in order to: better meet the Nation's health needs, many of which are behavioral in nature; realize the exciting scientific opportunities in behavioral and social science research, and; accommodate the changing nature of science, in which new fields and new frontiers of inquiry are rapidly emerging.

—Given the critical role of basic behavioral science research and training in addressing many of the Nation's most pressing public health needs, we ask the subcommittee to ensure that NIH leadership carries out its plan to create a cross-NIH basic behavioral research funding initiative, and coordinates with all Institutes and Centers to provide support for basic behavioral science research.

—APS encourages the subcommittee to support behavioral science priorities at individual Institutes. Examples are provided in this testimony to illustrate the exciting and important behavioral and social science work being supported at NIH.

Mr. Chairman, members of the subcommittee: My name is Dr. Amy Pollick, and I am speaking on behalf of the APS. Thank you for the opportunity to provide this statement on the fiscal year 2010 appropriations for the NIH. As our organization's name indicates, APS is dedicated to all areas of scientific psychology, in research, application, teaching, and the improvement of human welfare. Our 21,000 members are scientists and educators at the Nation's universities and colleges, conducting NIH-supported basic and applied, theoretical and clinical research. They look at such things as: the connections between emotion, stress, and biology and the impact of stress on health; they look at how children grow, learn, and develop; they use brain imaging to explore thinking and memory and other aspects of cognition; they develop ways to manage debilitating chronic conditions such as diabetes and arthritis as well as depression and other mental disorders; they look at how genes and the environment influence behavioral traits such as aggression and anxiety; and they address the behavioral aspects of smoking and drug and alcohol abuse.

As a member of the Ad Hoc Group for Medical Research Funding, APS recommends $32.4 billion for NIH in fiscal year 2010, an increase of 7 percent more than the fiscal year 2009 appropriations level. This increase would halt the erosion of the Nation's public health research enterprise, and help restore momentum to our efforts to improve the health and quality of life of all Americans.

Within the NIH budget, APS is particularly focused on behavioral and social science research and the central role of behavior in health. The remainder of my testimony concerns the status of those areas of research at NIH.

HEALTH AND BEHAVIOR: THE CRITICAL ROLE OF BASIC AND APPLIED PSYCHOLOGICAL RESEARCH

Behavior is a central part of health. Many leading health conditions—such as heart disease; stroke; lung disease and certain cancers; obesity; AIDS; suicide; teen pregnancy; drug abuse and addiction; depression and other mental illnesses; neurological disorders; alcoholism; violence; injuries and accidents—originate in behavior and can be prevented or controlled through behavior.

As just one example: stress is something we all feel in our daily lives, and we now have a growing body of research that illustrates the direct link between stress and health problems:

—Chronic stress accelerates not only the size, but also the strength of cancer tumors;

—chronic stressors weaken the immune system to the point where the heart is damaged, paving the way for cardiac disease;

—children who are genetically vulnerable to anxiety and who are raised by stressed parents are more likely to experience greater levels of anxiety and stress later in life;

—animal research has shown that stress interferes with working memory; and

— stressful interactions may contribute to systemic inflammation in older adults, which in turn extends negative emotion and pain over time.

None of the conditions or diseases described above can be fully understood without an awareness of the behavioral and psychological factors involved in causing, treating, and preventing them. Just as there exists a layered understanding, from basic to applied, of how molecules affect brain cancer, there is a similar spectrum for behavioral research. For example, before you address how to change attitudes and behaviors around AIDS, you need to know how attitudes develop and change in the first place. Or, to design targeted therapies for bipolar disorder, you need to know how to understand how circadian rhythms work as disruptions in sleeping patterns have been shown to worsen symptoms in bipolar patients.

BASIC BEHAVIORAL SCIENCE RESEARCH NEEDS A STABLE INFRASTRUCTURE

Broadly defined, behavioral research explores and explains the psychological, physiological, and environmental mechanisms involved in functions such as memory, learning, emotion, language, perception, personality, motivation, social attachments, and attitudes. Within this, basic behavioral research aims to understand the fundamental nature of these processes in their own right, which provides the foundation for applied behavioral research that connects this knowledge to real-world concerns such as disease, health, and life stages. Basic behavioral research continues to fare poorly at NIH, a circumstance that jeopardizes the success of the entire behavioral research enterprise. Let me remind you of the current situation.

Traditionally, the National Institute of Mental Health (NIMH) was the home for far more basic behavioral science than any other Institute. Many basic behavioral and social questions were being supported by NIMH, even if their answers could also be applied to other Institutes. But NIMH has reduced its support for many areas of the most basic behavioral research, in favor of translational and clinical research. This means that previously funded areas now are not being supported.

NIMH's abrupt decision to narrow its portfolio came without adequate planning and happened at the expense of critical basic behavioral research. We favor a broader spectrum of support for basic behavioral science across NIH as appropriate and necessary for a vital research enterprise. But until other Institutes have the capacity to support more basic behavioral science connected to their missions, programs of research in fundamental behavioral phenomena such as cognition, emotion, psychopathology, perception, and development, will continue to languish.

Current NIH leadership recognizes this gap, and has asked the Directors of the National Institute of General Medical Sciences and the National Institute of Aging to co-lead a new initiative that supports and expands new basic behavioral research throughout NIH. In March 2009, NIH leadership confirmed its commitment to this Basic Behavioral Research Opportunity Network in testimony to this subcommittee, and APS asks you to ensure that NIH follows through with the planning and execution of this crucial step forward for basic behavioral science at NIH and ultimately the health of all Americans.

Despite the clear central role of behavior in health, behavioral research has not received the recognition or support needed to prevent, or reverse the effects of, behavior-based health problems in this Nation. APS asks that you continue to help make behavioral research more of a priority at NIH, both by providing maximum funding for those Institutes where behavioral science is a core activity, by encouraging NIH to advance a model of health that includes behavior in its scientific prior-

ities, and by encouraging stable support for basic behavioral science research at NIH.

BEHAVIORAL SCIENCE AT KEY INSTITUTES

In the remainder of my testimony, I would like to highlight examples of cutting-edge behavioral science research being supported by individual Institutes.

National Cancer Institute (NCI).—NCI's Behavioral Research Program continues to make excellent progress, supporting basic behavioral research as well as translational research on the development and dissemination of interventions in areas such as tobacco use, dietary behavior, sun protection, and decisionmaking. Recently, NCI's behavioral research branch has made concerted efforts to incorporate innovative social psychological theories into cancer prevention research. Basic social psychology provides useful and practical approaches for understanding risky health behaviors and tailoring interventions to reduce the incidence of cancer. For example, NCI funded a research program to assess differential psychological and physiological responses to exercise and the possible genetic and biological mechanisms of those responses. As a result, we now understand the influence of responses to cardiovascular exercise on future exercise behavior, and the researchers are evaluating an intervention to increase exercise behavior in sedentary participants. It is this kind of basic behavioral research that helps us understand how people are persuaded to adopt and maintain healthy behaviors. APS asks Congress to support NCI's behavioral science research and training initiatives and to encourage other Institutes to use these programs as models.

National Institute on Aging (NIA).—NIA's Division of Behavioral and Social Research has one of the strongest psychological science portfolios in all of NIH, and is supporting wide-ranging and innovative work. For example, normal aging may be accompanied by declines not only in such cognitive functions, but also in the processes supporting social and emotional behavior. However, we currently know little about the changes that may occur as we age. NIA-supported research into the brain mechanisms and cognitive processes underlying social and emotional behaviors in healthy older adults promises to dramatically increase our knowledge in this area. Using a combination of behavioral and neuroimaging methods to study social and emotional processing in normal aging, this research will lead to much greater understanding of the nature of aging-related changes in these central human characteristics. NIA's commitment to cutting-edge behavioral science is further illustrated by the Institute's leadership role in NIH's new initiative on the Science of Behavior Change. APS asks the subcommittee to support NIA's behavioral science research efforts and to increase NIA's budget in proportion to the overall increase at NIH in order to continue its high-quality research to improve the health and well being of older Americans.

National Institute on Drug Abuse (NIDA).—By supporting a comprehensive research portfolio that stretches across behavior, neuroscience, and genetics, NIDA is leading the Nation to a better understanding of drug abuse which is key to both prevention and treatment. One of the striking things about psychological science research is that it often dispels "common sense" intuition. For example, recent NIDA-supported research has shown that certain anti-drug media campaigns that include attention-grabbing features such as harsh content or strong graphics, have no positive effect, and that in fact the campaigns that use fewer such dramatic features actually lead to better processing of the public service announcement (PSA). This kind of message-framing research will be used to develop and tailor the most effective PSAs, such as those that focus on social risk rather than physical damage, to curtail use of a wide variety of illicit substances. NIDA is also encouraging brain imaging and prevention message investigators to work together, fostering increased validation of health communication models. APS asks the subcommittee to support this and other critical behavioral science research at NIDA, and to increase NIDA's budget in proportion to the overall increase at NIH in order to reduce the health, social, and economic burden resulting from drug abuse and addiction in this Nation.

Eunice Kennedy Shriver National Institute for Child Health and Human Development (NICHD).—Several Institutes recognize the value and relevance of basic behavioral research to their mission, and NICHD is to be particularly commended for its support of behavioral research on important topics such as mechanisms of cognition and learning, developmental trajectories of language, and linkages among brain, behavior, and genes. For example, studies have shown that caregiver behavior can modify genetic influences on social behavior. Children with a particular variation of the serotonin gene who live in families that provide low levels of social and emotional support were found to be at increased risk for extreme shyness and social withdrawal in middle school years. But those children whose families provide high

levels of support, and who have that same genetic variation, didn't show the same levels of shyness. Research supported by NICHD's behavioral science programs continues to yield fundamental new insights into understanding early cognitive and behavioral development that have the potential to change how and when medical and psychological specialists evaluate typical cognitive, social, and behavioral development during infancy. APS asks Congress to support NICHD's sustained behavioral science research portfolio and to encourage other Institutes to partner with NICHD to maximize the development of interventions in early stages of life that have invaluable benefits in adulthood.

It's not possible to highlight all of the worthy behavioral science research programs at NIH. In addition to those reviewed in this statement, many other Institutes play a key role in the NIH behavioral science research enterprise. These include the National Institute of Dental and Craniofacial Research, the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, the National Heart, Lung, and Blood Institute, the National Institute of Diabetes and Digestive and Kidney Diseases, and the National Institute on Neurological Diseases and Stroke. Behavioral science is a central part of the mission of these institutes, and their behavioral science programs deserve the subcommittee's strongest possible support.

This concludes my testimony. Again, thank you for the opportunity to discuss NIH appropriations for fiscal year 2010 and specifically, the importance of behavioral science research in addressing the Nation's public health concerns. I would be pleased to answer any questions or provide additional information.

PREPARED STATEMENT OF THE AMERICAN PHYSIOLOGICAL SOCIETY

The American Physiological Society (APS) thanks the Chairman and all the members of this subcommittee for their support for the National Institutes of Health (NIH). The funds you included in the American Recovery and Reinvestment Act of 2009 (ARRA) are providing the NIH with a substantial influx of resources at a crucial time. Several consecutive years of stagnant budget growth had been eroding the scientific capacity painstakingly built up during the doubling. The rapid distribution of ARRA funds will allow scientists to explore new avenues of promising research through the funding of additional grants, which is already building momentum and sparking excitement in the research community. The stimulus funds represent a first step toward enabling NIH to maintain and to increase employment for highly skilled workers, purchase critical equipment and supplies, and enhance research capacity at institutions across the country. However, consistent future budget growth for NIH will be necessary to sustain this momentum beyond the period of stimulus spending and prevent an abrupt halt in these new research initiatives after the ARRA. Furthermore, absent a continued increase in support for NIH, as many as 20,000 jobs created in the biomedical sciences by the stimulus money could be lost. Therefore, the APS urges you to make every effort to provide the NIH with a 7 percent increase in fiscal year 2010.

The APS is a professional society dedicated to fostering research and education as well as the dissemination of scientific knowledge concerning how the organs and systems of the body work. APS was founded in 1887 and now has nearly 10,000 member physiologists. APS members conduct NIH-supported research at colleges, universities, medical schools, and other public and private research institutions across the United States. The APS offers these comments on the budget recognizing both the enormous financial challenges facing our Nation and the great opportunity before us to make progress against disease.

As a result of improved healthcare, Americans are living longer and healthier lives in the 21st century than ever before. However, diseases such as heart failure, diabetes, cancer, and emerging infectious diseases such as the swine flu continue to inflict a heavy burden on our population. The NIH invests heavily in basic research to explore the mechanisms and processes of disease. This investment will result in new tools and knowledge that can be used to design novel treatments and prevention strategies.

The NIH selects and funds investigator-initiated research of only the highest scientific merit through the use of the peer review system. Among the breakthroughs in the last year:

—NIH-funded researchers discovered that people with certain genetic variants are at increased risk for a stroke. This genetic link provides molecular clues to how strokes develop and also moves the field closer to personalized medicine. This work was performed by researchers who collaborated to study large populations

of patients over a long period of time, and is an example of research that was supported by multiple institutes within the NIH.[1]

—Scientists recently discovered that adults retain brown fat, a metabolically active type of fat tissue that was previously thought to exist only in infants and children. Because brown fat burns calories and energy, there is hope that this discovery could lead to new treatments for obesity and diabetes.[2]

—Researchers studying obesity and diet in an animal model found that chronic consumption of high levels of fructose leads to excess weight gain and molecular changes when paired with a high-fat, high-calorie diet. Understanding the physiological changes associated with the development of obesity is a first step toward the design of interventions that could prevent the serious health consequences associated with being overweight.[3]

Over the past several years, the Office of the Director has supplemented existing research programs with new types of awards as part of the NIH Roadmap for Medical Research. These include the New Innovator, Pioneer and Transformative Research Award Programs. Such programs support bold and creative researchers as they engage in high-risk, high-reward research, thus allowing more flexibility to explore novel ideas and challenge existing paradigms. The NIH is also using these programs as a model for distributing funds under the ARRA. The Research and Research Infrastructure "Grand Opportunities" program will fund potentially high-impact areas of science that will benefit from short-term funding.

The NIH is also home to the Institutional Development Award (IDeA) Program. Established in 1993, the goal of the IDeA program is to broaden the geographic distribution of NIH funds by serving researchers and institutions in areas that have not historically received significant NIH funding. IDeA builds research capacity and improves competitiveness in those States through the development of shared resources, infrastructure, and expertise. IDeA currently serves institutions and investigators in 23 States and Puerto Rico.

In addition to supporting research, the NIH must also address workforce issues to ensure that our Nation's researchers are ready to meet the challenges they will face in the future. Recent data from the NIH shows that the average age of NIH supported principal investigators is now 50.8 years.[4] This is up nearly 12 years from the average principal investigator's age of 39.1 years in 1980. In addition, the average age at which a researcher obtains their first major research award from NIH has increased to 42.4 years. As the scientific workforce continues to age, and more researchers retire, there may be an insufficient number of young scientists who are trained to replace them. Over the last year, the NIH has put in place policies to help new investigators succeed in competing for their first major research awards. However, efforts will be successful only if funds are available to continue to support the careers of new and young investigators beyond the period of their first grant.

The APS joins the Federation of American Societies for Experimental Biology (FASEB) and the Ad Hoc Group for Medical Research Funding in urging that NIH be provided with a 7 percent increase in fiscal year 2010 to permit the agency to maintain its current wide-ranging and important research efforts.

PREPARED STATEMENT OF THE ASSOCIATION OF REHABILITATION NURSES

INTRODUCTION

On behalf of the Association of Rehabilitation Nurses (ARN), I appreciate having the opportunity to submit written testimony to the Senate Labor, Health and Human Services, and Education, and Related Agencies Subcommittee regarding funding for nursing and rehabilitation related programs in fiscal year 2010. ARN represents professional nurses who work to enhance the quality of life for those affected by physical disability and/or chronic illness. ARN understands that Congress has many concerns and limited resources, but believes that chronic illness and physical disability are heavy burdens on our society that must be addressed.

REHABILITATION NURSES AND REHABILITATION NURSING

Rehabilitation nurses help individuals affected by chronic illness and/or physical disability adapt to their disability, achieve their greatest potential, and work toward

---

[1] M. A. Ikram et al, New England Journal of Medicine 360, 1718–28. (April 23, 2009).

[2] A. M. Cypress et al, New England Journal of Medicine 360, 1509–17. (April 9, 2009).

[3] A. Shapiro et al, American Journal of Physiology—Regulatory, Integrative and Comparative Physiology 295, R1370–75. (November, 2008).

[4] http://grants.nih.gov/grants/new_investigators/resources.htm#data (accessed April 29, 2009).

productive, independent lives. They take a holistic approach to meeting patients' medical, vocational, educational, environmental, and spiritual needs. Rehabilitation nurses begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness. They continue to provide support in the form of patient and family education and empower these individuals when they return home, or to work, or school. The rehabilitation nurse often teaches patients and their caregivers how to access systems and resources.

Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. Rehabilitation nurses base their practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximal independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/skilled nursing facilities, long-term acute care facilities, comprehensive outpatient rehabilitation facilities; and private practice, just to name a few.

To ensure that patients receive the best quality care possible, ARN supports Federal programs and research institutions that address the national nursing shortage and conduct research on medical rehabilitation and nursing and traumatic brain injury. Therefore, ARN respectfully requests that the subcommittee provide increased funding for the following programs:

NURSING WORKFORCE AND DEVELOPMENT PROGRAMS AT THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

ARN supports efforts to resolve the national nursing shortage, including appropriate funding to address the shortage of qualified nursing faculty. Rehabilitation nursing requires a high-level of education and technical expertise, and ARN is committed to assuring and protecting access to professional nursing care delivered by highly educated, well-trained, and experienced registered nurses for individuals affected by chronic illness and/or physical disability.

According to the Department of Health and Human Services, the Federal Nursing Workforce Development program at the Health Resources and Services Administration (HRSA), an estimated 36,750 nurses need to be recruited, educated, and retained to meet the current demands of the healthcare system. Efforts to recruit and educate individuals interested in nursing have been thwarted by the shortage of nursing faculty. In 2007, due to the nursing faculty shortage, more than 40,000 qualified applicants were not able to matriculate in nursing school. The number of full-time nursing faculty required to "fill the nursing gap" is approximately 40,000, and, currently, there are less than 20,000 full-time nursing faculty members. Further exacerbating this issue, HRSA predicts that the nursing shortage is expected to grow to 41 percent by 2020.

ARN strongly supports the national nursing community's request of $263 million in fiscal year 2010 funding for Federal Nursing Workforce Development programs at HRSA.

NIDRR

NIDRR provides leadership and support for a comprehensive program of research related to the rehabilitation of individuals with disabilities. As one of the components of the Office of Special Education and Rehabilitative Services at the U.S. Department of Education, NIDRR operates along with the Rehabilitation Services Administration and the Office of Special Education Programs.

The mission of NIDRR is to generate new knowledge and promote its effective use to improve the abilities of people with disabilities to perform activities of their choice in the community, and also to expand society's capacity to provide full opportunities and accommodations for its citizens with disabilities. NIDRR conducts comprehensive and coordinated programs of research and related activities to maximize the full inclusion, social integration, employment and independent living of individuals of all ages with disabilities. NIDRR's focus includes research in areas such as employment; health and function; technology for access and function; independent living and community integration; and other associated disability research areas.

ARN strongly supports the work of NIDRR and encourages Congress to provide the maximum possible fiscal year 2010 funding level.

NATIONAL INSTITUTE OF NURSING RESEARCH (NINR)

ARN understands that research is essential for the advancement of nursing science, and believes new concepts must be developed and tested to sustain the continued growth and maturation of the rehabilitation nursing specialty. The National

Institute of Nursing Research (NINR) works to create cost-effective and high-quality health care by testing new nursing science concepts and investigating how to best integrate them into daily practice. NINR has a broad mandate that includes seeking to prevent and delay disease and to ease the symptoms associated with both chronic and acute illnesses. NINR's recent areas of research focus include the following:

—End of life and palliative care in rural areas;
—Research in multi-cultural societies;
—Bio-behavioral methods to improve outcomes research; and
—Increasing health promotion through comprehensive studies.

ARN respectfully requests $178 million in fiscal year 2010 funding for NINR to continue its efforts to address issues related to chronic and acute illnesses.

TRAUMATIC BRIAN INJURY (TBI)

Approximately 1.5 million American children and adults are living with long-term, severe disability, as a result of traumatic brain injury (TBI). Moreover, this figure does not include the 150,000 cases of TBI suffered by soldiers returning from wars in Iraq and Afghanistan.

The annual national cost of providing treatment and services for these patients is estimated to be nearly $60 million in direct care and lost workplace productivity. Continued fiscal support of the Traumatic Brain Injury Act will provide critical funding needed to further develop research and improve the lives of individuals who suffer from traumatic brain injury.

Continued funding of the TBI Act will promote sound public health policy in brain injury prevention, research, education, treatment, and community-based services, while informing the public of the need support for individuals living with TBI and their families.

ARN strongly supports the current work being done by the Centers for Disease Control and Prevention (CDC) and HRSA on TBI programs. These programs contribute to the overall body of knowledge in rehabilitation medicine.

ARN urges Congress to support the following fiscal year 2010 funding requests for programs within the TBI Act: $10 million for CDC's TBI registries and surveillance, prevention and national public education and awareness efforts; $20 million for the HRSA Federal TBI State Grant Program; and $13.3 million for the HRSA Federal TBI Protection and Advocacy Systems Grant Program.

CONCLUSION

ARN appreciates the opportunity to share our priorities for fiscal year 2010 funding levels for nursing and rehabilitation programs. ARN maintains a strong commitment to working with Members of Congress, other nursing and rehabilitation organizations, and other stakeholders to ensure that the rehabilitation nurses of today continue to practice tomorrow. By providing the fiscal year 2010 funding levels detailed above, we believe the subcommittee will be taking the steps necessary to ensure that our Nation has a sufficient nursing workforce to care for patients requiring rehabilitation from chronic illness and/or physical disability.

PREPARED STATEMENT OF THE ASSOCIATION FOR RESEARCH IN VISION AND OPHTHALMOLOGY

Association for Research in Vision and Ophthalmology (ARVO) has two major requests:

—For Congress to fund the National Institutes of Health (NIH) in fiscal year 2010 at $32.4 billion (a 7 percent increase more than fiscal year 2009); and
—For Congress to make vision health a priority in the total funding of NIH by increasing the National Eye Institute (NEI) funding to $736 million (also a 7 percent increase).

The requested 7 percent increase represents a 3 percent increase plus the 2009 biomedical inflation index.

ARVO commends Congress for actions taken in fiscal year 2008 and 2009 to fund NIH. This includes the $150 million fiscal year 2008 supplement for investigator-initiated grants, the $10.4 billion of NIH funding included in the American Recovery and Reinvestment Act, and the fiscal year 2009 inflationary increase of 3.2 percent. However, ARVO still has concerns about long-term, sustained, and predictable funding for vision research.

Vision disorders are the fourth most prevalent disability in the United States and the most frequent cause of disability in children.[1 2 3 4] Healthy vision contributes to injury prevention, independence, and economic security. Over the next 30 years the elderly population of the United States will double and if we fail to take action, age-related eye diseases (diabetic retinopathy, glaucoma, cataracts, and age-related macular degeneration) will quickly overburden our healthcare system. While age-related eye diseases are the most common visual impairments in the United States, childhood vision loss is also of great concern because of its lifelong economic burden.

ARVO requests $32.4 billion of NIH funding for fiscal year 2010. This represents a 7 percent increase more than fiscal year 2009.

This ensures that prior investments in training junior investigators and clinician scientists translate to future improvements in health and healthcare services.

If junior investigators are unable to obtain research grants from the NIH, then the prior Government investment in their training will not translate into future translational medical breakthroughs. These scientists will simply transfer acquired skills to other career options.[5]

With the doubling of the NIH budget (1993–2003) universities increased their infrastructure for training life science Ph.Ds and hired more full-time faculty.[6] NIH funding has since remained flat, resulting in decreased rates of grant funding. As a consequence many academic scientists have either lost their jobs or taken part-time positions.[7] The current economic crisis has further amplified the problem. In recent months, the private sector in the United States laid off more than 80,000 scientists.[8] We think the best solution is to maintain sustained and predictable funding for scientists at all stages. If the average age when scientists obtain their first source of independent NIH funding continues to rise (currently 43 years) and funding bodies continue to restrict many postdoctoral funding opportunities to 2–5 years, a generation of analytical thinkers will be forced to find more realistic career options.[9]

To maintain economic and global competitiveness, research and development is essential for the United States to remain competitive in a global market. Both corporate and Government support of research has been declining. Innovation is crucial for maintaining global competitiveness.[10] Since vision problems are a global economic concern, the prevention and treatment of ocular disease contributes to the economic well-being of the United States and international economy.

NIH and NEI have been leaders in basic research that translates to better vision therapies. The NEI Director (Paul Sieving, MD, Ph.D.) has reported that 25 percent of all genes identified to date are associated with eye disease. Research supported by the NEI is aimed at translating these genetic discoveries to improved diagnosis and therapy.[11 12 13 14 15] The NEI has worked in association with: (1) the National Institute on Aging to better diagnose, prevent, and treat age-related macular degeneration, diabetes, and cataract; (2) The National Institute of Neurological Disorders and Stroke to protect and regenerate cells that die from retinal degeneration and glaucoma; and (3) the National Institute of Diabetes and Digestive and Kidney Disorders on studies of diabetic retinopathy.

NEI-sponsored research has resulted in improved therapies for age-related macular degeneration and diabetic retinopathy, a promising gene therapy for retinitis pigmentosa, and genetic studies of glaucoma in minority populations that have a disproportional higher incidence of glaucoma.[16]

—To reduce the economic burden of eye disease on the United States healthcare system

---

[1] Federal Interagency Forum on Aging-Related Statistics. Older Americans 2000: key indicators of well-being. Washington, DC: U.S. Government Printing Office; 2000 Aug. 114 p.

[2] http://www.ncbi.nlm.nih.gov/pubmed/15078664

[3] http://www.healthypeople.gov/data/2010prog/focus28/2004fa28.htm

[4] http://www.preventblindness.org/vpus/

[5] http://www.the-scientist.com/article/display/16526/

[6] http://www.sauvonslarecherche.fr/IMG/pdf/the__postdoc__crisis.pdf

[7] http://sciencecareers.sciencemag.org/career__magazine/previous__issues/articles/2007__07__13/caredit.a0700099

[8] http://sciencecareers.sciencemag.org/career__magazine/previous__issues/articles/2009__04__10/caredit.a0900048

[9] http://www.brokenpipeline.org/brokenpipeline.pdf

[10] http://www.nsf.gov/statistics/nsb0803/start.htm#research

[11] http://www.v2020.org/page.asp?section=000100010002

[12] http://www.v2020eresource.org/newsitenews.aspx?tpath=news22007

[13] http://www.healthypeople.gov/HP2020/

[14] http://www.nei.nih.gov/resources/strategicplans/neiplan/frm__cross.asp

[15] http://www.nei.nih.gov/amd/

[16] http://www.eyeresearch.org/resources/NEI__factsheet.html ARVO

In 2008, 3,638,186 persons in the United States were blind. And 1 in 28 individuals older than age 40 has a visual disability . . . In 2010 more than half of baby boomers will be at high risk for developing age-related eye diseases. Adequate research funding of studies aimed at preventing these age related diseases will reduce future healthcare expenditures, particularly to the Medicare and Medicaid programs.[17] [18] [19]

Treatment of eye diseases in the United States costs $68 billion/year. Vision impaired adults are employed at 44 percent the rate of healthy individuals and earn an average of $10,000 less per year.[20] [21] [22] Vision science research leads to therapies that delay, prevent and treat blinding ocular disease, leading to increased productivity of our work force and savings in the cost of healthcare.

SUMMARY

ARVO urges fiscal year 2010 NIH and NEI funding at $32.4 billion and $736 million, respectively, reflecting an at least 7 percent increase more than fiscal year 2009.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR MICROBIOLOGY

The American Society for Microbiology (ASM) is pleased to submit the following testimony on the fiscal year 2010 appropriation for the Centers for Disease Control and Prevention (CDC). The ASM supports the fiscal year 2010 funding level of $8.6 billion for CDC recommended by the CDC Coalition and the Campaign for Public Health. Funding levels in recent years have not adequately supported the CDC mission to protect public health through health promotion and disease prevention. The ASM appreciates that the administration and Congress have included science and public health programs in the American Recovery and Reinvestment Act of 2009. It is essential, however, to also provide increased funding through the fiscal year 2010 appropriation and future fiscal years, at levels that sustain CDC programs to protect public health.

There are persistent challenges for the Nation's public health agencies at the Federal, State, and local levels. Among these are the nationwide outbreaks of swine influenza, salmonella food poisoning, and upsurges in vaccine preventable diseases such as measles and meningitis.

CDC is instrumental in preventing death and illness caused by infectious diseases, contamination of food or water, or release of bioterror agents. The recent public health concern surrounding human cases of swine influenza A (H1N1) virus infection illustrates the importance of CDC's role in the investigation and response to outbreaks of infectious diseases. CDC is working closely with officials in States where human cases of swine influenza A (H1N1) have been identified, as well as with health officials in other countries experiencing outbreaks of H1N1. CDC staff are deployed in the United States and internationally to provide guidance and technical support in response to this emerging health threat. During a rapidly evolving situation, CDC is working to reduce transmission and severity of the disease and to provide information to healthcare providers, public health officials, and the public.

CDC COMBATS INFECTIOUS DISEASES

CDC mission specific components cover a wide spectrum of disease control and prevention activities. One of these, the Coordinating Center for Infectious Diseases (CCID), oversees national centers focused on immunization and respiratory diseases; zoonotic, vector-borne and enteric diseases; HIV/AIDS, viral hepatitis, sexually transmitted diseases and tuberculosis prevention; and healthcare associated infections, migration, and quarantine. CCID centers use the latest technological tools and scientific information to respond to emergent public health challenges as rapidly and effectively as possible.

Emerging Infectious Diseases.—Newly recognized infectious diseases attract considerable attention from the public and the research community, evidenced by swine influenza A (H1N1) virus infection, H5N1 avian influenza, severe acute respiratory

---

[17] http://www.ncbi.nlm.nih.gov/sites/entrez?cmd=Retrieve&db=pubmed&dopt=AbstractPlus&list__uids=15078664

[18] http://www.researchamerica.org/uploads/factsheet16vision.pdf

[19] http://www.preventblindness.org/advocacy/Action__Plan.pdf

[20] http://www.nei.nih.gov/

[21] http://www.eyeresearch.org/pdf/RA__Vision__08__V5.pdf

[22] http://www.ncbi.nlm.nih.gov/sites/entrez

syndrome (SARS), HIV/AIDS, so-called "mad cow" disease, West Nile Virus, and methicillin-resistant Staphylococcus aureus (MRSA) among others. The CDC must respond to these and other emerging diseases with scientific proficiency and round-the-clock readiness. The National Center for Preparedness, Detection, and Control of Infectious Disease's Division of Emerging Infections and Surveillance Services recruits partnerships across the CDC and with both national and international organizations, to track outbreaks and train laboratory scientists from around the world in preventing and responding to such threats. The CDC has repeatedly taken part in identifying previously unrecognized pathogens like the SARS virus. It also participates in relevant field research around the world.

Influenza Preparedness.—The CDC effort against influenza includes programs that focus on both seasonal and potential pandemic forms of the disease, such as human cases of swine influenza A virus infection. Every year, between 5 and 20 percent of the U.S. population gets the flu, more than 200,000 are hospitalized, and about 36,000 die. The CDC works with U.S. partners in health departments, clinical laboratories, vital statistics offices and healthcare providers to assess the annual burden of flu. Comprehensive CDC incidence reports use data from nine different sources, like the Nationally Notifiable Disease Surveillance System and the Emerging Infections Program's Influenza Project. In October 2008, the CDC contracted with the American Type Culture Collection to implement the CDC Influenza Reagent Resource, which will serve as a source of diagnostic material for laboratories in the event of an emerging pandemic. The agency also awarded $24 million for 55 projects at 29 State and local health departments to develop better pandemic preparedness models. Last fall, the Food and Drug Administration approved a lab test co-developed by CDC that can reliably detect flu viruses with results within four hours.

CDC extensively monitors the avian influenza virus H5N1 that has spread throughout Asia, the Middle East, and parts of Europe. Recognition that the relatively new virus could cause a human pandemic has mobilized public health institutions worldwide. There have been only 413 confirmed human cases in 15 countries (by March 30), but the sustained 60-plus percent mortality is unprecedented for an influenza virus. The CDC developed a measurement tool to help at-risk countries assess their ability to respond to an avian influenza pandemic. Moreover, it continues its laboratory and field research on H5N1 and other flu viruses. CDC scientists reported last year that some avian influenza A H7 virus strains have acquired new features that might boost their potential to cause human disease.

HIV/AIDS.—In August 2008, the CDC released its first estimates of HIV infections in the United States based on a new CDC-developed laboratory assay called serologic testing algorithm for recent HIV seroconversion (STARHS). The results, unfortunately, indicate that approximately 56,300 new U.S. HIV infections occurred in 2006, about 40 percent higher than CDC's former estimate. The STARHS technology is the basis for the first national surveillance system relying on direct measurement of new HIV infections and provides more precise estimates of HIV incidence. CDC continually tracks the nation's progress against this recalcitrant disease. For example, the CDC and other health agencies updated guidelines in March for the prevention and treatment of opportunistic infections in HIV-infected people.

Global Infectious Diseases.—Infectious diseases are responsible for 15 million (26 percent) of the 57 million annual deaths worldwide and the CDC is a valuable contributor to public health campaigns against these diseases. Examples include its vigorous distribution in developing countries of Haemophilus influenzae type b (Hib) vaccine. One of the leading causes of severe childhood pneumonia and meningitis, Hib disease annually causes an estimated 3 million illnesses and 400,000 deaths worldwide in children 5 years and younger. Hib vaccines have been widely used in industrialized countries for nearly 20 years, but underused in the poorest countries. The CDC estimates that this year use of Hib vaccine in these countries will exceed 80 percent, compared to less than 20 percent in 2004.

CDC funding supports rigorous research on globally significant diseases like malaria and tuberculosis, and underwrites incidence data gathered from around the world. The CDC is developing a network of Global Disease Detection Centers, along with the participating nations' ministries of health, academic institutions, the World Health Organization, and U.S. Departments of State and Defense. Centers currently operational are located in China, Egypt, Guatemala, Kenya, Thailand, and, added in 2008, Kazakhstan. They extend the reach of three established CDC programs in emerging infections, epidemiology training, and influenza. The Coordinating Office for Global Health oversees more than 200 CDC staff in more than 50 countries, as first-responders to disease outbreaks. In 2008, CDC responded to more than 90 international disease outbreaks and public health events and found 22 new pathogens.

An estimated 1.8 million airline passengers cross international borders daily, opening multiple routes for disease transmission. The CDC maintains a specific branch to deal with global migration and quarantine issues, using its GeoSentinel Network Surveillance System to collect information from 41 sentinel sites and 200 medical clinics in 75 countries around the world. CDC personnel now staff U.S. quarantine stations at 20 ports of entry and land border crossings. The CDC also provides U.S. travelers with health threat alerts; educational efforts last year included recommendations to the U.S. Olympic teams traveling to China.

Vaccination Campaigns.—CDC collects vaccine-related information to assist Federal, State, and local health officials. The CDC also invests considerable resources in educating the public on the importance of vaccination as a preventive tool. At times, vaccines can also alleviate disease rather than prevent initial infection. Last year, the CDC recommended that people age 60 and older be vaccinated against shingles to reduce the number of painful episodes, even in those with previous cases. The most recent CDC survey of childhood immunization in this country found that rates remain at or near record levels, with at least 90 percent coverage for all but one of the recommended series for young children. Still, more measles cases were reported in 2008 than any year since 1996 largely due to failure to vaccinate. Another CDC report concluded that marked reductions in rotavirus-caused gastroenteritis in U.S. infants and young children may be due to a recently introduced rotavirus vaccine, recommended by CDC in 2006 for routine immunization of infants. Rotavirus is the leading cause of severe gastroenteritis in the young, typically causing 55,000–70,000 U.S. hospitalizations and about 410,000 physician office visits annually. Every day, rotavirus kills about 1,600 children under age 5 worldwide.

CDC CONFRONTS HEALTHCARE-ASSOCIATED INFECTIONS, ANTIMICROBIAL RESISTANCE

Each year, healthcare-associated infections (HAI) account for an estimated 1.7 million infections and 99,000 associated deaths in the United States. With more than 1 billion hospital and doctor visits made by Americans each year, there unfortunately is ample opportunity for HAI exposure. A CDC report released in March estimates that the annual direct hospital cost of treating HAI ranges from $28.4 billion to $45 billion, and that improving infection control could save roughly $6 billion to $32 billion, depending on the percentage of infections preventable in healthcare settings. With 2009 healthcare costs expected to reach $2.5 trillion, saving resources through CDC-facilitated prevention clearly offers a sensible public health strategy.

CDC works to optimize practices for HAI prevention. For example, CDC reports that 85 percent of all invasive infections caused by methicillin-resistant Staphylococcus aureus (MRSA) are associated with healthcare settings. CDC guidelines help assure best practices in healthcare settings. Hospitals in a CDC-supported study reduced bloodstream and MRSA infections as much as 70 percent by implementing CDC prevention guidelines. Last September, CDC launched a public MRSA education campaign.

Antimicrobial resistance has emerged as a daunting global challenge, increasing the lethality of pathogens from extensively drug-resistant tuberculosis (XDR TB) to this year's flu virus strain highly resistant to the most commonly used prescription drug. Last year, 16 CCID surveillance systems and programs gathered incidence data on antimicrobial resistance among bacterial, fungal, parasitic and viral agents. CDC scientists are developing laboratory protocols and diagnostics for a growing list of drug-resistant pathogens. One example is a new protocol for molecular typing of methicillin-resistant S. aureus. The CDC's Antimicrobial Resistance Team also recently validated tests that will amend 2009 clinical and lab standards in testing microbial resistance to mupirocin (used for staph infections) and the carbapenem drugs used to treat enteric pathogens resistant to most other drugs.

CDC STRENGTHENS NATIONAL DEFENSES AGAINST BIOTERRORISM, PUBLIC HEALTH CRISES

The CDC's Terrorism, Preparedness and Emergency Response (TPER) funds support the Coordinating Office for Terrorism Preparedness and Emergency Response objectives. CDC provides science-based strategies and tactical coordination during public health events and maintains emergency response operations like the Strategic National Stockpile (SNS) and the Emergency Operations Center (EOC). The SNS is an invaluable national repository of antibiotics, antitoxins and other medical supplies that can be mobilized rapidly to augment State and local resources during a large-scale health emergency. Opened in 2003, the DEOC is staffed with experts 24/7/365, an integral part of the country's National Incident Management System.

The CDC's inaugural annual report on its TPER-funded activities released in January enumerates its wide-ranging activities. Activities include assessing current administration routes and dosage for anthrax vaccine, inspecting 110 research entities registered to possess microbes on the Federal select agents list, and mapping the DNA of the vaccinia virus (similar to smallpox virus) and tularemia bacteria for greater scientific insight into potential bioagents. TPER-funded capabilities help CDC respond more aggressively to public health crises of all kinds, far beyond the threat of bioterrorism. In fiscal year 2008, the EOC was activated in response to 55 domestic and 16 international events, including the floods in the Midwest, multistate Salmonella and E.coli 0157 outbreaks, and outbreaks of cholera and hemorrhagic fever in Africa.

The ASM concurs with the recommended level of $8.6 billion, which will provide needed new funding for CDC's programs that are so critical to protecting people in the United States and worldwide.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR MICROBIOLOGY

The American Society for Microbiology (ASM) appreciates the opportunity to submit a written statement on the fiscal year 2010 budget for the National Institutes of Health (NIH). The ASM is the largest single life science society with more than 42,000 members, many of whom receive funding from the NIH. We are grateful for the $10.4 billion increase in funding for the NIH in the American Recovery and Reinvestment Act (ARRA) and the 3.2 percent increase in funding for NIH in the fiscal year 2009 Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act. The additional ARRA funding enables NIH to support the ARRA goals to create and save jobs and increase purchasing power, as well as advance scientific research. The Nation's biomedical research enterprise will be kept more robust at a time when it is experiencing the adverse effects of the economic downturn and years of flat funding.

As Congress considers the fiscal year 2010 appropriation for NIH, the ASM recommends a budget of $32.4 billion, a 7 percent increase. The recommended funding increase will help NIH keep pace with expanded research opportunities and higher costs. It is important for NIH to prepare for the poststimulus years, in 2011 and beyond. It is also important to resume sustainable NIH funding, avoiding fluctuations for research and training programs that can disrupt projects, training, careers, and research progress. To perpetuate the benefits of ARRA funding, it is vitally important to provide sustained growth for the NIH in fiscal year 2010 and beyond.

More than 83 percent of the NIH budget is awarded through 50,000 competitive grants awarded to more than 325,000 researchers at more than 3,000 universities, medical schools, and other institutions in all 50 States. About 10 percent of the NIH budget supports research in NIH laboratories conducted by nearly 6,000 scientists. Research project grants are highly productive in terms of medical advances to benefit public health. NIH funding contributes to the Nation's economic recovery by stimulating new opportunities and investments in biotechnology and related industries, as well as expanding the skilled workforce critical to U.S. competitiveness in science and technology. NIH funding also impacts allied health workers, technicians, students, trade workers, and others who receive the leveraged benefits from NIH funding.

The following describes some of the compelling reasons for increased and sustained support for the NIH research mission and its proven benefit to technological innovation and public health.

NIH RESEARCH IS CRITICAL TO SCIENTIFIC PROGRESS

NIH Institutes and Centers fund research programs that address the Nation's challenges of safeguarding public health, security, and the economy. The National Institute of Allergy and Infectious Diseases (NIAID), for example, focuses on research to understand, treat, and prevent infectious, immunologic, and allergic diseases, leading to the development of vaccines, therapies and diagnostic tools. The NIAID also funds research on medical countermeasures against potential bioterror agents. The National Institute of General Medical Sciences (NIGMS) supports basic research on life processes in fields such as computational biology, genetics, and bioinformatics. NIH resources invested in the agency-wide Roadmap initiatives make possible projects that hold great potential but might otherwise not be funded due to difficulty and scope. Recently funded Roadmap projects include a network of nine centers using high-tech screening methods for drug discovery.

The NIH funding to individual researchers and research groups, through competitive peer-reviewed grants, is of particular consequence to the U.S. research enter-

prise. More than 120 discoveries made by NIH and NIH-supported researchers have garnered Nobel Prizes, and NIGMS has funded the Nobel Prize-winning work of 64 scientists. More than three-fourths of the U.S. recipients of the Nobel Prize in Physiology or Medicine received NIH support prior to their award. In fiscal year 2009 NIH is striving to lower the average age of first-time grant recipients to refresh the Nation's scientific investigator pool and help revitalize research in the United States. Our national anxiety over waning global competitiveness and a shrinking technical workforce argues for sustained NIH funding for both new and established investigators.

NIH investigator-initiated grants create new opportunities for original biomedical inquiry and expand training environments for students in technical fields. Investigator-initiated research projects lead to inventive solutions for medical problems. Each year, NIH also identifies, in consultation with the extramural research community, targeted areas within an emerging need or opportunity, and then requests grant applications from U.S. researchers. Focused opportunities announced last year by NIAID include studies to advance vaccine safety and development of assays for high-throughput drug screening. NIGMS-featured areas currently include computational models to detect, control, and prevent emerging infectious diseases. NIGMS also awards grants for nontraditional research through its Exceptional, Unconventional Research Enabling Knowledge Acceleration (EUREKA) program. NIH has placed new emphasis on supporting high-impact transformative research that might create new disciplines, revolutionary technologies, or otherwise radically change biomedical research. In 2008, it initiated transformative grant funding to foster investigator-initiated work considered high-risk but exceptionally promising.

NIH RESEARCH YIELDS MEDICAL ADVANCES

NIH supported research consistently produces significant discoveries with both real-world relevance and potential future use against emerging health threats. The following are selected examples of recently reported research that illustrate the vitality and creativity supported by NIH funding.

Antimicrobial Resistance and Drug Discovery.—Drug resistance spreading among microbial pathogens is complicating control of infectious diseases and adding to rising healthcare costs. Response by U.S. research institutions has been aggressive, including creation of a Federal Interagency Task Force co-chaired by NIAID, the Centers for Disease Control and Prevention, and the Food and Drug Administration. Causes of drug resistance are many, from overuse of prescription drugs to natural microbial mutations, and NIAID's research portfolio is equally diverse. In fiscal year 2007, the Institute invested more than $800 million to support basic and translational research on antimicrobials and on drug resistance. Recent results include:

—Scientists from NIAID, California, and China studied the genetics of the major strain of methicillin-resistant Staphylococcus aureus (MRSA), concluding that a radical shift may be needed in how scientists design MRSA therapeutics. MRSA causes an estimated 94,000 cases of infection annually in the United States, with more than 19,000 deaths.

—NIGMS-funded researchers are developing a new generation of antibiotic compounds that do not elicit drug resistance. The enzyme-inhibitor compounds interfere with "quorum sensing"—a process by which bacteria communicate with each other. Those in the current study work against Vibrio cholerae, which causes cholera, and E. coli 0157:H7, the food contaminant that annually causes about 110,000 illnesses in the United States.

To circumvent antimicrobial resistance, NIH researchers and their extramural collaborators are intensifying research strategies better suited to rapidly changing pathogens and disease demographics. These include state-of-the-art technologies that fuel 21st century drug discovery. A recent example is NIGMS-funded research using mass spectrometry technology to determine the molecular structure of a class of natural compounds called nonribosomal peptides (NRPs), intensely studied for their drug potential (penicillin is an NRP). A significant advance over previous approaches, it may help reprogram nonpathogenic E. coli into NRP minifactories.

Infectious Diseases.—Infectious diseases remain among the most difficult global health challenges, accounting for about one-quarter of all deaths and nearly two-thirds in sub-Saharan Africa. At NIAID and NIGMS, multiple programs and interdisciplinary strategies target the major causes of global death and disability, with cutting-edge tools like genomics and nanotechnology.

Influenza.—Despite the availability of influenza drugs and vaccines, seasonal influenza still kills more than 250,000 people worldwide each year. Public health officials are now concerned about reports that 98 percent of a H1N1 influenza virus

strain (1 of 3 circulating in the 2008–2009 season) are resistant to oseltamivir (Tamiflu), the leading influenza drug, compared to 11 percent resistance among all viral strains during the 2007–2008 season. The possibility of an influenza pandemic caused by the more lethal H5N1 avian flu virus has mobilized an international response from health agencies and medical researchers. In January, the Department of Health and Human Services awarded a contract to build the first U.S. manufacturing facility for cell-based influenza vaccines, expected to increase the Nation's current capacity to make vaccine by at least 25 percent and much less time. NIH funding contributed to this major advance in vaccine production and to other recent advances, such as:

—NIAID-supported scientists used new monoclonal techniques to create human influenza-fighting antibodies in the laboratory in a matter of weeks, rather than the months previously required. The antibodies have potential for diagnosis and treatment regimens that can respond more quickly to newly emerging strains of influenza.

—NIGMS-funded researchers used super-computer capabilities to identify more than two dozen new candidate drugs to treat avian influenza ("bird flu"), in preparation for a possible pandemic of drug-resistant H5N1 virus strains.

—Three research teams and a computer informatics group—part of the NIGMS-funded Models of Infectious Disease Agent Study (MIDAS) Network—modeled pandemic influenza in the United States, concluding mitigation is possible with prompt, coordinated use of social-distancing measures and antiviral treatment until vaccine is available.

HIV/AIDS.—An estimated 33 million adults and children are living with HIV infection worldwide, and about 2 million die each year from related causes. In the United States, where nearly 546,000 people have died thus far from HIV/AIDS-related illnesses, there currently are an estimated 1.1 million infected, with 21 percent unaware of their infection. HIV/AIDS as both a domestic and global threat is a high priority at NIH. Difficulties in developing preventative vaccines prompted a 2008 NIH vaccine summit and subsequent re-examination of NIH's research agenda. NIH-supported basic research is steadily adding to our understanding of HIV/AIDS, evidenced by recent discoveries in mechanisms of HIV protease inhibition and the NIGMS-funded success in seeing microscopically for the first time molecules grouping in living cells to form single HIV particles. Other recent advances include:

—A vaginal gel to prevent HIV infection in women has shown encouraging signs of success in a clinical trial in Africa and the United States. This is the first human clinical study to suggest that a microbicide may prevent male-to-female sexual HIV transmission.

—An extended course of the antiretroviral drug nevirapine helps the breastfeeding babies of HIV-infected mothers remain HIV-negative and live longer, according to several new studies. About 150,000 infants worldwide acquire HIV annually through breastfeeding.

—The incidence of childhood illness and death due to HIV infection can be dramatically decreased by testing very young babies for HIV and giving antiretroviral therapy (ART) immediately to those found infected—giving ART to HIV-infected infants beginning at an average age of 7 weeks made them four times less likely to die in the next 48 weeks.

Tuberculosis.—One-third of the world's 6.7 billion people are thought to be infected by Mycobacterium tuberculosis (Mtb), the microbe that causes tuberculosis. An estimated 13.7 million have the active form. Each year, about 1.7 million die from this age-old disease that has adopted some disturbing modern-day features, striking as co-infections with the HIV virus and becoming resistant to drug therapies used to treat tuberculosis. In 2007, about 9.3 million people developed new cases of TB; 1.37 million were also HIV positive. The rapid spread of multidrug- and extensively drug-resistant forms (MDR TB/XDR TB) is alarming—MDR TB currently accounts for an estimated 5 percent of all TB cases and the frequently fatal XDR TB has been detected in 46 countries thus far. In April 2008, NIAID launched an aggressive research agenda against drug-resistant tuberculosis. NIH-supported research from the past year includes:

—NIAID scientists and industry collaborators found that, when the candidate TB drug PA–854 is metabolized inside Mtb bacteria, a lethal dose of nitric oxide gas is produced, killing the pathogen and suggesting new ways to develop drugs capable of killing latent TB bacteria. Currently there are no drugs available to target latent tuberculosis infections.

—Scientists reported that two FDA-approved drugs work in tandem to kill the tuberculosis pathogen and could help counter drug-resistant forms. The drugs are already used to treat other bacterial diseases, but their effectiveness against TB

bacteria had not been studied. NIAID is planning a clinical trial this year in patients with MDR TB and XDR TB.

Malaria.—Nearly half of the world's population is at risk of contracting malaria, a preventable and curable mosquito-borne disease in more than 100 countries. The World Health Organization (WHO) estimates that 300 to 500 million cases of clinical malaria worldwide occur each year, killing 1.3 million people. Unfortunately, its impact is intensifying with the emergence of drug-resistant parasites and insecticide-resistant mosquitoes. In April 2008, NIAID announced its new strategic plan to accelerate malaria control and eradication. NIH research often involves international partners and encompasses all aspects of malaria, including these recent examples:

—NIGMS funding supported the genetic decoding of the parasite responsible for 40 percent of infections, Plasmodium vivax, 1 of 4 malaria parasites that routinely affect humans. The most common species outside Africa (including the United States), P. vivax is increasingly resistant to some antimalarial drugs.

—The NIAID-funded Malaria Research and Training Center in Mali completed the first clinical trial of a vaccine to block the malaria parasite from entering human blood cells.

—NIGMS-supported research described how harmless E. coli bacteria can be harnessed to synthesize an antimalarial compound in bulk, far less expensive than the current process.

INFECTIOUS DISEASE RESEARCH USES INTERDISCIPLINARY STRATEGIES AND NEW TECHNOLOGIES

NIAID and NIGMS, like other NIH Institutes and Centers, support productive basic research on literally hundreds of diseases, from periodic foodborne E. coli or Salmonella outbreaks to isolated cases of Ebola fever or anthrax. This enormous responsibility forces constant adaptation to new challenges, often through greater reliance on interdisciplinary strategies or novel research tools and technologies—epitomized by the large-scale, genetics-based initiatives made possible with today's powerful computing capabilities. In 2008, NIH launched a multi-Institute epigenomics initiative to better understand the role of the environment in regulating mammalian genes, through genome mapping, data analysis, and technology development. NIH also agreed to share databases from its Human Microbiome Project in support of the newly formed International Human Microbiome Consortium. Characterizing the human microbiome, which is the collective DNA of all the microbes living in or on the human body, will elucidate the relationship between microbes and humans during health and disease. Shared sample repositories overseen by databases expedite information exchange among scientists. Computerized screening of pathogen genomes similarly accelerates the search for treatments, vaccines, and diagnostics.

CONCLUSION

ASM is thankful that Congress recognizes both the medical benefits and economic impacts of biomedical research and has provided an infusion of funding for the NIH to uncover new knowledge that will improve public health. Investing in NIH will impact the health of people for years to come and the biomedical community is working to ensure wise investment of the new resources in fiscal year 2009. We are confident that investments in the NIH will result in new discoveries and innovations that can address many of our health and economic challenges.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR NUTRITION

The American Society for Nutrition (ASN) appreciates this opportunity to submit testimony regarding fiscal year 2010 appropriations for the National Institutes of Health (NIH) and the National Center for Health Statistics (NCHS). ASN is the professional scientific society dedicated to bringing together the world's top researchers, clinical nutritionists, and industry to advance our knowledge and application of nutrition to promote human and animal health. Our focus ranges from the most critical details of research to very broad societal applications. ASN respectfully requests $32.4 billion for NIH, and we request $137.5 million for NCHS in fiscal year 2010.

Basic and applied research on nutrition, nutrient composition, the relationship between nutrition and chronic disease and nutrition monitoring are critical to the health of all Americans and the U.S. economy. Awareness of the growing epidemic of obesity and the contribution of chronic illness to burgeoning healthcare costs has highlighted the need for improved information on dietary components, dietary intake, strategies for dietary change, and nutritional therapies. Preventable chronic

diseases related to diet and physical activity cost the economy more than $117 billion annually, and this cost is predicted to rise to $1.7 trillion in the next 10 years. It is for this reason that we urge you to consider these recommended funding levels for two agencies under the Department of Health and Human Services that have profound effects on nutrition research, nutrition monitoring, and the health of all Americans—NIH and NCHS.

NIH

NIH is the Nation's premier sponsor of biomedical research and is the agency responsible for conducting and supporting 90 percent (nearly $1 billion) of federally funded basic and clinical nutrition research. Nutrition research, which makes up about 4 percent of the NIH budget, is truly a trans-NIH endeavor, being conducted and funded across multiple Institutes and Centers. Some of the most promising nutrition-related research discoveries have been made possible by NIH support.

In order to fulfill the extraordinary promise of biomedical research, including nutrition research, ASN recommends an fiscal year 2010 funding level of $32.4 billion for the agency, which is a 7 percent increase ($2.1 billion) more than fiscal year 2009.

Over the past 50 years, NIH and its grantees have played a major role in the explosion of knowledge that has transformed our understanding of human health, and how to prevent and treat human disease. Because of the unprecedented number of breakthroughs and discoveries made possible by NIH funding, scientists are helping Americans to live longer, healthier, and more productive lives. Many of these discoveries are nutrition-related and have impacted the way clinicians prevent and treat heart disease, cancer, diabetes, and age-related macular degeneration.

During the next 25 years, the number of Americans with chronic disease is expected to reach 46 million, and the number of Americans older than age 65 is expected to be the largest in our Nation's history. Sustained support for basic and clinical research is required if we are to confront successfully the healthcare challenges associated with an older, and potentially sicker, population.

For several years in a row the NIH budget failed to keep up with inflation and subsequently, the percentage of dollars funding nutrition-focused projects declined. We applaud Congress' inclusion of funds for NIH in H.R. 1, the American Recovery and Reinvestment Act, and also the boost provided in the fiscal year 2009 omnibus appropriations bill. It is imperative that we continue our commitment to biomedical research and to fulfill the hope of the American people by making the NIH a national priority. Otherwise, we risk losing our Nation's dominance in biomedical research.

The 7 percent increase we recommend is an important step toward President Obama's campaign pledge to double funding for basic research over 10 years and is necessary to maintain both the existing and future scientific infrastructure. The discovery process—while it produces tremendous value—often takes a lengthy and unpredictable path. Recent experience has demonstrated how cyclical periods of rapid funding growth followed by periods of stagnation is disruptive to training, to careers, long-range projects and ultimately to progress. NIH needs sustainable and predictable budget growth to achieve the full promise of medical research to improve the health and longevity of all Americans.

CDC NCHS

NCHS, housed within the Centers for Disease Control and Prevention (CDC), is the Nation's principal health statistics agency. The NCHS provides critical data on all aspects of our healthcare system, and it is responsible for monitoring the Nation's health and nutrition status. Nutrition and health data, largely collected through the National Health and Nutrition Examination Survey (NHANES), is essential for tracking the health and well-being of the American population, and it is especially important for observing health trends in our Nation's children. Knowing both what Americans eat and how their diets directly affect their health provides valuable information to guide policies on food safety, food labeling, food assistance, military rations, and dietary guidance.

Over the past few years, flat and decreased funding levels have threatened the collection of this important information, most notably vital statistics and the NHANES. ASN was pleased to see that Congress appropriated an additional $11 million to the agency—for nearly $125 million total—in fiscal year 2009. This halted what would have been the beginning of drastic cuts to the agency's premier health surveys—NHANES and the National Health Information Survey—that were slated to occur should the agency not receive additional funds.

To continue support for the agency and its important mission, ASN recommends an fiscal year 2010 funding level of $137.5 million for the agency, which is a $12.5 million increase over fiscal year 2009.

Current funding levels for NCHS remain precarious. Before the recent increase in funds, NCHS had lost $13 million in purchasing power since fiscal year 2005 due to years of flat funding, coupled with inflation and the increased costs of technology and information security. These shortfalls forced the elimination of data collection and quality control efforts, threatened the collection of vital statistics, stymied the adoption of electronic systems and limited the agency's ability to modernize surveys to reflect changes in demography, geography, and health delivery.

Moreover, nearly 30 percent of the funding for NHANES comes from other Federal agencies such as the NIH and the Environmental Protection Agency. When these agencies face flat budgets or cuts, they withdraw much-needed support for NHANES, placing this national treasure in even greater jeopardy.

The obesity epidemic is a case in point that demonstrates the value of the work done by NCHS. It is because of NHANES that our Nation became aware of this growing public health problem, and as obesity rates have increased to 31 percent of American adults (which we know because of continued monitoring), so too have rates of heart disease, diabetes, and certain cancers. It is only through continued support of this program that the public health community will be able to stem the tide against obesity. Continuous collection of this data will allow us to determine not only if we have made progress against this public health threat, but also if public health dollars have been targeted appropriately. A recent report from the Institute of Medicine recognized the importance of NHANES and called for the enhancement of current surveillance systems to monitor relevant outcomes and trends with respect to childhood obesity.

Providing an additional $12.5 million in fiscal year 2010 continues the progress on the path to boost funding for the NCHS to $175 million by 2013. Reaching this level over 5 years, through annual increases of approximately $11–12 million, would allow the agency to reach what its supporters call "blue sky." Such an increase would ensure uninterrupted collection of vital statistics and sustain over-sampling of vulnerable populations.

ASN thanks your subcommittee for its support of the NIH and NCHS in previous years.

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF PLANT BIOLOGISTS

On behalf of the American Society of Plant Biologists (ASPB) we would like to thank the subcommittee for its extraordinary support of the National Institutes of Health (NIH) and ask that the subcommittee members encourage increased funding for plant biology research, which has contributed in innumerable ways to improving the lives of people throughout the world.

ASPB is an organization of more than 5,000 professional plant biologists, educators, graduate students, and postdoctoral scientists. A strong voice for the global plant science community, our mission—which is achieved through engagement in the research, education, and public policy realms—is to promote the growth and development of plant biology and plant biologists and to foster and communicate research in plant biology. The Society publishes the highly cited and respected journals Plant Physiology and The Plant Cell, and it has produced and supported a range of materials intended to demonstrate fundamental biological principles that can be easily and inexpensively taught in school and university classrooms by using plants.

PLANT BIOLOGY RESEARCH AND AMERICA'S FUTURE

Plants are vital to our very existence. They harvest sunlight, converting it to chemical energy for food and feed; they take up carbon dioxide and produce oxygen; and they are almost always the primary producers in the Earth's ecosystems. Plants and plant-based products directly or indirectly provide our food, our shelter, and our clothing.

Basic plant biology research is making many fundamental contributions in vital areas including health and nutrition, energy, and climate change. For example, because plants are the ultimate source of both human nutrition and nutrition for domestic animals, plant biology has the potential to contribute greatly to reducing healthcare costs as well as playing an integral role in drug discovery and therapies. Although the NIH does offer some funding support to plant biology research, with increased funding plant biologists can offer much more to advance the missions of

the NIH. In the next section, we highlight the particular relevance of plant biology research to human health.

PLANT BIOLOGY AND THE NIH

The mission of the NIH is to pursue "fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability" (http://www.nih.gov/about/index.html#mission). Plant biology research is highly relevant to this mission.

Plants are often the ideal model systems to advance our "fundamental knowledge about the nature and behavior of living systems," as they provide the context of multi-cellularity, while affording ease of genetic manipulation, a lesser regulatory burden, and inexpensive maintenance requirements. Many basic biological components and mechanisms are shared by both plants and animals. For example, a molecule named cryptochrome that senses light was identified first in plants and subsequently found to also function in humans, where it plays a central role in regulating our biological clock. Jet lag provides one familiar example of what happens to us when our biological clock is disrupted, but there are also human genetic disorders that have been linked to malfunctioning of the clock. As another example, some fungal pathogens can infect both humans and plants.

HEALTH AND NUTRITION

Plant biology research is also central to the application of basic knowledge to "extend healthy life and reduce the burdens of illness and disability." This connection is most obvious in the inter-related areas of nutrition and clinical medicine. Without good nutrition, there cannot be good health. One World Health Organization (WHO) study on childhood nutrition in developing countries concluded that more than 50 percent of the deaths of children less than 5 years of age could be attributed to malnutrition's effects in exacerbating illnesses such as respiratory infections and diarrhea. In other words, those illnesses would not have proved fatal had the children simply received proper nutrition. Strikingly, most of these deaths were not linked to severe malnutrition but only to mild or moderate nutritional deficiencies. Plant biology researchers are working today to improve the nutritional content of crop plants by, for example, increasing the availability of nutrients and vitamins such as iron, vitamin E and vitamin A. (Up to 500,000 children in the developing world go blind every year as a result of vitamin A deficiency).

By contrast, obesity, cardiac disease, and cancer take a striking toll in the developed world. Among many plant biology initiatives relevant to these concerns are research to improve the lipid composition of plant fats and efforts to optimize concentrations of plant compounds that are known to have anti-carcinogenic properties, such as the glucosinolates found in broccoli and cabbage.

DRUG DISCOVERY

Plants are also fundamentally important as sources of both extant drugs and drug discovery leads. In fact, more than 10 percent of the drugs considered by the WHO to be "basic and essential" are still exclusively obtained from flowering plants. Some historical examples are quinine, which is derived from the bark of the cinchona tree and was the first highly effective antimalarial drug; and the plant alkaloid morphine, which revolutionized the treatment of pain.

These pharmaceuticals are still in use today. A more recent example of the importance of plant-based pharmaceuticals is the anti-cancer drug taxol. The discovery of taxol came about through collaborative work involving scientists at the National Cancer Institute within NIH and plant biologists at the U.S. Department of Agriculture. The plant biologists collected a wide diversity of plant materials, which were then evaluated for anti-carcinogenic properties. It was found that the bark of the Pacific yew tree yielded one such compound, which was eventually isolated and named taxol after the tree's Latin name, Taxus brevifolia. Originally, taxol could only be obtained from the tree bark itself, but basic research led to identification of its molecular structure and eventually to its chemical synthesis in the laboratory.

On the basis of a growing understanding of metabolic networks, plants will continue to be sources for the development of new medicines to help treat cancer and other ailments. Taxol is just one example of a plant secondary compound. Since plants produce an estimated 200,000 such compounds, they will continue to provide a fruitful source of new drug leads, particularly if collaborations such as the one described above can be fostered and funded. With additional research support, plant biologists can lead the way to developing new medicines and biomedical applications to enhance the treatment of devastating diseases.

CONCLUSION

Despite the fact that plant biology research underlies so many vital practical considerations for our country, the amount invested in understanding the basic function and mechanisms of plants is small when compared with the impacts of this information on multibillion dollar sectors of the economy such as health, energy, and agriculture.

Clearly, the NIH does recognize that plants are a vital component of its mission. However, because the boundaries of plant biology research are permeable and because information about plants integrates with many different disciplines that are highly relevant to NIH, ASPB hopes that the subcommittee will provide additional resources through increased funding to NIH for plant biology in order to help pioneer new discoveries and new methods in biomedical research.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS

The American Society for Pharmacology and Experimental Therapeutics (ASPET) is pleased to submit written testimony in support of the National Institutes of Health (NIH) fiscal year 2010 budget. ASPET is a 4,500-member scientific society whose members conduct basic and clinical pharmacological research within the academic, industrial, and government sectors. Our members discover and develop new medicines and therapeutic agents that fight existing and emerging diseases as well as increasing our knowledge regarding how therapeutics work in humans.

ASPET members recognize the trust and support that Congress displayed with the recent $10.4 billion provided to the NIH in the American Recovery and Reinvestment Act (ARRA). This was a visionary attempt by Congress to stimulate the economy by restoring their historic support of the NIH which has lagged over the last 6 years as appropriations have failed to adequately fund the NIH to meet scientific opportunities and challenges to our public health. Prior to ARRA funding, the NIH research portfolio could barely keep pace with the inflation rate and the country's leadership in biomedical research was in danger. Since the completion of a bipartisan plan to double the NIH budget that ended in 2003 and prior to ARRA funding, the NIH budget had been going backwards.

For fiscal year 2010, ASPET urges Congress to increase funding for the NIH by 7 percent. This would be the first step toward the President's pledge to double funding for basic research over 10 years and importantly, would help to maintain existing and future scientific infrastructure. Scientific discovery takes time and a 7 percent increase in fiscal year 2010 and beyond will help NIH manage its research portfolio effectively without necessitating disruptions in continuity of existing grants to researchers throughout the country. Only through sustainable and predictable funding can NIH continue to fund the highest-quality biomedical research to help improve the health of all Americans and continue to make significant economic impact in many communities across the country. Failing to capitalize upon the ARRA investments in fiscal year 2010 and beyond will mean that NIH will have to dismantle newly built research capacity and terminate important research projects after the ARRA funds have been spent. This would have serious consequences for future scientific discovery. Scientific discovery takes time and is unpredictable. As recent experience has shown from the postdoubling experience, boom and bust cycles of rapid funding followed by significant periods of stagnation or retraction in the NIH budget diminish scientific process. If NIH cannot sustain its recent investments from the ARRA, a rapid diminishment of funding will further disrupt scientific careers among promising young and early career scientists who see little hope of promising and rewarding careers in biomedical research. It is critical to avoid a boom and bust cycle for NIH funding. Thus, appropriating NIH a 7 percent increase beginning in fiscal year 2010 will help achieve the full promise of biomedical research.

NIH IMPROVES HUMAN HEALTH AND IS AN ECONOMIC ENGINE

A 7 percent increase in fiscal year 2010 will help to reverse what ASPET feels is a wrong signal that has been sent to the best and brightest of our students who will not be able to or have chosen not to pursue a career in biomedical research. Failing to address the NIH scientific and infrastructure needs post-ARRA in 2010 and beyond will mean a significant reduction in research grants, jobs lost and the resulting phasing-out of research programs. Additionally, there would be a loss of scientific opportunities to discover new therapeutic targets to develop, and fewer discoveries that produce spin-off companies that employ individuals in districts around

the country. A 7 percent increase would provide the Institutes with an opportunity to fund more high-quality and innovative research, and provide the resources and incentives that will drive more young scientists to commit to careers supporting continuing improvements in public health. This investment will also go directly into supporting jobs for U.S. citizens and residents and will continue to stimulate the economy.

Many important drugs have been developed as a direct result of the basic knowledge gained from federally funded research, such as new therapies for breast cancer, the prevention of kidney transplant rejection, improved treatments for glaucoma, new drugs for depression, and the cholesterol lowering drugs known as statins that prevent 125,000 deaths from heart attack each year. AIDS-related deaths have fallen by 73 percent since 1995 and the 5-year survival rate for childhood cancers rose to almost 80 percent in 2000 from under 60 percent in the 1970s. NIH studies have indicated that adopting intensive lifestyle changes delayed onset of type 2 diabetes by 58 percent and that progesterone therapy can reduce premature births by 30 percent in women at risk.

Historically, our past investment in basic biological research has led to innovative medicines that have virtually eliminated diphtheria, whooping cough, measles and polio in the United States. Eight out of ten children now survive leukemia. Death rates from heart disease and stroke have been reduced by half in the past 30 years. Molecularly targeted drugs such as Gleevec™ to treat adult leukemia do not harm normal tissue and dramatically improve survival rates. NIH research has developed a class of drugs that slow the progression of symptoms of Alzheimer's disease. The robust past investment in the NIH has provided major gains in our knowledge of the human genome, resulting in the promise of pharmacogenetics and a reduction in adverse drug reactions that currently represent a major worldwide health concern.

But unless NIH can maintain an adequate funding stream scientific opportunities will be delayed, lost, or forfeited to biomedical research opportunities in other countries and the human and economic cost will continue to impact all of us.

Scientific inquiry leads to better medicine and there remain many challenges and opportunities that need to be addressed. Two issues specific to ASPET highlight the need for appropriate NIH funding levels.

—The need to increase support for training and research in integrative/whole organ science. This will help to develop skilled scientists trained to understand how drugs act in whole animals, including human beings. Support for training and research in integrative whole organ sciences has been affirmed in the fiscal year 2002 Labor, Health and Human Services, and Education, and Related Agencies Appropriations Report (107–84). The Senate report supports ASPET recommendation that "Increased support for research and training in whole systems pharmacology, physiology, toxicology, and other integrative biological systems that help to define the effects of therapy on disease and the overall function of the human body." These principles and recommendations are also affirmed in the FASEB Annual Consensus Conference Report on Federal Funding for Biomedical and Related Life Sciences Research for fiscal year 2002.

—The need to meet public health concerns over growing consumer use of botanical therapies and dietary supplements. These products have unsubstantiated scientific efficacy and may adversely impact the treatment of chronic diseases, create dangerous interactions with prescription drugs, and may cause serious side effects including death among some users. Through the NIH, research into the safety and efficacy of botanical products can be conducted in a rigorous and high-quality manner. Sound pharmacological studies will help determine the value of botanical preparations and the potential for their interactions with prescription drugs as well as chronic disease processes. This research will allow the FDA to review the available pharmacology and review valid evidence-based reviews to form a valid scientific foundation for regulating these products.

CONCLUSION

NIH and the biomedical research enterprise face a critical moment. For the first time in 6 years, NIH has the potential to meet many of the more promising scientific opportunities that currently challenge medicine. Reversing the trends of the last half decade is only part of the solution. In order to help sustain scientific progress it is critical that NIH receive 7 percent to continue the progress made under the ARRA. A 7 percent increase for the NIH in fiscal year 2010 will permit the NIH to make greater strides to prevent, diagnose and treat disease, improving the health of our Nation and restoring the NIH to its role as a national treasure that attracts and retains the best and brightest to biomedical research.

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF TROPICAL MEDICINE AND HYGIENE

OVERVIEW

The American Society of Tropical Medicine and Hygiene (ASTMH) appreciates the opportunity to submit written testimony to the Senate Labor, Health and Human, Services, and Education, and Related Agencies Appropriations Subcommittee. With more than 3,300 members, ASTMH is the world's largest professional membership organization dedicated to the prevention and control of tropical diseases.

We respectfully request that the subcommittee provide the following allocations in the fiscal year 2010 Labor, Health and Human, Services, and Education, and Related Agencies Appropriations bill to support a comprehensive effort to enhance malaria control programming globally:

—$18 million to the Centers for Disease and Control and Prevention (CDC) for malaria research, control, and program evaluation efforts with a $6 million set-aside for program monitoring and evaluation;

—$32.19 billion to National Institutes of Health (NIH);

—$5.07 billion to the National Institute of Allergy and Infectious Diseases (NIAID); and

—$73.5 million to the Fogarty International Center (FIC).

We very much appreciate the subcommittee's consideration of our views, and we stand ready to work with the subcommittee members and staff on these and other important global health matters.

ASTMH

ASTMH plays an integral and unique role in the advancement of the field of tropical medicine. Its mission is to promote global health by preventing and controlling tropical diseases through research and education. As such, ASTMH is the principal membership organization representing, educating, and supporting tropical medicine scientists, physicians, researchers, and other health professionals dedicated to the prevention and control of tropical diseases. Our members reside in 46 States and the District of Columbia and work in a myriad of public, private, and nonprofit environments, including academia, the U.S. military, public institutions, Federal agencies, private practice, and industry.

ASTMH's long and distinguished history goes back to the early 20th century. The current organization was formed in 1951 with the amalgamation of the National Malaria Society and the ASTMH. Over the years, the Society has counted many distinguished scientists among its members, including Nobel Laureates. ASTMH and its members continue to have a major impact on the tropical diseases and parasitology research carried out around the world.

ASTMH aims to advance policies and programs that prevent and control those tropical diseases which particularly impact the global poor. ASTMH supports and encourages Congress to expand funding for—and commitments to—national and international malaria control initiatives. As part of this effort, ASTMH recently conducted an analysis of federally funded tropical medicine and disease programs and developed fiscal year 2010 funding requests based on this assessment.

TROPICAL MEDICINE AND TROPICAL DISEASES

The term "tropical medicine" refers to the wide-ranging clinical, research, and educational efforts of physicians, scientists, and public health officials with a focus on the diagnosis, mitigation, prevention, and treatment of diseases prevalent in the areas of the world with a tropical climate. Most tropical diseases are located in either sub-Saharan Africa, parts of Asia (including the Indian subcontinent), or Central and South America. Many of the world's developing nations are located in these areas; thus tropical medicine tends to focus on diseases that impact the world's most impoverished individuals.

The field of tropical medicine encompasses clinical work treating tropical diseases, work in public health and public policy to prevent and control tropical diseases, basic and applied research related to tropical diseases, and education of health professionals and the public regarding tropical diseases.

Tropical diseases are caused by pathogens that are prevalent in areas of the world with a tropical climate. These diseases are caused by viruses, bacteria, and parasites which are spread through various mechanisms, including airborne routes, sexual contact, contaminated water and food, or an intermediary or "vector"—frequently an insect (e.g. a mosquito)—that transmits a disease between humans in the process of feeding.

MALARIA

Malaria is a global emergency affecting mostly poor women and children; it is an acute and sometimes fatal disease caused by the single-celled Plasmodium parasite transmitted to humans by the female Anopheles mosquito.

Malaria is an acute, often fatal disease caused by a single-celled parasite transmitted to humans by the female Anopheles mosquito. Malaria can cause anemia, jaundice, kidney failure, and death. Despite being treatable and preventable, malaria is one of the leading causes of death and disease worldwide. The World Health Organization (WHO) estimates there were 350 to 500 million malaria cases in 2000 and at least 1 million deaths from malaria, the vast majority of which were among young children in Africa. WHO estimates that one-half of the world's people are at risk for malaria, and that 109 countries are endemic for malaria. Malaria-related illness and mortality not only take a human toll, but also severely impact economic productivity and growth. The WHO has estimated that malaria reduces sub-Saharan Africa's economic growth by up to 1.3 percent per year.

Fortunately, malaria can be both prevented and treated using four types of relatively low-cost interventions: (1) indoor residual spraying of insecticide on the walls of homes; (2) long-lasting insecticide-treated nets; (3) Artemisinin-based combination therapies; and (4) intermittent preventive therapy for pregnant women. However, limited resources preclude the provision of these interventions and treatments to all individuals and communities in need.

REQUESTED MALARIA-RELATED ACTIVITIES AND FUNDING LEVELS

CDC Malaria Efforts

ASTMH calls upon Congress to fund a comprehensive approach to malaria control, including adequately funding the important contributions of CDC. CDC originally grew out of the WWII "Malaria Control in War Areas" program. Since its founding, the Atlanta-based agency has maintained a strong role in efforts to research and mitigate malaria. Although malaria has been eliminated as an endemic threat in the United States for more than 50 years, CDC remains on the cutting edge of global efforts to reduce the toll of this deadly disease.

CDC efforts on malaria fall into three broad areas—prevention, treatment, and vaccines. The agency performs a wide range of basic research within these categories, such as—

—investigation of the biology of host-parasite relationships;
—immune response to malaria;
—host genetic factors associated with malaria; parasite genetic diversity and drug resistance;
—HIV and malaria interaction; the efficacy of insecticide-treated nets in preventing illness and deaths;
—malaria and pregnancy;
—public health strategies for improving access to antimalarial treatment and delaying the appearance of antimalarial drug resistance;
—improved transmission reduction strategies; and
—vaccine development and evaluation.

Although endemic malaria has been eradicated in the United States, it remains one of world's leading causes of death and disease, and a significant proportion of CDC's malaria-focused work involves working in and with foreign countries to prevent the spread of malaria, and to assist in the treatment of those who have contracted the disease. CDC funding in fiscal year 2009 for global malarial activities is $9,396,000, which includes CDC's contribution to the $6.2 billion President's Malaria Initiative.

CDC participates in several global efforts, including:

—*The President's Malaria Initiative (PMI)*.—The PMI is a $6.2 billion, 9-year effort led by the U.S. Agency for International Development in conjunction with CDC and other Government agencies to lower the incidence of malaria in 15 targeted countries in sub-Saharan Africa by 50 percent.
—*Amazon Malaria Initiative*.—This program works with countries in South America to combat the re-emergence of malaria in that part of the world.
—*West Africa Network Against Malaria During Pregnancy*.—CDC works with countries in Francophone West Africa to encourage the use of intermittent preventive treatment with sulfadoxine-pyrimethamine (IPTp/SP) to prevent anemia and death in pregnant women and malaria-related low-birthweight in their newborns.
—*Preventing and Controlling Malaria During Pregnancy in Sub-Saharan Africa*.—CDC works with many partners to prevent and control malaria among pregnant women and their newborns in sub-Saharan Africa.

—*International Red Cross and the Expanded Program for Immunizations*.—CDC works with these groups to implement and evaluate the effectiveness of distributing ITNs during immunization campaigns and during routine vaccine visits.

CDC collaborations support treatment and prevention policy change based on scientific findings; formulation of international recommendations through membership on WHO technical committees; and work with Ministries of Health and other local partners in malaria-endemic countries and regions to develop, implement, and evaluate malaria programs. In addition, CDC has provided direct staff support to the WHO; UNICEF; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; and the World Bank—all stakeholders in the Roll Back Malaria Partnership.

NIH MALARIA PROGRAMS

As the premier biomedical research agency for the United States and the world, the NIH and its Institutes and Centers play an essential role in the development of new anti-malarial drugs, better diagnostics, and an effective malaria vaccine. NIH estimates that its fiscal year 2009 spending on malaria research will total $111 million while malaria vaccine efforts will receive $35 million. ASTMH urges that NIH malaria research portfolio and budget be increased by at least 6.6 percent in fiscal year 2010. To support a comprehensive effort to control malaria, ASTMH respectfully requests the following funding:

—$32.9 billion to NIH;
—$5.07 billion NIAID; and
—$73.5 million to the FIC for training that supports U.S. efforts targeting malaria and other neglected tropical diseases.

NIAID

Malaria continues to be among the most daunting global public health challenges we face. A long-term investment is needed to achieve the drugs, diagnostics and research capacity needed to control malaria. NIAID, the lead Institute for malaria research, plays an important role in developing the drugs and vaccines needed to fight malaria. ASTMH urges the subcommittee to increase NIAID funding so that present malaria research efforts be maintained and new areas explored such as:

—increasing fundamental understanding of the complex interactions among malaria parasites, the mosquito vectors responsible for their transmission and the human host;
—developing new diagnostics, drugs, vaccines, and vector management approaches; and
—enhancing both national and international research and research training infrastructure to meet malaria research needs.

FIC

Although biomedical research has provided major advances in the treatment and prevention of malaria, these benefits are often slow to reach the people who need them most. Highly effective anti-malarial drugs exist; when patients receive these drugs promptly, their lives can be saved. FIC plays a critical role in strengthening science and public health research institutions in low-income countries. By promoting applied health research in developing countries, the FIC can speed the implementation of new health interventions for malaria, TB, and neglected tropical diseases.

The FIC works to strengthen research capacity in countries where populations are particularly vulnerable to threats posed by malaria and neglected tropical diseases. FIC efforts that strengthen the research workforce in-country—including collaborations with U.S.-supported global health programs—help to ensure the continuous improvement of programs, adapting them to local conditions. This maximizes the impact of U.S. investments and is critical to fighting malaria and other tropical diseases.

FIC addresses global health challenges and supports the NIH mission through myriad activities, including:

—collaborative research and capacity building projects relevant to low- and middle-income nations;
—institutional training grants designed to enhance research capacity in the developing world, with an emphasis on institutional partnerships and networking;
—the Forum for International Health, through which NIH staff share ideas and information on relevant programs and develop input from an international perspective on cross-cutting NIH initiatives;
—the Multilateral Initiative on Malaria, which fosters international collaboration and co-operation in scientific research against malaria; and

—the Disease Control Priorities Project, is a partnership supported by FIC, The Bill & Melinda Gates Foundation, the WHO, and the World Bank to develop recommendations on effective healthcare interventions for resource-poor settings.

ASTMH urges the subcommittee to allocate additional resources to the FIC in fiscal year 2010 to increase these efforts, particularly as they address the control and treatment of malaria.

CONCLUSION

Thank you for your attention to these important global health matters. We know you face many challenges in choosing funding priorities, and we hope you will provide the requested fiscal year 2010 resources to those programs identified above. ASTMH appreciates the opportunity to share its views, and we thank you for your consideration of our requests.

PREPARED STATEMENT OF THE AMERICAN THORACIC SOCIETY

The American Thoracic Society (ATS) is pleased to submit our recommendations for programs in the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee purview. ATS, founded in 1905, is an independently incorporated, international education and scientific society that focuses on respiratory and critical care medicine. With approximately 18,000 members who help prevent and fight respiratory disease around the globe, through research, education, patient care and advocacy, ATS's long-range goal is to decrease morbidity and mortality from respiratory disorders and life-threatening acute illnesses.

RESPIRATORY DISEASE IN AMERICA

Respiratory disease is a serious problem in America. Respiratory disease is the third leading cause of death, responsible for 1 of every 7 deaths. Diseases effecting the lungs include chronic obstructive pulmonary disease, lung cancer, tuberculosis, influenza, sleep disordered breathing, pediatric lung disorders, occupational lung disease, sarcoidosis, asthma, and severe acute respiratory syndrome (SARS). The death rate due to chronic obstructive pulmonary disease (COPD) has doubled within the last 30 years and is still increasing, while the rates for the other three top causes of death (heart disease, cancer, and stroke) have decreased by more than 50 percent. The number of people with asthma in the United States has surged more than 150 percent since 1980 and the root causes of the disease are still not fully known. Cystic fibrosis and pulmonary hypertension, which jointly affect nearly 150,000 people in the United States, have no cure.

NATIONAL INSTITUTES OF HEALTH (NIH)

The ATS deeply appreciates the $10 billion in supplemental funding provided for the NIH in the American Recovery and Reinvestment Act and the 3.2 percent increase provided through the omnibus fiscal year 2009 appropriations legislation. This funding will allow the NIH to continue to fund, rather than curtail, groundbreaking research into diseases that affect millions of Americans like COPD, asthma, and tuberculosis. It is critical that this urgently needed reinvestment in biomedical research is reinforced through annual budget increases that include inflationary adjustments. We ask that this subcommittee provide a 7 percent increase for NIH in fiscal year 2010 so that the institute can respond to biomedical research opportunities and public health needs.

Despite the rising lung disease burden, lung disease research is underfunded. In fiscal year 2008, lung disease research represented just 20.4 percent of the National Heart Lung and Blood Institute's (NHLBI) budget. Although COPD is the fourth leading cause of death in the United States, research funding for the disease is a small fraction of the money that is invested for the other three leading causes of death. In order to stem the devastating effects of lung disease, research funding must continue to grow to sustain the medical breakthroughs made in recent years.

CENTERS FOR DISEASE CONTROL AND PREVENTION

In order to ensure that health promotion and chronic disease prevention are given top priority in Federal funding, the ATS supports a funding level for the Centers for Disease Control and Prevention (CDC) that enables it to carry out its prevention mission, and ensure an adequate translation of new research into effective State and local public health programs. We also ask that the CDC budget be adjusted to reflect increased needs in chronic disease prevention, infectious disease control, in-

cluding TB control to prevent the spread of drug-resistant TB, and occupational safety and health research and training. The ATS recommends a funding level of $8.6 billion for the CDC in fiscal year 2010. There are four lung diseases that illustrate the need for further investment in research and public health programs: COPD, pediatric lung disease, asthma and tuberculosis.

COPD

COPD is the fourth leading cause of death in the United States and the third leading cause of death worldwide. Yet, the disease remains relatively unknown to most Americans. COPD is the term used to describe the airflow obstruction associated mainly with emphysema and chronic bronchitis and is a growing health problem. CDC estimates that 12 million patients have COPD while an additional 12 million Americans are unaware that they have this life threatening disease.

Today, COPD is treatable but not curable. Medical treatments exist to relieve symptoms and slow the progression of the disease. Fortunately, promising research is on the horizon for COPD patients. Despite these leads, the ATS feels that research resources committed to COPD are not commensurate with the impact the disease has on the United States and that more needs to be done to make Americans aware of COPD, its causes and symptoms. According to the NHLBI, COPD costs the U.S. economy an estimated $37 billion per year. We recommend that the subcommittee encourage NHLBI and other NIH Institutes to devote additional resources to finding improved treatments and a cure for COPD. The ATS commends the NHLBI for its leadership on educating the public about COPD through the National COPD Education and Prevention Program. As this initiative continues, we encourage the NHLBI to maintain its partnership with the patient and physician community.

While additional resources are needed at NIH to conduct COPD research, CDC has a role to play as well. To address the increasing public health burden of COPD, the ATS encourages the CDC to create a COPD program at the Center for Chronic Disease Prevention and Health Promotion. We ask that the subcommittee provide an appropriation of $1 million in fiscal year 2010 for this program. We are hopeful that the program will include development of a national COPD response plan, expansion of data collection efforts and creation of other public health interventions for COPD. The ATS also encourages the CDC to add COPD-based questions to future CDC health surveys, including the National Health and Nutrition Evaluation Survey (NHANES), the National Health Information Survey (NHIS) and the Behavioral Risk Factor Surveillance Survey (BRFSS).

PEDIATRIC LUNG DISEASE

Lung disease affects people of all ages. The ATS is pleased to report that infant death rates for various lung diseases have declined for the past 10 years. However, of the seven leading causes of infant mortality, four are lung diseases or have a lung disease component. In 2005, lung diseases accounted for more than 19 percent of all infant deaths under 1 year of age. It is also widely believed that many of the precursors of adult respiratory disease start in childhood. The ATS encourages the NHLBI to continue with its research efforts to study lung development and pediatric lung diseases.

ASTHMA

The ATS believes that the NIH and the CDC must play a leadership role in assisting individuals with asthma. National statistical estimates show that asthma is a growing problem in the United States. Approximately 22.2 million Americans currently have asthma, of which 12.2 million had an asthma attack in 2005. African Americans have the highest asthma prevalence of any racial/ethnic group. The age-adjusted death rate for asthma in the African-American population is three times the rate in whites.

SLEEP

Sleep is an essential element of life, but we are only now beginning to understand its impact on human health. Several research studies demonstrate that sleep illnesses and sleep disordered breathing affect an estimated 50–70 million Americans. A recent study conduced by CDC found that roughly 10 percent of Americans had not gotten enough rest at any point in the previous 30 days. The public health impact of sleep illnesses and sleep disordered breathing is still being determined, but is known to include traffic accidents, lost work and school productivity, cardiovascular disease, obesity, mental health disorders, and other sleep-related

comorbidities. Despite the increased need for study in this area, research on sleep and sleep-related disorders has been underfunded. The ATS recommends a funding level of $2 million in fiscal year 2010 to support activities related to sleep and sleep disorders at the CDC, including for the National Sleep Awareness Roundtable (NSART), surveillance activities, and public educational activities. The ATS also recommends an increase of funding for research on sleep disorders at the Nation Center for Sleep Disordered Research (NCSDR) at the NHLBI.

TUBERCULOSIS

Tuberculosis (TB) is the second leading global infectious disease killer, claiming 1.7 million lives each year. It is estimated that 9–14 million Americans have latent tuberculosis. Drug-resistant TB poses a particular challenge to domestic TB control owing to the high costs of treatment and intensive health care resources required. Treatment costs for multidrug-resistant (MDR) TB range from $100,000 to $300,000, which can cause a significant strain on State public health budgets. The global TB pandemic and spread of drug resistant TB present a persistent public health threat to the United States.

Despite low rates, persistent challenges to TB control in the United States remain. Specifically: (1) racial and ethnic minorities continue to suffer from TB more than majority populations; (2) foreign-born persons are adversely impacted; (3) sporadic outbreaks/clusters occur, outstripping local capacity; (4) continued emergence of drug resistance threaten our ability to control TB; and (5) there are critical needs for new tools for rapid and reliable diagnosis, short, safe and effective treatments, and vaccines.

In recognition of the need to strengthen domestic TB control, the Congress passed the Comprehensive Tuberculosis Elimination Act (Public Law 110–392) in October, 2008. This historic legislation was based on the recommendations of the Institute of Medicine and revitalized programs at CDC and the NIH with the goal of putting the United States back on the path to eliminating TB. The new law authorizes an urgently needed reinvestment into new TB diagnostic, treatment and prevention tools. The ATS, in collaboration with Stop TB USA, recommends a funding level of $210 million in fiscal year 2010 for CDC's Division of TB Elimination, as authorized under the Comprehensive TB Elimination Act.

The NIH has a prominent role to play in the elimination of tuberculosis through the development of new tools to fight the disease. We encourage the NIH to expand efforts, as requested under the Comprehensive TB Elimination Act, to develop new tools to reduce the rising global TB burden, including faster diagnostics that effectively identify TB in all populations, new drugs to shorten the treatment regimen for TB and combat drug resistance, and an effective vaccine.

FOGARTY INTERNATIONAL CENTER TB TRAINING PROGRAMS

The Fogarty International Center (FIC) at NIH provides training grants to U.S. universities to teach AIDS treatment and research techniques to international physicians and researchers. Because of the link between AIDS and TB infection, FIC has created supplemental TB training grants for these institutions to train international health care professionals in the area of TB treatment and research. These training grants should be expanded and offered to all institutions. The ATS recommends Congress provide $70 million for FIC in fiscal year 2010, which would allow the expansion the TB training grant program from a supplemental grant to an open competition grant.

RESEARCHING AND PREVENTING OCCUPATIONAL LUNG DISEASE

The National Institute of Occupational Safety and Health (NIOSH) is the sole Federal agency responsible for conducting research and making recommendations for the prevention of work-related diseases and injury. The ATS recommends that Congress provide $340.1 million in fiscal year 2010 for NIOSH to expand or establish the following activities: the National Occupational Research Agenda (NORA); tracking systems for identifying and responding to hazardous exposures and risks in the workplace; emergency preparedness and response activities; and training medical professionals in the diagnosis and treatment of occupational illness and injury.

CONCLUSION

Lung disease is a growing problem in the United States. It is this country's third leading cause of death. Lung disease and breathing problems are a leading killer of babies under the age of one year. Worldwide, tuberculosis is the second leading

infectious disease killer. The level of support this subcommittee approves for lung disease programs should reflect the urgency illustrated by these numbers. The ATS appreciates the opportunity to submit this statement to the subcommittee.

PREPARED STATEMENT OF THE ASSOCIATION OF WOMEN'S HEALTH, OBSTETRIC AND NEONATAL NURSES

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) appreciates the opportunity to provide testimony on fiscal year 2010 appropriations for the Department of Health and Human Services (HHS).

AWHONN is a nonprofit membership organization made up of 23,000 nurses who care for mothers, their newborns, and women of all ages. AWHONN members are registered nurses, nurse practitioners, certified nurse-midwives, and clinical nurse specialists who work in hospitals, independent practices, universities and community clinics throughout the United States. Our mission is to promote the health of women and newborns.

Nurses are typically the first and most consistent point of contact in the healthcare setting. Evidence suggests that they spend more time with patients—up to four times on average—than any other healthcare provider. As such, nurses have a unique perspective on the healthcare system and the public health programs and agencies funded under HHS.

We thank the subcommittee for providing generous funding in past years and we are truly appreciative for the public health funding included in the American Recovery and Reinvestment Act of 2009. Recognizing the challenges the subcommittee will face in fiscal year 2010 in reconciling various expenditures in the face of overall budget deficits, please find our funding recommendations for fiscal year 2010 below.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

As a member of the Friends of the Health Resources and Services Administration coalition, AWHONN recommends $8.5 billion for HRSA in fiscal year 2010.

HRSA programs support health professions education, healthcare services for underserved populations, programs to address the special needs of mothers and children, and more. For several years, HRSA has suffered from relatively level funding. In light of these difficult economic times, support for the Nation's safety net system is especially critical.

One of the most important aspects of HRSA's mission is to ensure a healthcare workforce that is sufficient to meet the needs of patients and communities.

Nursing Workforce Development Programs, title VIII of the Public Health Service Act

Along with the Nursing Community coalition, AWHONN recommends $215 million for title VIII programs in fiscal year 2010. An adequate supply of nurses is essential to ensuring that all Americans receive quality healthcare. Title VIII programs help to address the Nation's ongoing nursing and nurse faculty shortage by providing scholarships and loan repayment programs to nursing students, recent graduates and nursing school faculty. Title VIII also provides grants to schools of nursing and health centers to foster greater diversity and improved retention rates in the nursing workforce.

Maternal and Child Health (MCH) Block Grant, Title V of the Social Security Act

AWHONN recommends $850 million for the MCH Block Grant in fiscal year 2010. The MCH Block Grant, the only Federal program of its kind, is devoted to improving the health of women and children. For more than 70 years, the program has provided a source of flexible funding for States and territories to address their unique needs related to improving the health of mothers and children. Today, this program provides prenatal services to more than 2 million mothers—almost half of all mothers who give birth annually—and primary and preventive care to more than 17 million children, including almost 1 million children with special needs. Fully funding the MCH block grant will enable States to expand critical health services.

We recommend $30 million for newborn screening activities, which are currently funded under the MCH block grant Special Projects of Regional and National Significance. Newborn screening is a vital public health activity used to identify and treat genetic, metabolic, hormonal, and functional conditions in newborns. Screening detects disorders in newborns that, if left untreated, can cause disability, mental retardation, serious illnesses or even death. While nearly all babies born in the United States undergo newborn screening for genetic birth defects, the number and quality of these tests vary from State to State.

NATIONAL INSTITUTES OF HEALTH (NIH)

AWHONN, along with others in the science advocacy community, support increased funding for NIH in fiscal year 2010. Scientific research done at the NIH is leading to better patient care. In fact, federally funded research is responsible for nearly every major medical advancement in the last 50 years. While AWHONN supports the NIH in its entirety, several Institutes are especially important to the advancement of nursing and the health of women and newborns.

The Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD)

The rate of preterm birth has increased 20 percent since 1990. The NICHD supports critical research into the causes and treatments for preterm birth.

AWHONN, along with the March of Dimes, recommends that Congress provide at least a 7 percent increase for NICHD in fiscal year 2010, a portion to be used to begin establishing transdisplinary research centers that focus on preterm birth. NICHD needs additional resources to expand research on the underlying causes of preterm birth taking into account the recommendations of the experts who participated in the Surgeon General's Conference on Preterm Birth in the summer of 2008.

National Institute of Nursing Research (NINR)

AWHONN, along with the American Nurses Association and the American Association of Colleges of Nursing, recommends $178 million for NINR in fiscal year 2010.

NINR supports nurse-led research that contributes to advancing high-quality, evidence-based care across the lifespan. Research at NINR has targeted, among other topics, health disparities, risk reduction, chronic illnesses, and care for rural and underserved populations. NINR promotes a uniquely important nursing perspective, as there is no caregiver that interacts with patients more or is more trusted by patients than nursing professionals. There is no other body that funds important nursing research similarly in this country, and NINR research has contributed measurably to more efficient and effective healthcare as our Nation struggles to fill continuing staffing shortages and gaps in healthcare services.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

The CDC is dedicated to protecting health and promoting quality of life through the prevention and control of disease, injury, and disability. While AWHONN supports the CDC in its entirety, several agencies and programs are especially important to the advancing the health of women and newborns.

Safe Motherhood/Infant Health

The Safe Motherhood/Infant Health program works to promote infant and reproductive health. AWHONN is especially concerned with issues associated with prematurity. Preterm birth is the leading cause of neonatal death in the United States. In 2006, more than half a million babies—1 in 8 babies—were born prematurely in the United States.

In 2005, AWHONN launched its Late Preterm Initiative to address the special needs of infants born between 34 and 36 completed weeks of gestation. While many late preterm infants may appear healthy at birth, they are at risk for prematurity-related complications, increased morbidity and mortality and have an increased rate of rehospitalization in the first month of life.

Currently, the CDC is partnering with a number of universities and organizations to support research related to preterm birth and the reasons for disparities between racial and ethnic groups. AWHONN recommends a $6 million increase in the preterm birth line fiscal year 2010. This funding will allow the CDC to expand epidemiological work to evaluate the social, biological, and medical factors associated with preterm birth as authorized in the PREEMIE Act of 2006 (Public Law 109–450).

National Center on Health Statistics (NCHS)

NCHS is the Nation's principal health statistics agency, providing critical data on all aspects of the U.S. healthcare system. The agency provides data on healthcare trends, information that is essential for public health planning. However, current funding levels are threatening the collection of vital information, especially complete data on maternity and infant health status.

AWHONN, along with the Friends of NCHS, recommends at least $137.5 million for NCHS in fiscal year 2010. Additionally, we urge Congress to allocate $15 million bolus funding to support States and territories as they implement the 2003 birth certificates and electronic systems to collect these data.

PREPARED STATEMENT OF THE ANIMAL WELFARE INSTITUTE

The Animal Welfare Institute (AWI) respectfully requests that the subcommittee include the following report language regarding the funding of research involving the use of dogs and/or cats:

None of these funds shall be used for the purchase of, or research on, dogs or cats obtained from those USDA licensed Class B dealers who acquire dogs or cats from third parties (i.e., individuals, dealers, breeders, and animal pounds) and resell them.

In response to the request included in last year's appropriation bill, the National Academy of Sciences (NAS) established a committee in the summer of 2008 to assess if there is a scientific rationale for relying on dogs and cats obtained from United States Department of Agriculture (USDA) licensed Class B dealers. Information on the Committee on Scientific and Humane Issues in the Use of Random-source Dogs and Cats for Research (ILAR–K–08–01–A) can be found at: http://www8.nationalacademies.org/cp/projectview.aspx?key=48974. The results of its deliberations are expected to be public later this month.

Based on our review of the data submitted to the NAS Committee, the presentations given during those portions of the meetings that were open to public, and our own extensive experience regarding Class B-licensed dealers, we anticipate findings in keeping with the proposed report language above.

According to USDA, of the nearly 95,000 total dogs and cats used in research, 2,863 dogs and 267 cats were supplied by random source dealers during fiscal year 2007. There are a mere 10 Class B dealers currently licensed by USDA and selling live random source dogs and cats for experimentation. One other dealer is presently under a 5-year license suspension. These dealers are notorious for selling to laboratories animals who have been acquired illegally and for their widespread failure to comply with other minimum requirements under the Animal Welfare Act. In fact, at this time, half of the remaining 10 dealers are under investigation by USDA for apparent violations of the Animal Welfare Act (AWA), and USDA is pursuing seven separate investigations regarding apparent supply violations identified during tracebacks conducted of dealer records.

Data from USDA inspection reports reveal myriad problems with licensed Class B dealers (we can supply copies of these inspection reports if they are of interest): Needed veterinary care is lacking for many random source animals. Hookworm and mange are a widespread problem as is heartworm, particularly in the South. An Ohio dealer had a dog with mange on his head, around the eyes, ears and neck. Another dog had enlarged pupils and bulging eyes, and a third had dried loose dark stool. An Indiana dealer was cited by USDA for dogs suffering from "loose stool with some blood," "loose stool with a drop of blood," "infected or irritated eye," "mange-like lesions," "ring-worm like lesions," "sore on left carpus which was red and warm to the touch," and an animal with "a bite wound to the right front foot." At another inspection, this dealer had two animals who were limping; one had a large tumor on his foot. A third animal had a bite laceration on his face. Another record notes a chronic cough in an underweight dog and a dog with a purulent discharge from his nose. In most cases there is no record of any veterinary care, and after being cited by USDA inspectors, given the poor status of the animals, they are typically killed. An Illinois dealer was cited by USDA for "euthanizing dogs with truck exhaust and tying sick dogs out at the corner of the property where they would die." Later he shifted to use of an electric current administered via clips.

Research institutions may reject animals delivered by a dealer because of the poor condition of the dogs and cats, leaving them to be hauled from location to location in search of a taker. If not, the animal may be taken back and left to die or may simply be shot. Some at research institutions have let USDA know of their concerns. One such email identified a cat "in very poor condition: cache[c]tic, severely matted hair coat and a severe case of ear mites." It went on to note:

"Many of the cats that we receive are wild or are almost wild. I do not understand where these cats come from and how they are examined for health certificates. I thought the animals had to come from someone who had raised and bred the animals on their property or from a specific shelter."

The conditions for housing, feeding, and care can be problematic as well. An Ohio dealer was cited by USDA inspectors for contaminated straw, wet with urine and excessive feces. Excessive flies. Water receptacles contaminated with black and green algae—a thick layer. A dealer in Indiana had dogs unable to avoid contact with excreta. Another dealer's inspection report notes, "Some 70–75 percent dogs have water and bread and little bits of dog food floating in water. There were some

dogs that had only bread and water. Some had dog food floating in water. Most of dogs had not eaten the watery food blend. About 70 percent of the total dogs had nonpotable water. Water was mixed with bread and dog food and sitting in the direct sun."

In addition, there are widespread problems with record-keeping and acquiring animals from illegal sources. Further, dealers commonly network with each other; that is, animals are sold from buncher (an unlicensed dealer) to dealer to another dealer before being sold for research. Also, typically, the buncher is immune from prosecution until he is caught by USDA and warned not to sell more than 25 animals in a year without a license again. Then he drops down to selling fewer animals so he is exempt from licensure, he sells some of the animals using the name of someone else he knows, or he steps forward and gets licensed for a while, makes a lot of money and then when USDA appears to be catching up with him, he turns in his license.

One example is the case of Clayton McDowell, a buncher with hunting dog kennels who didn't let the fact that he had no license stop him from selling 60 dogs to a USDA licensed Class B dealer in Illinois. According to USDA, he "knew about USDA licensing requirements. He stated he would quit selling dogs to B dealers. He stated there was too much hassle with identification, record keeping." McDowell received a Letter of Warning from USDA, and he addressed the matter by getting licensed. Ultimately, he decided to quit operating as a licensed Class B dealer, though he continued selling hunting dogs, claiming he would only sell the dogs retail for hunting purposes.

Then there's a Kentucky dealer cited by a USDA inspector who repeatedly failed to include essential details on the acquisition sheets, such as the seller's address, driver's license number, and vehicle tag number. He was found to have failed to collect this information on 3 different dates regarding 13 animals. And a Michigan dealer was cited for receiving stray cats from the city of Howard City. The city has no pound, but the licensed dealer was willing to step in and collect cats. An Illinois dealer was cited on at least three separate occasions for his failure to maintain complete records.

A veterinarian at a research facility expressed concern in an email to USDA that the animals it received from a dealer appeared to be "companion animals." A neutered male Airedale, an intact male Weimeriner and a male chocolate Labrador all were affectionate and obeyed commands. Similarly, the cats received by the facility were "some of the most obedient and affectionate cats that we ever met."

Another common pattern is for individuals to pass the business on to other members of the family after carefully showing them the ropes. Sometimes a former employee of a dealer, who has also learned how to work the system, may go off on his own and get licensed as well. Though it's not a formal program, in essence some dealers offer an apprenticeship.

Brothers living in Missouri ran their licensed Class B dealer operation as a team, then one of them retired and the other's wife joined him in running the business. USDA finally caught up with the pair, and they were charged with a laundry list of violations, including failure to maintain records that fully and correctly disclose the identities and other required information of the persons from whom dogs were acquired on 51 separate occasions, including one incident that pertained to 43 dogs. Further, they were charged with failing to provide complete certifications on seven separate occasions, including one that pertained to 195 dogs. The husband died before the case was resolved and though the wife was fined $107,250, the judge suspended $100,000 of it. The story doesn't end here. The couple's son and daughter-in-law, after helping mom close down her business, set up their own Class B dealer operation.

During a House Agriculture Subcommittee hearing held back in 1996, then Assistant Secretary of Agriculture Michael Dunn described his frustration with random source dealers: "Every time we develop a new way to look for something, they develop a new way to hide it." An insurmountable hurdle for USDA is that the AWA allows anyone who claims to have bred and raised an animal to profit by selling the animal to a random source dealer—and how can USDA be expected to disprove it? In addition, with animals transported back and forth across the country, how on earth is USDA supposed to keep up with the movement of animals? USDA has spent years inspecting random source dealers four times a year instead of once a year as is done with all other licensees and registrants under the AWA. In the meantime, unlike any other licensees covered under the AWA, this one group of licensees—Class B dealers selling dogs and cats for research—have a long-standing problem maintaining complete and accurate records.

The Animal Welfare Act was passed in 1966 to address the illegal supply of dogs and cats to laboratories, and here we are 43 years later, and these problems are

still widespread. What has changed significantly over this lengthy period of time is the availability of animals from sources other than random source dealers. Given the problems inherent in the use of licensed Class B dealers, researchers have increasingly and successfully shifted to acquiring most of their dogs and cats from licensed Class A breeders—and by using these dealers instead, the researchers will receive animals who have been raised under controlled conditions, and the health and vaccination status and the genetic background on each individual animal will be known. In addition, some dogs and cats are being bred for experimentation at registered research facilities, and in some cases, inexpensive random type animals are purchased directly from animal pounds.

NIH has told this subcommittee that it is "committed to ensuring the appropriate care and use of animals in research." However, NIH has left the decision of whether or not to buy dogs and cats from random source dealers "to the local level on the basis of scientific need." NIH defends the use of licensed Class B dealers, arguing that these dealers are needed to obtain "animals that may not be available from other sources, such as genetically diverse, older, or larger animals." In fact, in the rare circumstance that a researcher asserts the need for such animals, they can be obtained directly from pounds, as noted previously.

The distinction between nonpurpose-bred animals from pounds versus licensed Class B dealers must be made. By using licensed Class B dealers (middlemen) instead of pounds, researchers are contributing to the problem. In their search to fill researchers' demands for "genetically diverse, older or larger animals," random source dealers and their suppliers may be stealing pets from backyards and farms or they may be acquiring them from individuals who did not breed and raise them as required by the AWA.

All animals used in research should be obtained from lawful sources. Taxpayer dollars, in the form of NIH extramural grants, must not continue to fund research using dogs and cats from dealers whose modus operandi is illegal acquisition of animals, fraudulent or incomplete records, and other illicit activities. Proper oversight of NIH's dispersal of extramural grants to those engaged in research using dogs and/or cats is urgently needed.

PREPARED STATEMENT OF BIG BROTHERS BIG SISTERS OF AMERICA

Big Brothers Big Sisters of America (BBBSA) supports $17 million in fiscal year 2010 for the Department of Education's Mentoring programs, $50 million for the Mentoring Children of Prisoners program and $50 million for the Volunteer Generation Fund.

Chairman Harkin and Ranking Member Cochran, thank you for the opportunity to submit this testimony for the subcommittee's record.

BBBSA is the Nation's oldest and largest mentoring organization. We have grown over the last 105 years to serve more than 250,000 at-risk youth in communities across the Nation. Our 392 agencies are located in all 50 States, Guam, and Puerto Rico. We match at-risk youth with a caring adult in a one-to-one mentoring relationship. These matches make a significant difference in the life of a child and are the foundation for developing the full potential of boys and girls as they grow to become competent, confident, and caring men and women. BBBSA offers an array of programs and services that focus on promoting positive youth development, helping each child discover his or her full potential.

With 17 million at-risk children growing up in America, the need for a proven strategy to reverse the statistics and to support their successful development has never been more critical. We believe that BBBS mentoring provides a significant return on investment, particularly compared to the consequences of social and educational failure. According to Independent Sector, the value of volunteer work was estimated at $20.25 per hour in 2008. Last year, our Bigs contributed more than 13 million volunteer hours at an estimated value of $676 million.

BBBSA original, core program model is its community-based match. Bigs are matched with Littles referred to the program by a parent, and typically a match will spend about 3 hours per week together. Professional case-management staff at each local agency guide Bigs and provide them with the support necessary to ensure a healthy and lasting relationship with their Littles. It is through the relationship with these committed adults that at-risk children can to begin to gain their own sense of self-confidence and develop healthy aspirations for the future.

Research has shown that BBBS mentoring works as a strategy to support at-risk youth. In 1995, Public/Private Ventures released its landmark impact study, which found that children matched with a Big Brother or Big Sister were:

—46 percent less likely to begin using illegal drugs;

—27 percent less likely to begin using alcohol;
—52 percent less likely to skip school;
—37 percent less likely to skip a class;
—more confident of their performance in schoolwork; and
—getting along better with their families.

SCHOOL-BASED MENTORING (MENTORING FOR SUCCESS GRANTS)

Our mentoring programs have grown exponentially over the last 10 years. A major source of this growth is the expansion of BBBSA school-based program model. Locating our service in schools has offered a strong complement to the traditional community-based approach and has resulted in a significant increase in volunteer recruitment. Further, because children are referred by teachers, it connects the positive impact of the BBBSA relationships directly with the educational enrichment for each matched child.

The President's fiscal year 2010 budget outline for the Department of Education has recommended that the Department's mentoring program be eliminated. This recommendation was made in follow-up to a Federal study examining outcomes for school-based mentoring. The findings of the study are generating important and welcome dialogue. BBBSA appreciates the focus on quality programs and has reached out to the administration to offer our input in finding the most effective way to achieve positive outcomes for children.

We believe that well-run school based mentoring programs can and do have real impact. We have both the local and national evidence to prove this, including a more recent evaluation by P/PV. In fact, findings from the P/PV study led us to adopt significant changes to the way we run our own school-based programs in order to ensure longer and stronger matches that lead to concrete and measurable outcomes for the young people we serve. As a learning organization, we take seriously our responsibility to respond to research and continually improve our service delivery.

In 2003, with support from Atlantic Philanthropies, BBBSA began a comprehensive study of our school-based mentoring program and evaluated impacts on randomly selected mentored youth compared to nonmentored youth in a control group. The scope of the study paralleled the BBBS Impact Study of Community-Based Mentoring conducted by P/PV in the 1990s and was the first nationwide, randomized study of school-based mentoring ever undertaken.

Among the findings:
—Three factors lead to better outcomes—
  —Socio-emotional match activities;
  —Matches that met more often and for longer periods; and
  —A strong school environment and involvement by teachers and principals;
—School-based mentoring has positive academic outcomes during the first year of the match, including higher grades, higher feelings of academic competence, greater number of assignments completed, fewer serious school infractions, and less skipping of school;
—But largely because so many matches did not continue into the second year, these outcomes were for the most part not sustained in the second year;
—Training, supervision, and school support are critical in fostering stronger and longer relationships; and
—The cost of school-based mentoring is only slightly less than community-based mentoring.

The challenge was clear: longer matches and closer relationships meant stronger impacts and so how were we going to create longer matches and their corresponding increased, longer-lasting outcomes? The recommendations, coming out of the Study, of our internal School-Based Mentoring Task Force were:
—Start matches as early in the school year as possible;
—Ensure that volunteers provide at least one school year of mentoring;
—Build programs in feeder schools to sustain matches and provide youth with consistency through school transitions;
—Select supportive schools for program involvement and continually foster these partnerships;
—Explore ways to bridge the summer gap such as taking school-based mentoring out of the school year and increasing match contacts and treating school-based mentoring as a year-round program with strong match support;
—Develop indices of match length that reflect the summer break and, in this way, are more sensitive predictors of impacts; and
—Explore more ways to provide volunteers (particularly young volunteers) with the support and ongoing training they need to create high-quality, effective mentoring relationships.

While BBBSA supports the administration's position of only funding effective programs going forward, we have proposed partnering with the Department of Education to ensure that existing grantees do not have to prematurely close any current mentoring relationships. We understand that the cost of honoring the last class of grants which were awarded in fiscal year 2008 would require Congress to provide $17 million for the program in fiscal year 2010.

AMACHI (MENTORING CHILDREN OF PRISONERS)

An estimated 2.4 million children have an incarcerated parent—and BBBS' Amachi program addresses this critical need. The goal of Amachi is to demonstrate that the best way to stop the vicious cycle of substance abuse, delinquency, and incarceration among children of incarcerated parents is to give the children what they need the most—a supportive and stable adult who will help them discover their own strengths, abilities, and resistance skills. Volunteers for the program are recruited through their congregations and matched with at-risk children and youth, spending time each week with the child to gradually build a supportive relationship. Research has shown that children and youth of incarcerated parents are at higher risk of child abuse, neglect, illiteracy, drug and alcohol abuse, crime, violence, and premature death than are their peers. A BBBS mentor in the life of an at-risk child can dramatically reduce a child's chance of falling prey to these risks. We respectfully request level funding for the "Mentoring Children of Prisoners" program in fiscal year 2010.

VOLUNTEER GENERATION FUND (CORPORATION FOR NATIONAL SERVICE)

In the wake of President-elect Obama's "call to service" in January, also known as National Mentoring Month, BBBSA saw a significant increase in volunteer applications. As the economic crisis deepens, these Big Brothers and Big Sisters will be helping to meet the critical demand our disadvantaged youth have for friendship, especially during these challenging times. There is an interest among Americans to serve the community and BBBSA is anxious to harness this hope. The bipartisan citizen service legislation signed in to law by President Obama on April 21 will expand opportunities for citizens to serve, will direct this service toward the Nation's most urgent challenges, and provides Congress the change to invest in new and innovative solutions to our most persistent social problems. In particular, BBBSA respectfully requests that $50 million for the Volunteer Generation Fund in fiscal year 2010 to spur innovation in volunteer recruitment and management.

As we all work to change how our children grow up in America, BBBSA is your proud partner.

LETTER FROM THE BRAIN INJURY ASSOCIATION OF AMERICA

MAY 6, 2009.

Hon. TOM HARKIN,
Chairman, Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

Hon. THAD COCHRAN,
Ranking Member, Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

DEAR MR. CHAIRMAN HARKIN AND RANKING MEMBER COCHRAN: Thank you for the opportunity to submit this written testimony with regard to the fiscal year 2010 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill. My testimony is on behalf of the Brain Injury Association of America (BIAA), our national network of State affiliates, and hundreds of local chapters and support groups from across the country.

A traumatic brain injury (TBI) is a blow or a jolt to the head that temporarily or permanently disrupts brain function—i.e., who we are and how we think, act, and feel. In the civilian population alone every year, more than 1.5 million people sustain brain injuries from falls, car crashes, assaults and contact sports. Males are more likely than females to sustain brain injuries. Children, teens, and seniors are at greatest risk.

And now we are seeing an increasing number of servicemembers returning from the conflicts in Iraq and Afghanistan with TBI, which has been termed one of the signature injuries of the war. A recent study conducted by the RAND Corporation found that 320,000 troops, or 19 percent of all service members, returning from Operations Enduring Freedom and Iraqi Freedom may have experienced a TBI during deployment. Many of these returning servicemembers are undiagnosed or

misdiagnosed and subsequently they and their families will look to community and local resources for information to better understand TBI and to obtain vital support services to facilitate successful reintegration into the community.

For the past 12 years Congress has provided minimal funding through the Health Resources and Services Administration (HRSA) Federal TBI Program to assist States in developing services and systems to help individuals with a range of service and family support needs following their loved one's TBI. Similarly, the grants to State Protection and Advocacy Systems to assist individuals with traumatic brain injuries in accessing services through education, legal, and advocacy remedies are woefully underfunded. Rehabilitation, community support, and long-term care systems are still developing in many States, while stretched to capacity in others. Additional numbers of individuals with TBI as the result of war-related injuries only adds more stress to these inadequately funded systems.

BIAA respectfully urges you to provide States with the resources they need to address both the civilian and military populations who look to them for much needed support in order to live and work in their communities.

With broader regard to all of the programs authorized through the TBI Act, BIAA specifically requests:

—$11 million for the Centers for Disease Control and Prevention (CDC) TBI Registries and Surveillance, Prevention and National Public Education/Awareness;
—$20 million for the HRSA Federal TBI State Grant Program; and
—$6 million for the HRSA Federal TBI Protection & Advocacy (P&A) Systems Grant Program.

The TBI Act Amendments of 2008, authorizes the Department of Health and Human Services, HRSA to award grants to (1) States, American Indian Consortia, and territories to improve access to service delivery and to (2) State P&A Systems to expand advocacy services to include individuals with TBI. For the past 12 years the HRSA Federal TBI State Grant Program has supported State efforts to address the needs of persons with TBI and their families and to expand and improve services to underserved and unserved populations including children and youth; veterans and returning troops; and individuals with co-occurring conditions

In fiscal year 2009, HRSA reduced the number of State grant awards to 15, in order to increase each monetary award from $118,000 to $250,000. This means that many States that had participated in the program in past years have now been forced to close down their operations, leaving many unable to access TBI care.

Increasing the program to $20 million will provide funding necessary for each State including the District of Columbia, the American Indian Consortium to sustain and expand State service delivery; and to expand the use of the grant funds to pay for such services as Information & Referral (I&R), service coordination and other necessary services and supports identified by the State.

Similarly, the HRSA TBI P&A Program currently provides funding to all State P&A systems for purposes of protecting the legal and human rights of individuals with TBI. State P&As provide a wide range of activities including training in self-advocacy, outreach, I&R, and legal assistance to people residing in nursing homes, to returning military seeking veterans benefits, and students who need educational services.

Effective Protection and Advocacy services for people with a TBI leads to reduced government expenditures and increased productivity, independence, and community integration. However, advocates must possess specialized skills, and their work is often time-intensive. A $6 million appropriation would trigger a formula that would ensure that each P&A can provide a significant PATBI program with appropriate staff time and expertise.

Funding for the TBI Model Systems is urgently needed to ensure that the Nation's valuable TBI research capacity is not diminished, and to maintain and build upon the 16 TBI Model Systems research centers around the country.

The TBI Model Systems of Care program represents an already existing vital national network of expertise and research in the field of TBI, and weakening this program would have resounding effects on both military and civilian populations. The TBI Model Systems are the only source of nonproprietary longitudinal data on what happens to people with TBI. They are a key source of evidence-based medicine, and serve as a "proving ground" for future researchers.

In order to make this program more comprehensive, Congress should provide $13.3 million in fiscal year 2010 funding for the National Institute on Disability and Rehabilitation Research's TBI Model Systems of Care Program, in order to add four new centers and two collaborative research projects. In addition, given the national importance of this research program, the TBI Model Systems of Care program should receive "line-item" status within the broader NIDRR budget.

We ask that you consider favorably these requests for the HRSA Federal TBI Program, NIDRR TBI Model Systems Program, and for CDC to gather needed data, shepherd public awareness, education, and prevention programs; as well as the sustain and bolster TBI Model Systems that conduct vital research.

Sincerely,

SUSAN H. CONNORS,
President/CEO.

PREPARED STATEMENT OF THE CROHN'S AND COLITIS FOUNDATION OF AMERICA

Mr. Chairman and members of the subcommittee, thank you for the opportunity to submit testimony on behalf of the 1.4 million Americans living with Crohn's disease and ulcerative colitis. My name is Gary Sinderbrand and I have the privilege of serving as the Chairman of the National Board of Trustees for the Crohn's and Colitis Foundation of America (CCFA). CCFA is the Nation's oldest and largest voluntary organization dedicated to finding a cure for Crohn's disease and ulcerative colitis—collectively known as inflammatory bowel diseases (IBD).

Let me say at the outset how appreciative we are for the leadership this subcommittee has provided in advancing funding for the National Institutes of Health (NIH). Hope for a better future for our patients lies in biomedical research and we are grateful for the recent investments that you have made in this critical area.

Mr. Chairman, Crohn's disease and ulcerative colitis are devastating inflammatory disorders of the digestive tract that cause severe abdominal pain, fever and intestinal bleeding. Complications include arthritis, osteoporosis, anemia, liver disease and colorectal cancer. We do not know their cause, and there is no medical cure. They represent the major cause of morbidity from digestive diseases and forever alter the lives of the people they afflict—particularly children. I know, because I am the father of a child living with Crohn's disease.

Seven years ago, during my daughter, Alexandra's sophomore year in college, she was taken to the ER for what was initially thought to be acute appendicitis. After a series of tests, my wife and I received a call from the attending GI who stated coldly: Your daughter has Crohn's disease, there is no cure and she will be on medication the rest of her life. The news froze us in our tracks. How could our vibrant, beautiful little girl be stricken with a disease that was incurable and has ruined the lives of countless thousands of people?

Over the next several months, Alexandra fluctuated between good days and bad. Bad days would bring on debilitating flares which would rack her body with pain and fever as her system sought equilibrium. Our hearts were filled with sorrow as we realized how we were so incapable of protecting our child.

Her doctor was trying increasingly aggressive therapies to bring the flares under control.

Asacol, Steroids, Mercaptipurine, Methotrexate, and finally Remicade. Each treatment came with its own set of side effects and risks. Every time A would call from school, my heart would jump before I picked up the call in fear of hearing that my child was in pain as the flares had returned. Ironically, the worst call came from one of her friends to report that A was back in the ER and being evaluated by a GI surgeon to determine if an emergency procedure was needed to clear an intestinal blockage that was caused by the disease. Several hours later, a brilliant surgeon at the University of Chicago, removed over a foot of diseased tissue from her intestine. The surgery saved her life, but did not cure her. We continue to live every day knowing that the disease could flare at any time with devastating consequences.

From the point of hearing the news, I refused to accept the fact that this disease could not be cured. As I studied all the relevant data I could find, I reached out to the organization that seemed to be repeatedly mentioned, The CCFA. This organization is leading the fight in research, education and support on behalf of the 1.4 million Americans that suffer from these illnesses.

I made a pest of myself at the national office seeking knowledge about how the fight was being staged. The more I learned the more I believed that we could do better. I was invited to join the national board and 6 years later, I have the privilege of leading an extraordinary staff of professionals and a network of volunteers across our entire country.

We are making dramatic progress that is the result of the scientific excellence of our funded researchers and our volunteer scientific leadership as well as the rapid advancement of available technology. It is now not "if" we will cure IBD, but "when."

Mr. Chairman, I will focus the remainder of my testimony on our appropriations recommendations for fiscal year 2010.

RECOMMENDATIONS FOR FISCAL YEAR 2010

NIH

Throughout its 40-year history, CCFA has forged remarkably successful research partnerships with the NIH, particularly the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), which sponsors the majority of IBD research, and the National Institute of Allergy and Infectious Diseases (NIAID). CCFA provides crucial "seed-funding" to researchers, helping investigators gather preliminary findings, which in turn enables them to pursue advanced IBD research projects through the NIH. This approach led to the identification of the first gene associated with Crohn's—a landmark breakthrough in understanding this disease.

To further accelerate genetic research and advance understanding of IBD, NIDDK issued a research solicitation to establish an IBD Genetics Consortium approximately 8 years ago. This effort was informed by recommendations from external experts. Funding for the Consortium's six centers began in 2002, and intensive data and sample collection, genetic analysis, and recruitment of new patients and their families have been under way. In 2006, the Consortium published the major discovery of a new IBD gene. Some sequence variations in this gene, called IL23R, were found to increase susceptibility to IBD, while another variant actually confers protection. This gene was known previously to be involved in inflammation, and its newly discovered association with IBD may lead to the development of better therapies for IBD. In recognition of the success of the Consortium's large-scale collaborative effort, NIDDK decided to continue support for the program beyond its initial 5-year period which was slated to end in fiscal year 2007.

Renewed funding in fiscal year 2008 has enabled the Consortium to continue its genetic studies and recruit additional patients and relatives (as well as subjects without IBD for comparison). This expansion will facilitate the identification of additional predisposing genes and enable genetic analyses of certain patient subgroups, such as those from minority populations or those who experience an early onset form of IBD. These findings may then be used to pursue genetically based diagnostic tests that allow for earlier diagnosis and treatment intervention. In addition, the data can be used to identify new molecular targets for therapeutic development that are specifically targeted to a unique subset of patients.

Mr. Chairman, we are grateful for the leadership of Dr. Stephen James, Director of NIDDK's Division of Digestive Diseases and Nutrition, for pursuing this and other opportunities in IBD research aggressively. Fortunately, the field of IBD is widely viewed within the scientific community as one of tremendous potential. CCFA's scientific leaders, with significant involvement from NIDDK, have developed an ambitious research agenda entitled "Challenges in Inflammatory Bowel Diseases" that seeks to address many opportunities that currently exist. We look forward to working with NIDDK and the subcommittee to pursue these research goals in the coming years.

For fiscal year 2010, CCFA joins with other patient and medical organizations in recommending a 7 percent increase in funding for the NIH. We specifically encourage the subcommittee to support the invaluable work of the NIDDK and NIAID.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

IBD Epidemiology Program

Mr. Chairman, as I mentioned earlier CCFA estimates that 1.4 million people in the United States suffer from IBD, but there could be many more. We do not have an exact number due to these diseases' complexity and the difficulty in identifying them.

We are extremely grateful for your leadership in providing funding over the past 5 years for an epidemiology program on IBD at CDC. This program is yielding valuable information about the prevalence of IBD and increasing our knowledge of the demographic characteristics of the IBD patient population. If we are able to generate an accurate analysis of the geographic makeup of the IBD patient population, it will provide us with invaluable clues about the potential causes of IBD.

I should note that the latest phase of this project focuses on Rhode Island. The "Ocean State Crohn's & Colitis Area Registry" is identifying each new case of inflammatory bowel disease diagnosed in the State. The result will be a unique, population-based cohort of newly diagnosed patients to be followed prospectively over time—the first of its kind in the United States, and one of very few such cohorts in the world. The goals of the study include: (1) describing the incidence rates of Crohn's disease and ulcerative colitis; (2) describing disease outcomes; and (3) identifying factors that predict disease outcomes. To date more than 85 newly diagnosed patients of all ages have been enrolled into the study.

Mr. Chairman, to continue this important epidemiological work in fiscal year 2010, CCFA recommends a funding level of $700,000, an increase of $16,000 more than fiscal year 2009.

PEDIATRIC IBD PATIENT REGISTRY

Mr. Chairman, the unique challenges faced by children and adolescents battling IBD are of particular concern to CCFA. In recent years we have seen an increased prevalence of IBD among children, particularly those diagnosed at a very early age. To combat this alarming trend CCFA, in partnership with the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition, has instituted an aggressive pediatric research campaign focused on the following areas:

—*Growth/Bone Development*.—How does inflammation cause growth failure and bone disease in children with IBD?

—*Genetics*.—How can we identify early onset Crohn's disease and ulcerative colitis?

—*Quality Improvement*.—Given the wide variation in care provided to children with IBD, how can we standardize treatment and improve patients' growth and well-being?

—*Immune Response*.—What alterations in the childhood immune system put young people at risk for IBD, how does the immune system change with treatment for IBD?

—*Psychosocial Functioning*.—How does diagnosis and treatment for IBD impact depression and anxiety among young people? What approaches work best to improve mood, coping, family function, and quality of life.

The establishment of a national registry of pediatric IBD patients is central to our ability to answer these important research questions. Empowering investigators with HIPPA compliant information on young patients from across the Nation will jump-start our effort to expand epidemiologic, basic and clinical research on our pediatric population. We encourage the subcommittee to support our efforts to establish a Pediatric IBD Patient Registry with the CDC in fiscal year 2010.

Once again Mr. Chairman, thank you very much for the opportunity to be with you today. I look forward to any questions you may have.

PREPARED STATEMENT OF THE CHILDREN'S ENVIRONMENTAL HEALTH NETWORK

The Children's Environmental Health Network (the Network) appreciates this opportunity to comment on the fiscal year 2010 appropriations to the Departments of Health and Human Services and Education for activities that protect children from environmental hazards. The Network appreciates the wide range of priorities that you must consider for funding. We urge you to give priority to those programs that directly protect and promote children's environmental health. In so doing, you will improve not only our children's health, but also their educational outcomes and their future.

The Network is a national organization whose mission is to promote a healthy environment and to protect the fetus and the child from environmental health hazards. We recognize that children, in our society, have unique moral standing. The Children's Environmental Health Network was created to promote the incorporation of basic pediatric facts such as these in policy and practice:

—Children's bodies and behaviors differ from adults. In general, they are more vulnerable than adults to toxic chemicals.

—Children are growing. Pound for pound, children eat more food, drink more water and breathe more air than adults. Thus, they are likely to be more exposed to substances in their environment than are adults. Children are different from adults in how their bodies absorb, detoxify, and excrete toxicants.

—Children's systems, such as their nervous, reproductive, and immune systems, are developing. This process of development creates periods of vulnerability when toxic exposures may result in irreversible damage when the same exposure to a mature system may result in little or no damage.

—Children behave differently than adults, leading to a different pattern of exposures to the world around them. For example, because of their hand-to-mouth behavior, they ingest whatever may be on their hands, toys, household items, and floors. Children play and live in a different space than do adults. For example, very young children spend hours close to the ground where there may be more exposure to toxicants in dust and carpets as well as low-lying vapors such as radon or pesticides.

—Children have a longer life expectancy than adults; thus they have more time to develop diseases with long latency periods that may be triggered by early environmental exposures, such as cancer or Parkinson's disease.

Clear, sound science underlies these principles. A solid consensus in the scientific community supports these concepts. The world in which today's children live has changed tremendously from that of previous generations. There has been a phenomenal increase in the substances to which children are exposed. According to the Environmental Protection Agency (EPA), more than 83,000 industrial chemicals are currently produced or imported into the United States. Traces of hundreds of chemicals are found in all humans and animals. Every day, children are exposed to a mix of chemicals, most of them untested for their effects on developing systems.

We urge the subcommittee to provide the necessary resources for the Federal programs and activities that help to protect children from environmental hazards. The key programs in your jurisdiction are below.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) AND THE NATIONAL ENVIRONMENTAL HEALTH CENTER (NEHC)

The Network strongly supports the work of the CDC and the NEHC, especially NEHC's efforts to continue and expand its biomonitoring program and to continue its national report card on exposure information, using the highly respected National Health and Nutrition Examination Survey. A vital CDC responsibility in pediatric environmental health is to assist in filling the major information gaps that exist about children's exposures.

The Network supports a funding level of $8.6 billion for CDC's core programs in fiscal year 2010. The Network urges the subcommittee to provide an additional $19.6 million for CDC's Environmental Health Laboratory in fiscal year 2010. The Network believes it is especially critical for the NEHC to gather and publish expanded information in the report card on children's exposures.

PUBLIC HEALTH TRACKING

The CDC's National Environmental Public Health Tracking Program helps to track environmental hazards and the diseases they may cause, coordinating and integrating local, State, and Federal health agencies' collection of critical health and environmental data. We urge the subcommittee to provide $50 million for the tracking network in fiscal year 2010 to expand it to additional States and support the continued development of a sustainable, nationwide Network.

Additionally, data on children's "real world" exposure and disease are critically needed. Since children spend hours every day in school and child care, we urge you to direct the Tracking Program to include grants for pilot methods for tracking children's health in schools and child care settings.

GLOBAL CLIMATE CHANGE

We strongly urge the subcommittee to designate $50 million for the CDC to help the public prepare for and adapt to the potential health effects of global climate change in fiscal year 2010.

Global climate change presents major challenges to public health. Children, as a vulnerable subpopulation, are among those at greatest risk of harm. Children in communities that are already disadvantaged will be the most harmed. Recent studies have detailed how children's physical and social health may be harmed, ranging from respiratory diseases and melanoma (due to atmospheric changes), to gastrointestinal diseases (due to increased water contamination), to an increased range for some diseases (malaria, dengue, encephalitides, Lyme disease), to increased rates of malnutrition (due to severe drought and severe precipitation), to the harm caused by displacement, water and food insecurity, and forced migration (caused by drought, increased rain and severe storms, and rising sea levels) and the resulting international conflict and political unrest.

It is imperative that the Federal Government undertake efforts to mitigate and adapt to climate change. Providing funding to the CDC for preparing for the potential health effects of global climate change is an important step.

NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES (NIEHS) AND CHILDREN'S ENVIRONMENTAL HEALTH RESEARCH CENTERS OF EXCELLENCE

NIEHS is a vital institution in our efforts to understand how to protect children, whether it is identifying and understanding the impact of substances that are endocrine disruptors, or better understanding childhood exposures that may not affect health until decades later, or seeking answers to many other important questions.

The Children's Environmental Health Research Centers, funded by NIEHS and the EPA, play a key role in protecting children from environmental hazards. With budgets of $1 million per year per center (unchanged over more than 10 years), this program generates valuable research. A unique aspect of this program is the requirement that each Center actively involves its local community in a collaborative partnership, leading both to community-based participatory research projects and to the translation of research findings into child-protective programs and policies. Researchers have embraced this funding mechanism because of the ability it gives them to do interdisciplinary research and to be involved in the community—things that are not easy to do using other grant mechanisms. The scientific output of these centers has been outstanding. For example, four of the Centers had findings that clearly showed that prenatal exposure to a widely used pesticide affected developmental outcomes at birth and early childhood. Another recent example is the finding of a biomarker in newborns for childhood leukemia, firmly establishing the important role of prenatal environment factors in causation of this disease.

Unfortunately, almost all of the existing 12 centers are currently operating on no-cost extensions. We strongly support the center concept and the network of centers. We also support current efforts by NIEHS and the EPA to competitively renew and to expand this valuable program by adding four formative centers. However, only five of the existing centers are to be renewed. If centers are shuttered, we will lose access to valuable populations such as urban children with asthma or children in farm communities exposed to pesticides. We will lose the ability to learn about issues like early puberty concerns, exposures in school settings, and pre-adolescent and adolescent outcomes.

Thus, we urge the subcommittee to appropriate at least $15 million for the NIEHS share of funding so that, in concert with the EPA contribution, an adequate number of centers (old and new) will have funding in fiscal year 2010.

In addition, the Network urges the subcommittee to support NIEHS by increasing its overall budget, and that of the Superfund research program, by 5 percent more than last year's level and directing that included in this increase would be a $5 million increase specifically for research on children's environmental health issues. The Superfund research program has supported some vital children's research but funding has been level over the last 4 years.

NATIONAL CHILDREN'S STUDY (NCS)

The NCS is examining the effects of environmental influences on the health and development of more than 100,000 children in 105 communities across the United States, following them from before birth until age 21. The NCS will be one of the richest research efforts ever geared toward studying children's health and development and will form the basis of child health guidance, interventions, and policy for generations to come. The NCS will provide a better understanding of how children's genes and their environments interact to affect their health and development, thus improving the health and well-being of all children.

Enrollment in the NCS began this January, after 8 years of planning and development. The Network urges the subcommittee to continue its enthusiastic support for the NCS in this and future years, including full funding of $195 million in fiscal year 2010. The Network also asks the subcommittee to direct the National Institute of Child Health and Human Development to assure that protocols are in place for measuring exposures in the child care and school settings. The Network believes it is critically important to understand how school and child care exposures differ from home exposures very early in the NCS.

PEDIATRIC ENVIRONMENTAL HEALTH SPECIALTY UNITS (PEHSU)

A key, but dramatically underfunded, program is the PEHSU network. Funded by the Agency for Toxic Substances and Disease Registry and the EPA, the PEHSUs form a network with a center in each of the U.S. Federal regions, plus one center in Canada and one in Mexico. PEHSU professionals provide quality medical consultation for health professionals, parents, caregivers, and patients. Last year, the entire program, covering the 10 U.S. centers, received less than $2 million. These centers have done tremendous work on these small budgets. We urge the subcommittee to provide funding for this program in fiscal year 2010 at the level of $200,000 per center (compared to the $120,000 for each center last year).

SCHOOL ENVIRONMENTAL HEALTH

Each school day, about 54 million children and 7 million adults spend a full week inside schools. Unfortunately, many of the Nation's public and private school facilities are shoddy or even "sick" buildings whose environmental conditions harm chil-

dren's health and undermine attendance, achievement, and productivity. In 1996, GAO reported that more than 13 million children were compelled to be in schools that threatened their health and safety. Two Federal statutes that would create a foundation for healthy schools are already in place, authorizing the U.S. Department of Education and the EPA to address school environments. Unfortunately, to date neither of these programs have been funded.

We strongly urge the subcommittee to provide the $25 million authorized by the Healthy and High Performance Schools Act (Public Law 107–110) to the grant program for State agencies to develop and disseminate information and assistance on high performance school design standards. The subcommittee should also direct the Department of Education to conduct a National Priority Study, as required under HHPS, on the impacts of decayed facilities on children and to report to Congress. To date, Education has only produced a brief review of the scientific literature.

These programs and activities are especially vital in light of the "stimulus" funds for school modernization or renovation. The stimulus bill does not require consideration of environmental health or children's health and safety. Yet, without specific consideration of health, steps to "green" a school—such as increasing insulation at a school to improve energy efficiency—can have unintended harmful side effects, such as creating or exacerbating indoor air quality problems.

CHILD CARE ENVIRONMENTAL HEALTH

Thirteen million preschoolers—60 percent of young children—are in child care. Millions of preschoolers—our youngest and most vulnerable population—enter care as early as 6 weeks of age and can be in care for more than 40 hours per week. Yet little is known about the environmental health status of our child care centers nor how to assure that they are protecting this important group of children. The Network is working to correct these gaps.

We ask the subcommittee to direct the Department of Health and Human Services Assistant Secretary for Children and Families to report on the Administration for Children and Families activities that protect children from environmental hazards in childcare settings, especially in the Office of Head Start.

In conclusion, investments in programs that protect and promote children's health will be repaid by healthier children with brighter futures, an outcome we can all support. That is why the Network asks you to give priority to these programs. Thank you for the opportunity to testify on these critical issues.

PREPARED STATEMENT OF THE CYSTIC FIBROSIS FOUNDATION

NATIONAL INSTITUTES OF HEALTH (NIH)

On behalf of the Cystic Fibrosis Foundation (CFF), and the 30,000 people with cystic fibrosis (CF), we are pleased to submit the following testimony regarding fiscal year 2010 appropriations for CF-related research at NIH and other agencies.

ABOUT CF

CF is a life-threatening genetic disease for which there is no cure. People with CF have two copies of a defective gene, known as CFTR, which causes the body to produce abnormally thick, sticky mucus that clogs the lungs and results in fatal lung infections. The thick mucus in those with CF also obstructs the pancreas, making it difficult for patients to absorb nutrients from food.

Since its founding, CFF has maintained its focus on promoting research and improving treatments for CF. More than thirty drugs are now in development to treat CF, some which treat the basic defect of the disease, while others target its symptoms. Through the research leadership of CFF, the life expectancy of individuals with CF has been boosted from less than 6 years in 1955 to 37 years in 2007. This improvement in the life expectancy for those with CF can be attributed to research advances and to the teams of CF caregivers who offer specialized care. Although life expectancy has improved dramatically, we continue to lose young lives to this disease.

The promise for people with CF is in research. In the past 5 years, the CFF has invested more than $660 million in its medical programs of drug discovery, drug development, research, and care focused on life-sustaining treatments and a cure for CF. A greater investment is necessary, however, to accelerate the pace of discovery and development of CF therapies. This testimony focuses on the investment required to more rapidly and efficiently discover and develop new CF treatments aimed at controlling or curing CF.

SUSTAINING THE FEDERAL INVESTMENT IN BIOMEDICAL RESEARCH

This subcommittee and Congress are to be commended for their steadfast support for biomedical research, and their commitment to the National Institutes of Health (NIH), particularly the effort to double the NIH budget between fiscal year 1999 and fiscal year 2003 as well as the significant investment provided by the American Recovery and Reinvestment Act (ARRA). These increases in funding brought a new era in drug discovery that has benefited all Americans. Congress must adequately fund the NIH so that it can capitalize on scientific advances in order to maintain the momentum that the doubling and the infusion of funds from ARRA generated.

The flat-funding of the NIH since 2003 has decreased purchasing power, limiting the pursuit of critical research. CFF joins the Coalition for Health Funding to recommend increasing the budget for all health discretionary spending by 13 percent in fiscal year 2010, or $7.4 billion over the fiscal year 2009 Omnibus. This increased investment will help maintain the NIH's ability to fund essential biomedical research today that will provide tomorrow's care and cures. If the subcommittee is not able to recommend funding at this level, Congress should advise the NIH to focus on contributing funds to research partnerships that will accelerate therapeutic development to improve peoples' lives.

STRENGTHEING OUR NATION'S RESEARCH INFRASTRUCTURE

Because CF is a disease that impacts several systems in the body, several Institutes at the NIH share responsibility for CF research. We urge the NIH to pay special attention to advances in treatment methods and mechanisms for translating basic research across Institutes into therapies that can benefit patients across Institutes. CFF has been recognized for its own research approach that encompasses basic research through phase III clinical trials, and has created the infrastructure required to accelerate the development of new CF therapies. As a result, we now have a pipeline of more than 30 potential therapies that are being examined to treat people with CF.

THE CLINICAL AND TRANSLATIONAL SCIENCE AWARDS (CTSA)

CTSA program was a key component of the NIH's Roadmap initiative. The program is designed to transform how clinical and translational research is conducted, ultimately enabling researchers to provide new treatments more efficiently to patients. Tremendous effort brought institutions together to rally around this program, yet current funding levels make it difficult for the 39 programs (out of a planned 60) to succeed.

Key to the success of the CTSAs is the development of cost-sharing for use of infrastructure services. An example of this mechanism is the General Clinical Research Centers (GCRC), which allowed Institutes to reduce their research budgets by having investigators use the GCRC when clinical care such as inpatient stays, lab tests, nursing staff, was made available at no additional cost. Today, individual investigators must provide funds for clinical care cost-sharing from grants funded from other NIH Institutes. As research becomes more expensive and private capital dries up, it becomes even more critical to ensure support for translational research, that is, research that moves a potential therapy from development to the market. In order to maximize the potential of the CTSA, multiple Institutes within NIH must be able to provide financial resources for this critical program.

Supporting Clinical Research

A significant discrepancy persists between the funding awarded to clinical and basic laboratory investigators for first awards. The difference is even greater for second awards and prolonged funding of clinical investigators. The NIH must maintain support for translational research and the investigators piloting those projects. Without this support, the NIH stands to lose an entire generation of clinically trained individuals committed to clinical research. The "generation gap" that would be created by the loss of these clinical researchers would affect the ability of the NIH to conduct world-class clinical investigation and jeopardize the standing of the United States as the world's premiere source for biomedical research.

FACILITATING CLINICAL RESEARCH AND DRUG DEVELOPMENT

CFF applauds the NIH's efforts to encourage greater efficiency in clinical research. CFF has been a leader in creating a clinical trials network to achieve greater efficiency in clinical investigation. Because the CF population is so small, a more significant portion of people with the disease must partake in clinical trials than in most other diseases. This unique challenge prompted CFF to streamline our clin-

ical trials processes. Research conducted by CFF is more efficient than ever before and we are a model for other disease groups.

The Model of the Cystic Fibrosis Therapeutics Development Network

CFF's established clinical research program, the Therapeutics Development Network (TDN), plays a pivotal role in accelerating the development of new treatments to improve the length and quality of life for CF patients. Lessons learned from its centralization of data management and analysis and data safety monitoring in the TDN will be useful in designing clinical trial networks in other diseases. We urge the subcommittee to direct the NIH and other agencies to allocate additional funds for innovative therapeutics development models like the TDN. CFF urges the subcommittee to allocate additional resources for clinical research in order meet the demand for testing the promising new therapies for CF and other diseases.

Alterative Models for Institutional Review Boards

We are pleased that the Department of Health and Human Services has encouraged the exploration of alternative models of IRBs, including central IRBs, by the CTSA. We encourage Congress to urge the Department to demonstrate more aggressive leadership in persuading all academic institutions to accept review by a central IRB—without insisting on parallel and often duplicative review by their own IRB—at least in the case of multi-institutional trials in rare diseases. Such oversight could help provide greater expertise to improve trial design and enable critical research to move forward in a timelier manner without undermining patient safety.

RESEARCH COMPENSATION FOR SUPPLEMENTAL SECURITY INCOME (SSI)

An additional impediment in our effort to accelerate the development of new therapies is the Social Security Administration's (SSA) current SSI rules, which count research compensation for participation in a clinical drug study as income for determining SSI. This policy creates an unnecessary barrier to clinical trial participation for a significant number of people with CF, and thus severely limits efforts to develop new therapies. We urge the subcommittee to direct the SSA to disregard any compensation to an individual who is participating in a clinical trial testing rare disease treatments that has been reviewed and approved by an institutional review board and meets the ethical standards for clinical research for the purposes of determining that individual's eligibility for the SSI program.

Partnership with the National Center for Research Resources (NCRR)

The CTSA program, administered by the NCRR, encourages novel approaches to clinical and translational research, enhances the utilization of informatics, and strengthens the training of young investigators. CFF has enjoyed a productive relationship with the NCRR to support our vision for improving clinical trials capacity through its early financial support of the TDN. Recently, however, the NCRR decided to reject funding for disease-specific networks in favor of those without a disease focus. As a result of this policy, some of the best clinical research consortia are prohibited from competing for NCRR grants, including but not limited to the CF TDN. We urge the NCRR to reverse this decision.

SUPPORTING DRUG DISCOVERY

CFF's clinical research is fueled by a vigorous drug discovery effort; early stage translational research of promising strategies to find successful treatments for this disease. Several research projects at the NIH will expand our knowledge about the disease, and could eventually be the key for controlling or curing CF.

Exploring Protein Misfolding and Mistrafficking

We applaud the National Heart, Lung and Blood Institute (NHLBI), and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) for their initiatives that target research on protein misfolding, and urge an aggressive commitment to facilitate continued exploration in this area to build upon promising discoveries. We urge the NIH to continue to devote special attention to research in protein misfolding and mistrafficking, an area which could yield significant benefits for patients with CF and other diseases where misfolding is an issue.

Opportunities In Animal Models

CFF is encouraged by the NIH's investment in a research program at the University of Iowa to study the effects of CF in a pig model. The program, funded through research awards from both NHLBI and CFF, bears great promise to help make significant developments in the search for a cure. While a company has been established to produce the animals, the infrastructure and extensive animal husbandry

required to keep the animals alive and conduct research on them is available at few academic institutions. We urge additional funding to create a facility that would enable researchers from multiple institutions to conduct research with these models.

Facilitating Scientific Data Connections

An explosion of data is emerging from "big science" projects such as the Human Genome Project and the International HapMap Project. We encourage investments by NIH into the development of systems that permit the linkage of gene expression, protein expression and protein interaction data from independent laboratories. While construction of such an interface would be difficult, it would undoubtedly facilitate generations of new ideas and open new areas of medically important biology.

Increasing Investment in Inflammatory Response Research

CF, like diseases such as inflammatory bowel disease, chronic bronchitis, and rheumatoid arthritis, cause an intense inflammatory response. CFF enthusiastically supports investments by the NIH to gain a greater understanding of inflammatory signaling and inflammatory cascades, which would lead to improved methods of safely interfering with the inflammatory process and contributing to the health and well being of the U.S. population.

Supporting High Throughput Screening

The subcommittee should urge the NIH to continue to fund high throughput screening initiatives in keeping with the NIH Roadmap suggestions. Support for the follow-up and optimalization of compounds identified through this type of screening can help to bridge the development gap and bring about more drugs that can make it to patients' bedsides.

Funding Systems Biology Platforms

In order to rapidly accelerate the identification of potential biomarkers and understand the mechanisms of action of CFTR function, data generated from multiple laboratories and scientific must be integrated. To address this, CFF has partnered with a systems biology company called GeneGo to generate a CF-focused systems biology platform to illustrate the various effects of CFTR dysfunction in multiple cell systems. CFF urges NIH to provide additional funding to support research efforts aimed at leveraging systems biology platforms to integrate multiple disciplines within the CF research community in order to accelerate drug development and biomarker validation for CF.

Small Business Innovation Research Program at NIH

Small Business Innovation Research (SBIR) program grants allocated by the NIH have helped many small biotechnology and pharmaceutical companies to develop vital treatments for a variety of diseases. Several companies developing CF treatments have used SBIR grants to fund their development process.

The SBIR program could provide further support by directing that a portion of all grants awarded be used for rare disease research. With such a small portion of the population likely to purchase the drugs, research to produce drugs to treat rare diseases is often considered too large a financial risk to take on. It is important to note, however that there are more than 25 million Americans with a rare disease. By directing even small dollar grants to develop drugs for these diseases, Congress can eliminate some of the risk that keeps biotechnology and pharmaceutical companies from developing drugs for rare diseases.

The NIH has wisely focused on translational research as a touchstone for ensuring the relevance of the agency to the American public. CFF is the perfect example of this notion, having devoted our own resources to developing treatments through drug discovery, clinical development, and clinical care. Several of the drugs in our pipeline show remarkable promise in clinical trials and we are increasingly hopeful that these discoveries will bring us even closer to a cure. Encouraged by our successes, we believe the experience of CFF in clinical research can serve as a model of drug discovery and development for research on other orphan diseases and we stand ready to work with NIH and congressional leaders. On behalf of CFF, we thank the subcommittee for its consideration.

PREPARED STATEMENT OF THE CENTER FOR GLOBAL HEALTH POLICY

The Center for Global Health Policy of the Infectious Diseases Society of America (IDSA) is pleased to submit testimony about the urgent need to increase funding for the Department of Health and Human Services' programs that address two deadly global pandemics—HIV/AIDS and tuberculosis.

IDSA represents more than 8,000 infectious diseases and HIV physicians and scientists devoted to patient care, education, research, prevention, and public health. Nested within the IDSA is the HIV Medicine Association (HIVMA), representing more than 3,500 physicians, scientists, nurse practitioners, and other health professionals working in HIV medicine. In 2008, IDSA and HIVMA launched the Infectious Diseases Center on Global Health Policy and Advocacy to address global HIV/AIDS, tuberculosis, and HIV/TB co-infection. Under the leadership of a scientific advisory committee of world-renowned scientific experts in these areas, IDSA works to educate policymakers, U.S. Government program implementers and the media about evidence-based policies and programs and the value of U.S. leadership in combating these deadly and synergistic epidemics.

GLOBAL HIV/AIDS PANDEMIC

There are 33 million people living with HIV/AIDS in the world, with 22 million of them or 67 percent living in sub-Saharan Africa. AIDS kills 2 million people annually. U.S. leadership has been the catalyzing force for preventing millions of infections, ensuring access to lifesaving HIV treatment for 3 million persons in developing countries, and providing care and support to millions of additional people, including orphans and vulnerable children. Despite tremendous progress, only about one-third of persons in developing countries who are clinically eligible for antiretroviral therapy are receiving it, and an ongoing and robust prevention campaign is essential to reduce the more than 7,000 new HIV infections that still occur on a daily basis.

The National Institutes of Health (NIH)-funded HIV research at the NIH research led to the development of lifesaving antiretroviral therapy, identified the efficacy of antiretroviral therapy during pregnancy to prevent mother-to-child transmission, demonstrated the HIV prevention benefits of male circumcision, and is paving the road to the availability of an effective microbicide. The Centers for Disease Control and Prevention (CDC) have been a critical implementing partner in the U.S. response to the global HIV epidemic, working with health ministries in developing countries to launch HIV prevention and treatment programs, conducting public health evaluation research, and supporting heavily impacted countries in their efforts to monitor and to employ evidence based strategies in response to their particular epidemics.

TUBERCULOSIS

Tuberculosis is the second leading global infectious disease killer, claiming more than 1.7 million lives annually. Worldwide, one-third of the world's population is infected with TB and nearly 9 million people develop active TB disease each year. In recent years, highly drug-resistant forms of TB have emerged. Drug-resistant tuberculosis is a direct result of human failure—failure to adequately detect and treat TB and to develop the necessary tools to effectively address this ancient and deadly scourge.

In 2006, the CDC and the World Health Organization (WHO) reported the findings from a survey of TB reference laboratories around the world indicating that 20 percent of M. tuberculosis isolates were multi-drug resistant (MDR)—that is, TB strains resistant to the two most potent drugs in the four-drug TB regimen. Four percent of these MDR–TB strains were resistant to multiple second-line drugs and were deemed extensively drug-resistant TB or XDR–TB. Mortality from XDR–TB can be as high as 85 percent, and close to 100 percent in individuals co-infected with HIV/AIDS. The increase in MDR–TB and the advent of XDR–TB have triggered grave alarm in the scientific community about the potential for an untreatable XDR–TB epidemic. In 2007, WHO estimated that there were 500,000 cases of MDR–TB and only 1 percent of these cases were treated according to WHO standards.

The global pandemic and alarming spread of drug-resistant TB present a persistent public health threat to the United States. Tuberculosis is an airborne infection.

Drug-resistant TB anywhere in the world easily translates into drug-resistant TB everywhere.

DEADLY SYNERGY OF HIV/TB CO-INFECTION

The costly MDR TB epidemic in the United States in the early 1990s emerged against a background of HIV infection in high HIV prevalence cities like New York City and Miami. Today, HIV–TB co-infection is ravaging sub-Saharan Africa. TB is the leading cause of death of persons with HIV worldwide. Tuberculosis facilitates HIV disease progression, and persons with HIV have poorer TB treatment outcomes than their non-HIV-infected counterparts. According to the WHO, in 2007, there

were at least 1.37 million cases of HIV positive TB—nearly 15 percent of the total incident cases. There were 456,000 deaths among this group.

CDC—TUBERCULOSIS

Last year, Congress passed landmark legislation—the Comprehensive Tuberculosis Elimination Act of 2008—Public Law 110–873. This bill authorizes a number of actions that will shore up State TB control programs, enhance United States capacity to deal with the serious threat of drug-resistant tuberculosis and escalate our efforts to develop urgently needed new "tools" in the form of drugs, diagnostics, and vaccines. Realizing these goals will require additional resources; at a minimum, it is critical that the funding authorized for fiscal year 2010 in this important new law—$210 million—be appropriated for the CDC Division of TB Elimination. While this represents an increase more than current funding, the scientific community, including the National Coalition for the Elimination of Tuberculosis, has estimated that $528 million will be needed annually to implement strategies through the CDC that will advance the goal of TB elimination.

Funds are desperately needed to increase the clinical trial capacity of the Tuberculosis Trials Consortium (TBTC) to evaluate promising new drugs for MDR TB and to support clinical trials for vaccine candidates that hold the hope of eliminating the scourge of TB from the face of the earth. Additional financial support is also needed for the Tuberculosis Epidemiologic Studies Consortium (TBESC)—critical partnerships between TB control programs and academic institutions aimed at designing, conducting and evaluating programmatically relevant research.

Strengthening CDC's Division of TB Elimination to conduct research and support State TB control programs will protect our communities, and help ensure that another devastating outbreak of drug-resistant tuberculosis that plagued several American cities in the late 1980s does not recur. Ultimately, modest Federal investments will prevent the necessity to expend huge resources treating MDR–TB and XDR–TB, which can cost $468,000 per case to treat.

CDC—GLOBAL AIDS PROGRAM (GAP)

CDC's Global AIDS Program (GAP) helps resource-poor countries prevent HIV infection; improve treatment, care, and support for people living with HIV; and build healthcare capacity and infrastructure. To meet these objectives, CDC sends clinicians, epidemiologists and other health professionals to help foreign governments and health institutions with a range of prevention, care, and support activities. Working closely with health ministries in developing countries, CDC helps build sustainable public health capacity in laboratory services and systems, including country capacity to design and implement HIV surveillance systems and surveys.

The CDC GAP also plays an important role in helping governments monitor and evaluate the impact of HIV prevention, care and treatment programs. CDC GAP also works with the Office of the Global AIDS Coordinator as the lead on HIV prevention, and also works to evaluate the impact of US HIV prevention, treatment and care and support funding. For example, CDC GAP is currently conducting a public health evaluation (PHE) to assess the impact of PEPFAR funding on developing country health systems and access to other healthcare services. A funding level for CDC'GAP program of at least $218 million is essential.

NIH

NIH is the world's flagship biomedical research institution, supporting basic science research, behavioral research, drug and diagnostic development and research training. Unfortunately in recent years, NIH funding has eroded, and stagnant funding has resulted in decreasing support for original research and cuts in clinical trial networks. With only 1 in 4 approved research applications receiving funding, the pipeline for critical discoveries is dwindling and young scientists are being forced to turn their attention to different professional pursuits.

IDSA is extremely pleased that the recently enacted stimulus bill contained an infusion of billions of desperately needed dollars for the NIH research enterprise. Congress rightfully acknowledged the role of scientific research in stimulating the economy. It is vital, however, that the long overdue increases in funding enjoyed by the NIH in the economic stimulus bill are maintained and enhanced in this year's funding bill—funding that will ultimately translate into improvements in individual and public health, both domestically and globally.

HIV/AIDS RESEARCH

The successes of the HIV research investment is a testament to the value of research investment. A robust and comprehensive research portfolio was responsible for the rapid and dramatic gains in our HIV knowledge base, gains that resulted in reductions in mortality from AIDS of nearly 80 percent in the United States and in developing countries where treatment has been made available. Remarkable discoveries helped us to reduce mother-to-child HIV transmission to nearly 1 percent in the United States and this intervention has prevented HIV infection in hundreds of thousands of children worldwide. A continued robust HIV research effort is essential to accelerate our progress in developing more effective prevention strategies, and supporting the basic research necessary to continue our work developing a vaccine that may end the deadliest pandemic in human history. Research to improve treatment strategies to aid prevention and to maximize the benefits of antiretroviral therapy, especially in underserved populations in the United States and in resource-limited settings is a high priority.

The National Institute on Allergies and Infectious Diseases (NIAID) is the principal funding resource for basic and clinical HIV research, but critical HIV research is conducted through a range of NIH Institutes under the leadership of the Office for AIDS Research (OAR).

TUBERCULOSIS RESEARCH

NIAID is also a critical player in tuberculosis research. In 2007, NIAID developed a research strategy for drug-resistant tuberculosis, but limited resources have slowed implementation of this strategy. According to the NIH Research Portfolio Online Reporting Tool, RePORT, NIH funding for tuberculosis research, including vaccine research totaled $160 million in fiscal year 2008—a modest level for an infectious disease that kills millions through a pathogen that is showing increasing resistance to available medications. In fact, funding for TB research has gone in the wrong direction since NIH spent $211 million on TB research in fiscal year 2007. A doubling of funding for TB research would be a reasonable response to the world disease burden and the current scientific opportunities.

We must increase our investment in TB research as highlighted in the enacted Comprehensive TB Elimination Act of 2008. We must have the resources to conduct clinical trials on new therapeutics for both drug-susceptible and drug-resistant TB, to test new diagnostics in point-of-care settings, and to evaluate promising TB vaccine candidates. We urgently need treatment regimens that are shorter in duration and less toxic. Research related to pediatric tuberculosis, including drug development, must be stepped up.

It is also imperative that research activities focused on HIV/TB co-infection continue with enhanced funding. Tuberculosis is the leading cause of death among persons with HIV/AIDS worldwide. TB is more difficult to diagnose in persons with HIV and a number of important anti-TB drugs interact with HIV antivirals. Critical questions remain about how best to sequence HIV and TB treatment in co-infected individuals—questions with life and death ramifications for millions of individuals, especially those living in sub-Saharan Africa. Tuberculosis threatens to undermine the tremendous progress that has been made in saving the lives of persons in developing countries through the provision of antiretroviral therapy.

GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

Historically, one-third of U.S. funding for the Global Fund has been appropriated through the NIAID budget and IDSA strongly supports a significant U.S. contribution to the Global Fund. U.S. support for the Global Fund to Fight AIDS, Tuberculosis and Malaria is a crucial part of U.S. global health diplomacy. The Global Fund is a country-led, performance-based partnership that embraces transparency and accountability, and fosters multilateral cooperation. The Global Fund provides a quarter of all international financing for AIDS globally, two-thirds for tuberculosis, and three-quarters for malaria. Through these efforts, the Global Fund has helped save 3.5 million lives in 140 countries

In Pakistan, for example, an American-based international aid group called Mercy Corps has, using Global Fund resources, partnered with the private sector on a broad TB public education campaign, training thousands of health workers, and strengthening lab capacity to test for TB. This work has dramatically increased Pakistan's ability to detect TB cases, and now Pakistan is counting on the Fund's strong, continued support to ensure medication is available to people with TB. Continued progress on TB is essential to development in Pakistan, since 80 percent of

Pakistanis afflicted with tuberculosis are in the most economically productive years of their lives, and the disease sends many self-sustaining families into poverty.

The Global Fund projects an $8 billion need for new and continuing programs in 2010, but only $3 billion in pledges are in place. The Labor, Health and Human Services, and Education, and Related Agencies budget, through NIH, has been a crucial source of funding for the U.S. contribution to the Fund, providing $300 million in fiscal year 2009. The Global Fund has requested that the United States triple its total contribution for fiscal year 2010. The portion of the U.S. contribution provided by NIH should therefore be tripled to $900 million. The economic, strategic and moral case for this contribution to the Global Fund is clear, and the United States must do its part to help close this funding gap.

The IDSA and the HIVMA have many funding priorities to champion in the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill including funds to address antimicrobial resistance, child and adult immunizations, pandemic influenza, the Ryan White CARE Act, and domestic HIV prevention. Thank you for the opportunity to highlight our funding priorities for research and programs related to global HIV and TB in the Labor, Health and Human Services, and Education, and Related Agencies account.

PREPARED STATEMENT OF CHILDREN AND ADULTS WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (CHADD)

BACKGROUND

At the Centers for Disease Control and Prevention (CDC) 1999 conference titled "Attention Deficit Hyperactivity Disorder: A Public Health Perspective," more than 150 experts gathered to discuss the public health concerns related to AD/HD and to explore areas for future research. The conference developed a public health research agenda which included recommendations on the establishment of: a resource for both professionals and the public regarding what is known about the epidemiology of AD/HD; an avenue of dissemination of educational materials related to the diagnosis of and intervention opportunities for AD/HD to primary care physicians, nurse practitioners, physicians assistants, mental health providers and educators; collaborations with other organizations to educate and promote what is known about AD/HD interventions, appropriate standards of practice, their effectiveness, and their safety; and a resource to the public for accurate and valid information about AD/HD and evidence-based interventions.

Congress responded to this research agenda in fiscal year 2002 by providing resources for the CDC to begin a partnership with CHADD[1] to develop the National Resource Center on AD/HD (NRC)—a significant development in recognizing the unique challenges faced by individuals with AD/HD across the lifespan.

The NRC's goals include improving the health and quality of life of individuals with AD/HD and their families; raising awareness and facilitating access to scientifically valid information and support services; and improving the understanding of the impact of AD/HD among healthcare specialists, educators, employers, and individuals with AD/HD. The NRC fulfills these goals by disseminating evidence-based research on AD/HD through a variety of mechanisms, including:

—a Web site (www.help4adhd.org) receiving on average 129,274 visits each month;

—a national call center, staffed by five professional health information specialists, including one bilingual health information specialist. The health information specialists responded to 9,051 individual inquiries during the last year on 10,018 different topical issues from parents, adults with AD/HD, mental health professionals, and educators;

—partnerships with minority health organizations to reach underserved populations;

—a series of more than 25 "What We Know" fact sheets on AD/HD, in both English and Spanish; and

—a comprehensive library and online bibliographic database of more than 3,000 evidence-based journal articles and reports on AD/HD.

The overwhelming demand for information and support on AD/HD by the public and the professional community has created an unprecedented need for additional

---

[1] Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) was founded by parents in 1987 in response to the frustration and sense of isolation experienced by parents and their children. CHADD is the leading national nonprofit organization for children and adults with AD/HD, providing the public and providers with education, advocacy, and support.

resources to keep pace with the requests for information received by the NRC and to provide outreach and resources to unserved and underserved populations.

WHAT IS AD/HD?

A 2005 report by the CDC found that parents reported approximately 7.8 percent of school-age children (4 to 17 years) had a diagnosis of Attention-Deficit/Hyperactivity Disorder (AD/HD).[2] Other evidence-based studies have documented that more than 70 percent of children with AD/HD will continue to experience symptoms of AD/HD into adolescence, and almost 65 percent will exhibit AD/HD characteristics as adults.[3] In addition, up to two-thirds of children with AD/HD will have at least one co-occurring disability with 50 percent of these children having a co-occurring learning disability.

Only half of all children with AD/HD receive the necessary treatment, with lower diagnostic and treatment rates among girls, minorities, and children in foster care. If untreated or inadequately treated, AD/HD can have serious consequences, increasing an individual's risk for school failure, unemployment, interpersonal difficulties, other mental health disorders, substance and alcohol abuse, injury, antisocial and illegal behavior, contact with law enforcement, and shortened life expectancy.[4] The availability of appropriate services and access to treatment can help individuals with AD/HD avoid negative outcomes and lead successful lives.

FISCAL YEAR 2010 APPROPRIATIONS REQUEST

The NRC has met and continues to meet the goals of improving the health and quality of life for individuals with AD/HD and their families; raising awareness and facilitating access to evidence-based information and support services; and improving the understanding of the impact of AD/HD among healthcare specialists, educators, employers, and individuals with AD/HD.[5]

Both the National Institutes of Health Consensus Conference on AD/HD (Nov. 1998) and the Centers for Disease Control and Prevention (CDC) Conference on Public Health and AD/HD (September 1999) concluded that AD/HD is a serious public health concern that needs to be addressed because of the potential economic burden associated with AD/HD. Numerous peer-reviewed journal articles have documented the significant healthcare cost of individuals with AD/HD.

In "AD/HD in Adults: What the Science Says," Barkley, Murphy & Fisher discuss the results of the few empirical studies that have been conducted regarding occupational functioning of clinic-referred adults with AD/HD. "Although opinions abound on the topic in trade books on ADHD in adults, there is very little research on the occupational functioning of clinic-referred adults with ADHD" (p. 276). One study conducted at UMASS found that adults with a diagnosis of AD/HD are more likely to self-report and have employers report difficulties with occupational functioning than their clinic-referred or community counterparts. In addition, the Milwaukee study (2006) found that individuals diagnosed as having AD/HD as children that persists until age 27 tend to be more severely affected in occupational functioning than clinic-referred adults or community counterparts. In addition, another study conducted by Biederman & Faraone (2006) concluded that individuals with AD/HD are less likely to be employed full time (34 percent of individuals with AD/HD com-

[2] Centers for Disease Control and Prevention (2005). *Mental Health in the United States: Prevalence of Diagnosis and Medication Treatment for Attention-Deficit/Hyperactivity Disorder.* Retrieved March 25, 2005, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a2.htm.

[3] Dulcan, M., and the Work Group on Quality Issues. (1997, October). AACAP official action: Practice parameters for the assessment and treatment of children, adolescents, and adults with Attention-Deficit/Hyperactivity Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, Supplement*, 36(10), 85S–121S.

[4] Barkley, R. A. (1997). *ADHD and the nature of self-control*. New York: The Guilford Press.

[5] Cuffe, S.P., Moore, C.G., & McKeown, R. (2009). ADHD and health services utilization in the National Health Survey. *Journal of Attention Disorders*, 12(4), 330–340.; Chan, E., Zhan, C., & Homer, C.J. (2002). Health care use and costs for children with Attention-Deficit/Hyperactivity Disorder, *Archives of Pediatrics & Adolescent Medicine*, 156, 504–511.; Rowland, A.S., Umbach, D.M., Stallone, L., Naftel, J., Bohlig, E.M., & Sandler, D. P. (2002). Prevalence of medication treatment for Attention Deficit—Hyperactivity Disorder among elementary school children in Johnston County, North Carolina, American Journal of Public Health, 92(2), 231–234.; Ray, T.G., Levine, P., Croen, L.A., Bokhari, F.A.S., Hu., T., & Habel, L.A. (2006). Attention-Deficit/Hyperactivity Disorder in children, *Archives of Pediatrics & Adolescent Medicine, 160*, 1063–1069.

pared to 59 percent of individuals without AD/HD).[7] In addition, the study found that the household incomes of adults older than the age of 25 were significantly lower among individuals with AD/HD when compared to individuals without AD/HD regardless of academic achievement or personal characteristics. The results of these three studies indicate the need for further research into the impact of AD/HD on the occupational functioning of adults and how best to reasonably accommodate their disability in the workplace because more than 30 percent of requested accommodations are at no cost to the employer but yet according to Biederman & Faraone the total cost of work loss among men and women with AD/HD is $2.6 billion, or 53 percent of the total $13 billion cost of adult ADHD in the United States.

Therefore, we are asking that the National Center on Birth Defects and Developmental Disabilities (NCBDDD) AD/HD line item be increased from $1.777 million to $2.377 million and that the funding for the NRC be increased from $980,000 to $1.280 million. This is a $600,000 increase in the AD/HD line and $300,000 increase in the NRC line. Historically, half of the increase to the AD/HD line item has been used to fund research on AD/HD. This increase will allow the NRC to further develop its outreach to the African-American and Hispanic-Latino communities, restore education campaigns at nurse, educator, and related conferences, and most importantly during this current economic climate to initiate an employment information specialist service.

REQUESTED REPORT LANGUAGE FOR FISCAL YEAR 2010

The subcommittee continues to support the activities of the CDC's NCBDDD and the National Resource Center (NRC) on AD/HD and has provided $2.377 million to continue this support, including $1.28 million to maintain and expand the activities at the NRC as it responds to the overwhelming demand for information and support services, reaches special populations in need, and educates health and education professionals on the impact of AD/HD on the ability individuals with AD/HD to lead successful, economically self-sufficient, and independent lives integrated into their communities with the necessary accommodations and supports.

PREPARED STATEMENT OF THE COALITION FOR HEALTH SERVICES RESEARCH

The Coalition for Health Services Research is pleased to offer this testimony regarding the role of health services research in improving our Nation's health. The Coalition's mission is to support research that leads to accessible, affordable, high-quality healthcare. As the advocacy arm of AcademyHealth, the Coalition represents the interests of 3,500 researchers, scientists, and policy experts, as well as 150 organizations that produce and use health services research.

Healthcare in the United States has the potential to improve people's health dramatically, but often falls short and costs too much. Health services research is used to understand how to better finance the costs of care, measure and improve the quality of care, and improve coverage and access to affordable services. Indeed, health services research is changing the face of American healthcare, uncovering critical challenges facing our Nation's healthcare system. For example, the 2000 Institute of Medicine (IOM) report To Err is Human found that up to 98,000 Americans die each year from medical errors in the hospital. Health services research also uncovered that disparities and lack of access to care in rural and inner cities result in poorer health outcomes. And, it found that obesity accounts for more than $92 billion in medical expenditures each year and has worse effects on chronic conditions than smoking or problem drinking.

Health services research does not just lift the veil on problems plaguing American healthcare; it also seeks ways to address them. Health services research framed the debate over healthcare reform in Massachusetts—forming the basis for that State's 2006 health reform legislation—and continues to frame the debate on the national stage today. It offers guidance on implementing and making the best use of health information technology, and getting the best care at the best value across a menu of treatment options. And there are increasing examples that demonstrate how comparative effectiveness research—an emerging science in the broader field of health services research—provides the scientific basis needed to determine what treatments work best, for whom, and in what circumstances.

Health services research can contribute greatly to better healthcare at better value. It is a true public good, providing a basis for improvements in our healthcare

---

[7] Biederman, J.,& Faraone, S.V. (2006). *The effects of attention-deficit/hyperactivity disorder on employment and household income*. MedGenMed, 8(3),12, Retrieved March 25, 2005, from http://www.medscape.com/viewarticle/536264.

system that will benefit the general public. Americans overwhelmingly agree. A recent opinion survey commissioned by Research!America found that 95 percent of Americans say it is important to support research focused on how well our healthcare system is functioning. After all, the investment in basic research and the development of new medicines and equipment is wasted if the health system cannot safely and effectively deliver that care.

For the last 6 years, the Coalition has been collecting data to track the Federal Government's expenditures for health services research and health data. From information provided to us by these funders—including Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC)—funding for this field remained relatively constant from fiscal year 2003—2008 and did not kept pace with inflation. In stark contrast, spending on healthcare overall has risen faster than the rate of inflation—from $1.4 trillion in 2000 to nearly $2.2 trillion in 2007. The total Federal investment in health services research and data by our estimates approaches $1.7 billion in fiscal year 2008—representing just 0.074 percent of the $2.2 trillion we spend on healthcare annually.

The Coalition for Health Services Research greatly appreciates the subcommittee's recent efforts to increase the Federal investment in health services research and comparative effectiveness research through the fiscal year 2009 Omnibus Appropriations Act and the American Recovery and Reinvestment Act of 2009. This funding provides a new high watermark for the field and represents the largest single funding increase health services research has experienced. With comprehensive health reform on the horizon, we ask that the subcommittee continue to strengthen the capacity of the health services research field to address the pressing challenges America faces in providing access to high-quality, cost-effective care for all its citizens.

AHRQ

AHRQ is the lead Federal agency charged with supporting unbiased, scientific research to improve healthcare quality, reduce costs, advance patient safety, decrease medical errors, and broaden access to essential services. Steady, incremental increases for AHRQ's Effective Health Care Program in recent years, as well as the $300 million provided to AHRQ in the American Recovery and Reinvestment Act as a down payment on health reform will help AHRQ generate more comparative effectiveness research and expand the infrastructure needed to increase capacity to produce this evidence. However, funding for AHRQ's broader health services research portfolio on health disparities, healthcare financing and organization, and access and coverage has languished as funding for AHRQ's base has remained relatively flat. Future investments should bolster these other important research topics to balance the recent investments in comparative effectiveness research. Comparative effectiveness research alone will not solve our health system challenges; the full spectrum of health services research on healthcare costs, quality, and access will be needed to support broader health reform efforts.

In fiscal year 2009, Congress provided AHRQ $13 million to reverse a decline in the number of, and funding for, grants that support researcher innovation and career development. AHRQ is using this funding for investigator initiated research grants to rejuvenate the free marketplace of ideas through the agency's new Innovations Research Portfolio. We request that Congress provide additional funding to sustain and expand investigator initiated grants in fiscal year 2010.

The Coalition remains concerned about AHRQ's limited investment in training grants for young researchers, which hit new lows in fiscal year 2009—just 40 awards totaling $5 million—down from nearly double that amount just 2 years ago. The Coalition requests that Congress will provide AHRQ more funding in fiscal year 2010 for training grants to ensure the field's capacity to respond to the growing public and private sector demand for health services research.

While targeted funding increases in recent years have moved AHRQ in the right direction, more core funding is needed to help AHRQ fulfill its mission. We join the Friends of AHRQ—a coalition of more than 250 health professional, research, consumer, and employer organizations that support the agency—in recommending a fiscal year 2009 base funding level of at least $405 million, an increase of $32 million more than the fiscal year 2009 level. This investment will allow AHRQ to restore its critical healthcare safety, quality, and efficiency initiatives; strengthen the infrastructure of the research field; and reignite innovation and discovery.

CDC

Housed within CDC, the National Center for Health Statistics (NCHS) is the Nation's principal health statistics agency, providing critical data on all aspects of our

healthcare system. Thanks to NCHS, we know that too many Americans are overweight and obese, cancer deaths have decreased, average life expectancy has increased, and emergency rooms are overcrowded. We also know how many people are uninsured, how many children are immunized, how many Americans are living with HIV/AIDS, and how many teens give birth.

Despite recent funding increases secured through your leadership, NCHS continues to feel the effects of long-term underinvestment, forcing the agency to eliminate or further postpone the collection of such vital information to the point where key data users now question whether NCHS itself is in good health. Years of flat funding and budget shortfalls forced the elimination of data collection and quality control efforts, threaten the collection of vital statistics, stymied the adoption of electronic systems, and limited the agency's ability to modernize surveys to reflect changes in demography, geography, and health delivery.

The Coalition joins the Friends of NCHS—a coalition of more than 250 health professional, research, consumer, industry, and employer organizations that support the agency—in recommending a base funding level of $137.5 million in fiscal year 2010 to ensure uninterrupted collection of vital statistics; restore other important data collection and analysis initiatives; to revise, pretest, and plan data collection activities for future calendar years, and modernize its systems to increase efficiency, interoperability, and security. In addition, we respectfully request that you provide NCHS $15 million in one-time funding to support the States and territories as they implement the 2003 birth certificates and electronic systems to collect birth data in real-time to facilitate public health monitoring and planning. Future supplemental funding will be required to implement the 2003 death certificates in all States and complete the automation of data collection. The Coalition greatly appreciates that through your leadership early versions of the American Recovery and Reinvestment Act in the House and Senate included $40 million for this infrastructure development; we were disappointed that it had to be eliminated from the final package.

While significant funding has been provided to improve the public health system's capacity to respond to a terrorist attack or a public health crisis such as pandemic flu, insufficient funding has been provided to support research that evaluates the effectiveness of our preparedness interventions and seeks to improve the delivery of public health services. For example, how cost effective are public health and prevention programs? How can the medical care and public health delivery systems be better linked? CDC's important Public Health Research program and Prevention Research Centers-a network of academic health centers that conduct public health research-have been flat funded since fiscal year 2006 at levels of $31 million and $29 million, respectively. The Coalition requests at least $35 million for Public Health Research and at least $33 million for Prevention Research Centers in fiscal year 2010. The programs seek ways to development, translate, and disseminate research to address obesity, diabetes, and heart disease, healthy aging and youth development, cancer risk, and health disparities.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Steady funding decreases for the Office of Research, Development and Information, together with an increasingly earmarked budget, has hindered CMS' ability to meet its statutory requirements and conduct new research to strengthen our public insurance programs—including Medicare, Medicaid, and SCHIP—which together provide coverage to nearly 100 million Americans and comprise 45 percent of America's total health expenditures. At a time when these programs pose significant budget challenges for both the Federal and State governments, it is critical that we adequately fund research to evaluate these programs' efficiency and effectiveness, and seek ways to manage their projected spending growth.

The Coalition supports increasing CMS's discretionary research and development budget from $31 million in fiscal year 2009 to a base fiscal year 2010 funding level of $45 million—in addition to funding for programmatic earmarks—as a critical down payment to help CMS recover lost resources and restore research to evaluate their programs, analyze pay for performance and other tools to update payment methodologies, and to further refine service delivery methods.

NIH

The NIH reported that it spent $743 million on health services research in fiscal year 2008—roughly 2.9 percent of its entire budget—making it the largest Federal sponsor of health services research. For fiscal year 2010, the Coalition recommends a health services research base funding level of at least $940 million—2.9 percent of the $32 billion the broader health community is seeking for NIH in fiscal year 2010. We encourage NIH to increase the proportion of their overall funding that

goes to health services research from 2.9 to 5 percent to assure that discoveries from clinical trials are effectively translated into health services. We also encourage NIH to foster greater coordination of its health services research investment across its Institutes.

In conclusion, the accomplishments of health services research would not be possible without the leadership and support of this subcommittee. As you know, the best healthcare decisions are based on relevant data and scientific evidence. At a time when you, your congressional colleagues, and members of the new administration are considering major health reform including ways to get more value for current expenditures, health services research and health data are needed more than ever to yield better information and lead to improved quality, accessibility, and affordability. We urge the subcommittee to accept our fiscal year 2010 funding recommendations for the Federal agencies funding health services research and health data.

PREPARED STATEMENT OF THE COALITION OF NORTHEASTERN GOVERNORS

The Coalition of Northeastern Governors (CONEG) is pleased to submit this testimony for the record to the Senate Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies regarding fiscal year 2010 appropriations for the Low Income Home Energy Assistance Program (LIHEAP).

The governors appreciate the subcommittee's continued support for the LIHEAP program, and we thank you for providing the full authorized amount of $5.1 billion in fiscal year 2009 LIHEAP funding. The governors recognize the considerable fiscal challenges facing the subcommittee this year. However, we urge you to maintain the $5.1 billion level in regular fiscal year 2010 LIHEAP block grant funding as well as contingency funds to address unforeseen energy emergencies.

LIHEAP is a vital safety net for millions of vulnerable low-income households—the elderly and disabled living on fixed incomes, the working poor, and families with young children. The highest level of LIHEAP assistance is provided to households with the lowest incomes that pay a high proportion of their income (up to 17 percent) for home energy. A December 2007 study by the Oak Ridge National Laboratory found that, in recent years, the increase in the cost of home energy has far outpaced the rate of inflation and the increase in household income. Even with continued belt-tightening, there is just no room in the budget of these low-income households to pay for increasing energy bills.

The current economic crisis exerts additional pressures on these households, making energy assistance more important now than ever before. In 2007, even before the current recession took hold, 8.7 million residential consumers had their electricity or natural gas service terminated for failing to pay their bills, according to a survey by the National Association of Regulatory Utility Commissioners (December 2008). The same survey found at the end of the 2007–2008 winter heating season, the number of electricity and natural gas residential households with past due accounts had jumped to almost 40 million consumers, and represented nearly $8.7 billion in past due accounts.

According to the National Energy Assistance Directors' Association, the $5.1 billion in fiscal year 2009 LIHEAP funding makes it possible for States to serve approximately 7.3 million households this year. This record number represents a 25 percent increase more than last year and reflects the increased unemployment rate and rise in home energy costs. Yet this is only a small portion of the LIHEAP-eligible households in today's economy.

If the $5.1 billion level of LIHEAP funding is not sustained in fiscal year 2010, States nationwide will be forced to eliminate more than 1.5 million families from the program in order to maintain some of the purchasing power of the LIHEAP grant for the program's poorest families, or to reduce benefit levels overall. States in the Northeast already incorporate various administrative strategies that allow them to deliver maximum program dollars to households in need. These include using uniform application forms to determine program eligibility, establishing a one-stop shopping approach for the delivery of LIHEAP and related programs, sharing administrative costs with other programs, and using mail recertification. Opportunities to further reduce LIHEAP administrative costs are limited, since they are already among the lowest of the human service programs.

In spite of these State efforts to stretch Federal and State LIHEAP dollars, the need for the program is far too great. Increased, predictable and timely Federal funding is vital for LIHEAP to assist the Nation's vulnerable, low-income households faced with exorbitant home energy bills. The CONEG governors urge the Subcommittee to provide $5.1 billion in regular block grant funding for LIHEAP in fis-

cal year 2010 as well as contingency funds to address unforeseen energy emergencies. This sustained level of funding will help States to provide meaningful assistance to households in need as millions of low-income citizen's struggle with simply unaffordable home energy bills. LIHEAP can continue to provide a vital safety net protecting these vulnerable households from the potentially deadly heat and cold.

PREPARED STATEMENT OF THE COUNCIL ON SOCIAL WORK EDUCATION

On behalf of the Council on Social Work Education (CSWE), I am pleased to offer this written testimony to the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies for inclusion in the official subcommittee record. I will focus my testimony on the importance of fostering a skilled, sustainable and diverse social work workforce through training and financial support programs at the Department of Health and Human Services and the Department of Education.

CSWE is a nonprofit national association representing more than 3,000 individual members as well as 650 graduate and undergraduate programs of professional social work education. Founded in 1952, this partnership of educational and professional institutions, social welfare agencies, and private citizens is recognized by the Council for Higher Education Accreditation as the sole accrediting agency for social work education in the United States. Social work education focuses students on leadership and direct practice roles helping individuals, families, groups, and communities by creating new opportunities that empower people to be productive, contributing members of their communities.

Vulnerable populations from all walks of life—defined here as children and adults with physical or mental disabilities, those living in poverty, trauma victims, aging individuals, returning veterans, individuals under stress or facing coping challenges both temporary and permanent, and segments of society needing assistance to adjust to changing circumstances or overcome injustices—are faced with hurdles which for some cannot be overcome alone. Social workers help vulnerable populations in society be as healthy and productive as possible by working with them to navigate societal and personal challenges. Social workers are employed in schools, hospitals, VA facilities, rehabilitation centers, social service locations, child welfare organizations, assisted living centers, nursing homes, and faith-based organizations.

TRAINING OPPORTUNITIES AND DEBT LOAD RELIEF FOR SOCIAL WORKERS

Recruitment and retention pose the most significant challenge to the success of the social work profession. This is true across all sectors (public and private), at all levels (from BSW to the doctoral level), and in all fields of practice (child welfare, public health, mental health, geriatrics, veterans, etc.).

The Nation needs a workforce that is skilled, diverse, and able to keep pace with demand. In 2004, the Bureau of Labor Statistics (BLS) reported that by 2012 a total of 209,000 social workers will be needed in the fields of child, family, and school social work; medical and public health social work; and mental health and substance abuse social work. In 2006, the BLS estimated there would be a total of 258,000 job openings for social workers due to growth and net replacement between 2006 and 2016 in the same fields.

While recruitment and retention can be a significant challenge for many professions, especially those dealing with public health and the delivery of social services, the problem is exceptionally widespread for social work. Recruitment into the social work profession faces many obstacles, the most prevalent being low wages.

As we look toward reforming the American healthcare system, we must consider the needs of the workforce that will be responsible for ensuring the health of the population. The recommendations for fiscal year 2010 would help to ensure that we are fostering a sustainable, skilled, and diverse workforce that will be able to keep up with the increasing demand.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

The various agencies within the HHS provide training and fellowship opportunities for social workers, as well as loan forgiveness programs to help social workers stay in the field. CSWE urges the subcommittee's support of the following HHS programs; this is not an exhaustive list:

Minority Fellowship Program, Substance Abuse and Mental Health Services Administration (SAMHSA).—The goal of the SAMHSA Minority Fellowship Program (MFP), which is administered through the Center for Mental Health Services, is to

achieve greater numbers of minority doctoral students preparing for leadership roles in the mental health and substance abuse field. According to SAMHSA, "Minorities make up approximately one-fourth of the population, but only about 10 percent of mental health providers are ethnic minorities." CSWE has been a grantee of this critical program for years, administering funds to exceptional minority social work students. Together with a program at the National Institute of Mental Health (NIMH), CSWE has supported more than 500 minority fellows since the program's inception, with about two-thirds of those students having gone on to receive their doctoral degrees. For fiscal year 2010, CSWE urges the subcommittee to fund the SAMHSA Minority Fellowship Program at $7.5 million. This program has suffered from flat and declining budgets over the last several years. Thankfully, due to congressional support, it has been restored year after year, despite efforts by the Bush administration to cancel it. President Obama's fiscal year 2010 budget request includes level funding for the MFP at about $4 million. Funding the MFP at $7.5 million would directly encourage more social workers of minority background to pursue doctoral degrees in mental health and substance abuse and will turnout minority mental health professionals equipped to provide culturally competent, accessible mental health and substance abuse services to diverse populations.

Institutional Research Training Program in Social Work (T32), NIMH.—NIMH within the National Institutes of Health (NIH) initiated a training program in the 1970s that sought to increase the number of minority doctoral students focusing their research in mental health. Like the SAMHSA program mentioned above, CSWE has ably administered a grant from NIMH for many years, which provides mentored training opportunities to minority social work researchers. The social work profession depends on culturally competent and culturally relevant research to assess the circumstances facing vulnerable populations and the needs of those populations to succeed in their circumstances; evaluate the accessibility to and effectiveness of existing social services; and determine best practices for social work educators and practitioners for serving the community. While this program has been successful in enhancing diversity among social workers conducting mental health research and has allowed more underrepresented social work researchers to be brought into the fold as NIH investigators, NIMH recently announced its plan to cancel the program in 2010 and transition the funds to support the traditional, non-diversity-focused T32 training program at NIMH. CSWE is very concerned about the implications of this decision, both on the diversity of researchers at NIMH and what we feel could lead to an absence of social work research at NIMH. We hope the subcommittee will encourage NIMH to take the necessary steps to enhance diversity of the NIH/NIMH grant pool and express to NIMH the value and importance of social work research to the study of mental health.

Title VII Health Professions Programs, Health Resources and Services Administration (HRSA).—The title VII health professions programs at HRSA provide financial support for education and development of the healthcare workforce. The emphasis of these programs is on improving the quality, diversity, and geographic distribution of the health professions workforce, and is currently the only Federal program to do so. These programs provide loans, loan guarantees and scholarships to students and grants to institutions of higher education and nonprofit organizations to help build and maintain a robust healthcare workforce. Social work students and practioners are eligible for title VII funding. We thank you for recognizing the value of these programs by providing $200 million in stimulus funding to the title VII and title VIII (nursing) programs in the American Recovery and Reinvestment Act of 2009 (Public Law 111–5). CSWE urges the subcommittee to provide $330 million for the title VII health professions programs for fiscal year 2010.

Loan Repayment Program, Indian Health Service (IHS).—The Loan Repayment Program at IHS offers repayment of health professions educational loans in exchange for a commitment to work at an IHS or other Indian health program priority site for a minimum of 2 years. Social workers are eligible to participate in this program, as defined in section 4(n) of the Indian Health Care Improvement Act (Public Law 94–437). With appropriate funding, this program can serve as an effective recruitment tool. However, the program has been grossly underfunded for a number of years. For example, last year IHS denied funding to 231 healthcare professionals already working in IHS as well as 95 recruits, due to a lack of resources. CSWE, a member of the Friends of Indian Health Coalition, urges the subcommittee to provide an additional $18.5 million above fiscal year 2009 funding for the IHS Loan Repayment Program for fiscal year 2010 in order to address the critical recruitment needs of the agency.

The last few years have seen the creation of a number of loan forgiveness and training programs for which social work would benefit, if adequately funded. CSWE urges the subcommittee to support the following programs at the Department of Education:

Graduate Assistance in Areas of National Need (GAANN) Program.—The GAANN program provides graduate traineeships in critical fields of study. Currently, social work is not defined as an area of national need for this program; however it was recognized by Congress as an area of national need in the Higher Education Opportunity Act of 2008 as discussed below. We are hopeful that the Department of Education will recognize the importance of including social work in the GAANN program in future years. Inclusion of social work would help to significantly enhance graduate education in social work, which is critically needed in the country's efforts to foster a sustainable health professions workforce. CSWE supports a budget of at least $41 million for GAANN in fiscal year 2010. However, if social work were to be added by the Department as a new area of national need, additional resources would need to be provided so as not to take funding away from the already determined areas of national need.

Loan Forgiveness for Service in Areas of National Need Program.—The Higher Education Opportunity Act of 2008 (Public Law 110–315) created the Loan Forgiveness for Service in Areas of National Need program. This program applies to full-time workers who are employed in areas of national need, such as social workers working in public or private child welfare agencies or mental health professionals with at least a master's degree in social work. CSWE urges full funding for this new program for fiscal year 2010.

In addition to these discretionary programs, a number of mandatory programs were created in the College Cost Reduction Act of 2007 (Public Law 110–84). We look forward to working with the Department of Education as these programs are implemented. Among the programs that include social work education are:

Income-based Repayment (IBR)Program.—IBR program will begin operation in July 2009. This new program caps Federal student loan payments at a reasonable percentage of income and cancels most remaining balances of student loans after 25 years. CSWE will be monitoring the implementation of this new program to assess the extent to which it is assisting social workers address their debt load reduction needs.

Income Contingent Payment for Public Sector Employment Program (Public Service Loan Forgiveness).—The College Cost Reduction Act of 2007 revised the Income Contingent Payment for Public Sector Employment program, which previously allowed a borrower who works in public service to pay their loans more than 25 years after which their debt would be forgiven. The law now states that public service workers working for an eligible nonprofit can cancel their loans after 10 years of service for loans taken out after October 1, 2007. Like the IBR program, CSWE plans to monitor the implementation of this program to assess its success in assisting social workers address high educational debt load.

We hope the subcommittee will take these points into consideration as you move forward in the fiscal year 2010 appropriations process.

PREPARED STATEMENT OF CENTRAL TECHNICAL SERVICES

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2010

Continue the Commitment to Providing the National Institutes of Health (NIH) and the National Library of Medicine (NLM) with meaningful funding increases on an annual basis. Continue to support and defend the NIH's public access policy, which requires that all final, peer-reviewed manuscripts are made available through NLM's pubmed central database within 12 months of publication. Continue to support the medical library community's important role in NLM's outreach, telemedicine, disaster preparedness and health information technology (health IT) initiatives.

On behalf of the Medical Library Association (MLA) and the Association of Academic Health Sciences Libraries (AAHSL), thank you for the opportunity to present testimony regarding fiscal year 2010 appropriations for the NLM.

MLA is a nonprofit, educational organization with more than 4,000 health sciences information professional members worldwide. Founded in 1898, MLA provides lifelong educational opportunities, supports a knowledge base of health information research, and works with a global network of partners to promote the impor-

tance of quality information for improved health to the healthcare community and the public.

AAHSL is comprised of the directors of the libraries of 142 accredited American and Canadian medical schools belonging to the Association of American Medical Colleges. AAHSL's goals are to promote excellence in academic health sciences libraries and to ensure that the next generation of health professionals is trained in information-seeking skills that enhance the quality of healthcare delivery.

Together, MLA and AAHSL address health information issues and legislative matters of importance through a joint legislative task force and a Government Relations Committee.

THE IMPORTANCE OF ANNUAL FUNDING INCREASES FOR NLM

I thank the subcommittee for its leadership and hard work on the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), the economic stimulus package. As you know, the important mission of NIH and the important role that NLM plays in fulfilling that mission were hampered by past-years of near level funding. The investment in NIH and NLM provided by the stimulus package will not only create meaningful employment opportunities, it will also revitalize NLM's programs, which are focused on improving the public health.

We are pleased that the recently passed fiscal year 2009 omnibus appropriations package contains funding increases for NIH and NLM that will bolster their baseline budgets. We hope that this funding is an indication of the subcommittee's intention to provide annual, meaningful increases for NIH and NLM in the coming years.

I am confident that the recovery funding and the fiscal year 2009 budget increases will stimulate the economy, stimulate biomedical research, and in the case of NLM, improve the dissemination of health information to researchers, practitioners, and the general public. Moving forward, it will be critical to provide NIH's baseline budget with the funding increases necessary to allow the short-term growth generated by the stimulus to become a long-term investment towards improved public health through bolstered health information programs.

Building and Facility Needs

NLM has had tremendous growth in its basic functions related to the acquisition, organization, and preservation of an ever-expanding collection of biomedical literature. It also has been assigned a growing set of set of responsibilities related to the collection, management, and dissemination genomic information, clinical trials information, and disaster preparedness and response. As a result, NLM faces a serious shortage of space, for staff, library materials, and information systems. Digital archiving—once thought to be a solution to the problem of housing physical collections—has only added to the challenge, as materials must often be stored in multiple formats (physical and digital) and as new digital resources demand increasing amounts of storage space. As a result, the space needed for computing facilities has also grown. In order for NLM to continue its mission as the world's premier biomedical library, a new facility is urgently needed. The NLM Board of Regents has assigned the highest priority to supporting the acquisition of a new facility. Further, Senate Report 108–345 that accompanied the fiscal year 2005 appropriations bill acknowledged that the design for the new research facility at NLM had been completed, and the subcommittee urged NIH to assign a high priority to this construction project so that the information-handling capabilities and biomedical research are not jeopardized.

The Growing Demand for NLM's Basic Services

As the world's foremost digital library and knowledge repository in the health sciences, NLM provides the critical infrastructure in the form of data repositories and integrated services such as GenBank and PubMed that are helping to revolutionize medicine and advance science to the next important era—individualized medicine based on an individual's unique genetic differences.

NLM's clinical trials database, ClinicalTrials.gov, which was launched in February 2000 and lists registration information on more than 70,000 U.S. and international trials for a wide range of diseases, also now serves as a repository for summary results information. The expanded system serves not only as a free, but invaluable resource for patients and families who are interested in participating in trials of new treatments for a wide range of diseases and conditions, but also as an important source of information for clinicians interested in understanding new treatments and for those involved in evidence-based medicine and comparative effectiveness research.

As the world's largest and most comprehensive medical library, services based on NLM's traditional and electronic collections continue to steadily increase each year.

These collections stand at more than 11.4 million items—books, journals, technical reports, manuscripts, microfilms, photographs, and images. By selecting, organizing and ensuring permanent access to health science information in all formats, NLM is ensuring the availability of this information for future generations, making it accessible to all Americans, irrespective of geography or ability to pay, and ensuring that each citizen can make the best, most-informed decisions about their healthcare. Without NLM our Nation's medical libraries would be unable to provide the quality information services that our Nation's health professionals, educators, researchers, and patients have all come to expect.

DEFEND PUBLIC ACCESS

The Appropriations Committee has shown unprecedented foresight and leadership by using the annual spending bills as the vehicle to establish a public access policy at the NIH. The current policy requires that all NIH-funded researchers deposit their final, peer-reviewed manuscripts in NLM's PubMed Central database within 12 months of publication. This policy will not only help NIH better manage its portfolio of research, but will contribute to the development of a biomedical informatics infrastructure that will stimulate further discovery by enabling a much greater and tighter interlinking of information from NLM's wide-ranging set of databases. It also contributes to outreach initiatives by providing much-needed access to health literature to those without direct access to medical libraries. While the fiscal year 2009 omnibus package made this policy permanent moving forward, challenges remain and we urge the subcommittee to continue to defend this policy.

SUPPORT AND ENCOURAGE NLM PARTNERSHIPS WITH THE MEDICAL LIBRARY COMMUNITY

Outreach and Education

NLM's outreach programs are of particular interest to both MLA and AAHSL. These activities are designed to educate medical librarians, health professionals and the general public about NLM's services. NLM has taken a leadership role in promoting educational outreach aimed at public libraries, secondary schools, senior centers and other consumer-based settings. Furthermore, NLM's emphasis on outreach to underserved populations assists the effort to reduce health disparities among large sections of the American public. One example of NLM's leadership is the "Partners in Information Access" program, which is designed to improve the access of local public health officials to information needed to prevent, identify and respond to public health threats. With nearly 6,000 members in communities across the country, the National Network of Libraries of Medicine (NNLM) is well-positioned to ensure that every public health worker has electronic health information services that can protect the public's health.

With help from Congress, NLM, NIH and the Friends of NLM, launched NIH MedlinePlus Magazine in September 2006. This quarterly publication is distributed in doctors' waiting rooms, and provides the public with access to high-quality, easily understood health information. Collaborating with the National Alliance for Hispanic Health, a Spanish version is now available, NIH MedlinePlus Salud. NLM also continues to work with medical librarians and health professionals to encourage doctors to provide MedlinePlus "information prescriptions" to their patients. This initiative also encourages genetics counselors to prescribe the use of NLM's Genetic Home Reference Web site.

"Go Local" is another exciting service that engages health sciences libraries and other local and State agencies in the creation of Web sites that link from MedlinePlus to relevant information on local pharmacies, hospitals, doctors, nursing homes, and other health and social services. In Iowa, for example, University of Iowa librarians developed an Iowa Go Local site that enables users to find local health resources by Iowa county or city. It allows Iowa citizens to link directly from a MedlinePlus health topic, for example asthma, to local services, such as clinics, pulmonary specialists, and support groups in the geographic area selected. By collecting such information in one place, Go Local also provides a platform for enhancing access to the information needed to prepare for and respond to disasters and emergencies.

MLA and AAHSL applaud the success of NLM's outreach initiatives, particularly those initiatives that reach out to medical libraries and health consumers. We ask the subcommittee to encourage NLM to continue to coordinate its outreach activities with the medical library community in fiscal year 2010.

EMERGENCY PREPAREDNESS AND RESPONSE

MLA and AAHSL are pleased that NLM has established a Disaster Information Management Research Center to expand NLM's capacity to support disaster response and management initiatives, as recommended in the NLM Board of Regents Long Range Plan for 2006–2016. We ask the subcommittee to show its support for this initiative, which has a major objective of ensuring continuous access to health information and effective use of libraries and librarians when disasters occur. Following Hurricane Katrina, for example, NLM worked with health sciences libraries across the country to provide health professionals and the public with access to needed health and environmental information by: (1) quickly compiling web pages on toxic chemicals and environmental concerns; (2) rapidly providing funds, computers and communication services to assist librarians in the field who were restoring health information services to displaced clinicians and patients; and (3) rerouting interlibrary loan requests from the afflicted regions through the NNLM. Presently, libraries are a significant, but underutilized resource for community disaster planning and management efforts, which NLM can help to deploy. With assistance from its NNLM, NLM is working with health sciences libraries to develop continuity of operations and backup plans and is exploring the role that specially trained librarians—disaster information specialists—can play in providing information services to emergency personnel during a crisis. MLA and AAHSL see a clear role for NLM and the NNLM in the Nation's disaster preparedness and response activities.

HEALTH IT AND BIOINFORMATICS

NLM has played a pivotal role in creating and nurturing the field of biomedical informatics. Not only has NLM developed key biomedical databases, but for nearly 35 years, NLM has supported informatics research and training and the application of advanced computing and informatics to biomedical research and healthcare delivery including a variety of telemedicine projects. Many of today's informatics leaders are graduates of NLM-funded informatics research programs at universities across the country. Many of the country's exemplary electronic health record systems benefited from NLM grant support.

A leader in supporting, licensing, developing, and disseminating standard clinical terminologies for free U.S.-wide use (e.g., SNOMED), NLM works closely with the Office of the National Coordinator for Health Information Technology (ONCHIT) to promote the adoption of interoperable electronic records.

MLA and AAHSL encourage the subcommittee to continue its strong support of NLM's medical informatics and genomic science initiatives, at a point when the linking of clinical and genetic data holds increasing promise for enhancing the diagnosis and treatment of disease. MLA and AAHSL also support health information technology initiatives in ONCHIT and the Agency for Healthcare Research and Quality that build upon initiatives housed at NLM.

PREPARED STATEMENT OF THE CLOSE UP FOUNDATION

Mr. Chairman, my name is Timothy S. Davis, President and CEO of the Close Up Foundation and I submit this testimony in support of our $5 million appropriations request for the Close Up Fellowship Program.

Close Up Foundation is a nonprofit, nonpartisan civic education organization dedicated to the idea that, within a democracy, informed, active citizens are essential to a responsive Government. Close Up's mission is to inform, inspire, and empower students and their teachers to exercise their rights and accept the responsibilities of citizens in a democracy. Close Up's experiential methodology emphasizes that democracy is not a spectator sport, and provides young people with the knowledge and skills to participate in the democratic process. Our students are a diverse group—coming from every State and beyond and from all walks of life. More than 650,000 have graduated from our experiential programs.

Three core principles of Close Up are: (1) family income should not be a barrier to a students' participation, (2) commitment to diversity—outreach should reach a broad cross section of young people, and (3) enrollment should be open to all students, not just student leaders or high academic achievers.

The Close Up Fellowship Program provides financial assistance to economically disadvantaged students and their teachers to participate on week-long Close Up Washington civic education programs. The Fellowship Program, authorized in Federal law since 1972 and currently authorized under section 1504 of the No Child Left Behind Act, has been continuously funded by a Congressional appropriation, through a U.S. Department of Education grant, for more than 35 years. Close Up

makes every effort to ensure the participation of students from rural, small town, and urban areas and gives special consideration to students with special educational needs, including students with disabilities, ethnic minority students, and students with migrant parents. Student fellowships recipients are selected by their schools and must qualify according to the income eligibility guidelines.

As in most years, funding for the Close Up Fellowship Program was not included in the President's budget submitted to Congress. Close Up respectfully requests that Congress again include funding for this important program through the appropriations process. I also wish to address some of the arguments made by the administration for eliminating the Close Up Fellowship Program.

The administration's claim that peer organizations of Close Up provide scholarships to participants without Federal assistance is misleading. The average family income of a Close Up Fellowship recipient is approximately $24,000. To the extent that other nonprofit civic education organizations claim to provide scholarships, they usually are provided only to high academic achievers and certainly not on the scale and volume provided by Close Up. None of these organizations reach the numbers of economically disadvantaged students and teachers from under-resourced schools as Close Up does. Twenty-five percent of Close Up participants each year receive fellowship support provided through a mix of Federal funds and contributions raised from private sources by the Close Up Foundation.

Close Up is also concerned with the administration's statement that our private fundraising efforts would allow our civic education program to continue. The statement misses the point. The result of elimination of the Close Up Fellowship Program would immediately deny participation to deserving and diverse students who, but for the fellowship program, would be unable to attend. In turn, this would make Close Up's student composition dramatically less diverse. While Federal funding represents a small portion of Close Up's revenue, it is a critical portion of our funding that permits us to reach as many economically disadvantaged students as we do.

Finally, the administration wrongly asserted that it had minimal evidence that Close Up had a positive impact on the participating students and teachers. Close Up measures impact in four principle ways:

Qualitative Data (some of our findings include):

—97 percent of teachers said the program helped their students understand the role of a citizen in a democracy; 94 percent of students agreed.

—94 percent of teachers said the program helped their students understand current policy issues facing the United States; 94 percent of students agreed.

—91 percent of teachers said the program complements what they teach in school.

—95 percent of students said the program helped them understand that other students have views other than their own.

—78 percent of students said that the program inspired them to become more involved in activities in civic activities when they return home.

Qualitatively Data:

—Close Up conducts weekly focus groups with students and teachers about their program experience and its impact on their lives.

—Close Up assembles anecdotal information from teachers regarding the performance of their students and their community action projects.

College Credit:

—The University of Virginia and the University of Indiana, after a comprehensive evaluation of the academic value of the Close Up civic education programs, grant the opportunity for Close Up participants to receive undergraduate credit (students) and graduate credit (teachers), respectively.

Local Support:

—Thousands of schools organize and fundraise each year to send their young people on a Close Up program. Approximately 18,000 students and teachers participate annually.

—Local education officials have concluded that Close Up is of such value as to permit students and teachers to sacrifice a week of school and absence from all of their classes to participate.

—Many school systems contribute scarce budget dollars to help students attend while most others provide resources for substitute teachers.

Close Up Fellowship recipients add diversity to the student body on Close Up programs. The fellowship program thus benefits not only the recipient but all Close Up student program participants.

Close Up is grateful to the United States Congress for its long-standing support of the Close Up Fellowship Program through the appropriations process. Tens of

thousands of young people have been able to participate on Close Up Washington civic education programs as a result of the Federal funding.

Close Up's fiscal year 2010 request is based on its desire to significantly increase the number of economically disadvantaged young people who participate on Close Up Washington civic education programs. The funds, which assist the disadvantaged and provide seed money for at-risk schools and communities to participate on these life transforming programs, are more important now than ever. Given the current economic climate, it will be more challenging for communities to raise the necessary funds for participation on Close Up programs. The Federal funding bridges that gap and Close Up feels that with aggressive outreach into economically distressed communities we can continue to provide these experiences to our young people.

Close Up's appropriations request reflects the increasing cost of providing these important Washington programs. The cost of airfare, accommodations, food and local transportation skyrocketed during the decade that Close Up Fellowship funding remained flat at just under $1.5 million. The increase in the appropriations amount to $1.942 million in fiscal year 2008 has helped combat a small portion of those increased costs but still results in a sharp decrease in the number of economically disadvantaged students that Close Up has been able to serve. We believe that during hard economic times it is even more imperative for the Federal Government to invest in the civic education of young people. And, by investing in a Close Up education, the Government also supports the suffering transportation and hospitality economic sectors.

Senators have the opportunity to meet with Close Up groups from their States during Close Up "Capitol Hill Day". They see the excitement and pride as our students gain the confidence to express their views on the public policy issues that most directly affect their lives. Through workshops, seminars and the experience of being in Washington, Close Up instills these students with the knowledge and skills to become active citizens in our democracy.

Many of your constituents would not be able to participate in this life altering program without the benefit of the Close Up Fellowship Program. There is no better investment that we can make in our Nation's future than building educated and responsible citizens, one person at a time.

Close Up respectfully requests that the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Services appropriate $5 million for the Close Up Fellowship Program.

LETTER FROM THE DIGESTIVE DISEASE NATIONAL COALITION

Washington, DC, May 22, 2009.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

Hon. THAD COCHRAN,
Ranking Member, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

DEAR SENATORS HARKIN AND COCHRAN: Thank you very much for your continued leadership in advancing healthcare policy.

The Digestive Disease National Coalition (DDNC) is an advocacy organization comprised of the major national voluntary and professional societies concerned with digestive diseases. The DDNC focuses on improving public policy related to digestive diseases and increasing public awareness with respect to the many diseases of the digestive system. The DDNC works cooperatively to improve access to and the quality of digestive disease healthcare in order to promote the best possible medical outcome and quality of life for current and future patients with digestive diseases.

In this capacity, the DDNC applauds the long-range research agenda as stated in the March 2009 publication Opportunities and Challenges in Digestive Diseases Research: Recommendations of the National Commission on Digestive Diseases by the National Institute of Diabetes, and Digestive, and Kidney Diseases (NIDDK). The DDNC requests that the subcommittee consider the following recommendations for the fiscal year 2010 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill:

—A 6.5 percent funding increase for the National Institutes of Health, with a proportional increase for the NIDDK; and

—An increase of $75 million for the VA Medical and Prosthetic Research Program for a total of $555 million.

Thank you for the opportunity to present the views of the digestive disease community. Please do not hesitate to contact me if there is any more information you would like us to provide for your consideration.

Sincerely,

DR. PETER BANKS,
President.

LINDA K. AUKETT,
Chair.

PREPARED STATEMENT OF THE DYSTONIA MEDICAL RESEARCH FOUNDATION

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2010

Provide a funding increase of at least 7 percent for the National Institutes of Health (NIH) and its Institutes and Centers.

Urge the National Institute on Neurological Disorders and Stroke (NINDS), the National Institute on Deafness and Other Communication Disorders (NIDCD), and the National Eye Institute (NEI) to expand their research portfolios on dystonia.

Urge the NIH Office of Rare Diseases (ORD) to explore opportunities to partner with the Dystonia Medical Research Foundation (DRMF) and advance dystonia research.

Dystonia is a neurological movement disorder characterized by powerful and painful involuntary muscle spasms that cause the body to twist, repetitively jerk, and sustain postural deformities. There are several different variations of dystonia, including; focal dystonias, which affect specific parts of the body, and generalized dystonia, which affect many parts of the body at the same time. Some forms of dystonia are genetic and others are caused by injury or illness. Dystonia does not affect a person's consciousness or intellect, but is chronic and progressive. In North America alone, conservative estimates indicate that between 300,000 and 500,000 individuals suffer with dystonia. Currently, there is no known cure and treatment options remain limited.

While the underlying mechanisms of dystonia remain a mystery and the onset of symptoms can occur for a number of reasons, two therapies have emerged with proven health benefits to the dystonia patient community. Botulinum toxin injections and deep brain stimulation have shown varying degrees of success, depending on the individual, in alleviating a dystonia patient's symptoms. More research is needed to fully understand how to combat and cure dystonia, and in the mean time, maintaining patient access to life-improving therapies remains critical.

DEEP BRAIN STIMULATIONS (DBS)

DBS is a surgical procedure that was originally developed to treat Parkinson's disease, but is now being applied to severe cases of dystonia. A neurostimulator, or brain pacemaker, is surgically implanted and delivers electrical stimulation to the areas of the brain that control movement. While the exact reasons for effectiveness are unknown, the electrical stimulation blocks abnormal nerve signals that cause abnormal muscle spasms and contractions.

Since DBS was approved for use by dystonia patients in 2003, it has drastically improved the lives of many individuals. Results have ranged from quickly regaining the ability to walk and speak, to regaining complete control over ones body and returning to an independent life as an able-bodied person. DBS is currently used to treat severe cases of generalized dystonia, but its promising role in treating focal dystonias is being explored and requires continuous support. Surgical interventions are a crucial and active area of dystonia research and may continue to lead to the development of promising treatment options.

BOTULINUM TOXIN INJECTIONS (BOTOX/MYOBLOC)

The introduction of botulinum toxin as a therapeutic tool in the late 1980s revolutionized the treatment of dystonia by offering a new, localized method to significantly relieve symptoms for many people. Botulinum toxin, a biological product, is injected into specific muscles where it acts to relax the muscles and reduce excessive muscle contractions.

Botulinum toxin is derived from the bacterium Clostridium botulinum. It is a nerve "blocker" that binds to the nerves that lead to the muscle and prevents the release of acetylcholine, a neurotransmitter that activates muscle contractions. If the message is blocked, muscle spasms are significantly reduced or eliminated.

Injections of botulinum toxin should only be performed by a physician who is trained to administer this treatment. The physician needs to know the clinical features and study the involuntary movements of the person being treated. The physician doing the treatment may palpate (touch) the muscles carefully, trying to ascertain which muscles are over-contracting and which muscles may be compensating. In some instances, such as in the treatment of laryngeal dystonia, a team approach including other specialists may be required.

For selected areas of the body, and particularly when injecting muscles that are difficult or impossible to palpate, guidance using an electromyograph (EMG) may be necessary. For instance, when injecting the deep muscles of the jaw, neck, or vocal cords, an EMG-guided injection may improve precision since these muscles cannot be readily palpated. An EMG measures and records muscle activity and may help the physician locate overactive muscles.

Injections into the overactive muscle are done with a small needle, with one to three injections per muscle. Discomfort at the site of injections is usually temporary, and a local anesthetic is sometimes used to minimize any discomfort associated with the injection. Many dystonia patients frequently rely on botulinum toxins injections to maintain their improved standard of living due to the fact that the benefits of the treatment peak in approximately 4 weeks and lasts just 3 or 4 months. Currently, FDA-approved forms of botulinum toxin include Botox and Myobloc.

DYSTONIA AND NIH

Currently, three Institutes at NIH conduct medical research into dystonia. They are NINDS, NIDCD, and NEI.

NINDS has released important Program Announcements in recent years to study the causes and mechanisms of dystonia. These awards cover a wide range of research areas, which included gene discovery, the genetics and genomics of dystonia, the development of animal models of primary and secondary dystonia, molecular and cellular studies inherited forms of dystonia, epidemiology studies, and brain imaging. DMRF often works with NINDS to support as much critical research as possible and advance understating of dystonia.

NIDCD has funded many studies on brainstem systems and their role in spasmodic dysphonia. Spasmodic dysphonia is a form of focal dystonia, and involves involuntary spasms of the vocal cords causing interruptions of speech and affecting voice quality. Our understanding of spasmodic dysphonia has been greatly enhanced by research initiatives at NIDCD, like the brainstem systems studies.

NEI focuses some of its resources on the study of blepharospasm. Blepharospasm is an abnormal, involuntary blinking of the eyelids from an unknown cause that is associated with abnormal function of the basal ganglion. The condition can progress to the point where facial spasms develop. Presently, NEI is conducting a study entitled, Mexiletine for the Treatment of Focal Dystonia and a Doxilr Blepharospasm Treatment Trial, both of which have the potential to significantly improve treatment options for blepharospasm patients.

An emerging area of NIH that has the potential to stimulate important, new research into dystonia is ORD housed in the Office of the Director. ORD can facilitate research networks into certain rare conditions by pulling together resources housed at other NIH Institutes and Centers. Given the prevalence of dystonia, the DMRF would like to work more closely with ORD to stimulate and support new research opportunities.

DMRF also supports many extramural researchers studying dystonia. Research includes: exploring improved clinical rating scales for dystonia, elevations of sensory motor training, utilizing Botox as a possible treatment for focal hand dystonia, characterization of abnormalities in sensory regions of the brain, treatments for spasmodic dysphonia, DBS (the direct electrical stimulation of specific brain targets), noninvasive transcranial brain stimulation, anatomy imaging of the effect of dystonia on brain activity, and exploring the link between laryngitis and spasmodic dysphonia.

Recent years of near level-funding at NIH have negatively impacted the mission of its Institutes and Centers. For this reason, DMRF applauds initiatives like Senator Arlen Specter's (D-PA) successful effort to provide NIH with $10.4 billion in stimulus funds. IFFGD urges this subcommittee to show strong leadership in pursuing substantial funding increase through the regular appropriations process in fiscal year 2010.

For fiscal year 2010, DMRF recommends a funding increase of at least 7 percent for NIH and its Institutes and Centers.

For fiscal year 2010, DMRF recommends that NINDS, NIDCD, and NEI be urged to increase their research activities regarding dystonia and partner with voluntary health organizations to promote dystonia research and awareness.

For fiscal year 2010, DMRF asks the subcommittee to urge ORD to consider ways it can partner with DMRF and support dystonia research.

DMRF

DMRF was founded more than 30 years ago and has been a membership-driven organization since 1993. Since our inception, the goals of DMRF have remained: to advance research for more effective treatments of dystonia and ultimately find a cure; to promote awareness and education; and support the needs and well being of affected individuals and their families.

Thank you for the opportunity to present the views of the dystonia community.

PREPARED STATEMENT OF THE FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY

The Federation of American Societies for Experimental Biology (FASEB), respectfully requests a funding increase of at least 7 percent above the fiscal year 2009 baseline level for the National Institutes of Health (NIH) in fiscal year 2010. This funding level is an important step toward President Obama's campaign pledge to double funding for basic research over 10 years and is necessary to maintain both the existing and future scientific infrastructure. We are in a crucial time for science in the United States. After years of stagnant funding for research, Congress has recently made significant new investments in NIH. The scientists and researchers represented by FASEB are sincerely grateful to Congress for your faith in the research community and your generosity in providing the resources that are essential for progress in science.

As a Federation of 22 professional scientific societies, FASEB represents nearly 90,000 life scientists, making us the largest coalition of biomedical research associations in the Nation. FASEB's mission is to advance health and welfare by promoting progress and education in biological and biomedical sciences, including the research funded by NIH, through service to its member societies and collaborative advocacy. FASEB enhances the ability of biomedical and life scientists to improve—through their research—the health, well-being, and productivity of all people.

We especially thank and commend Congress for including the extraordinary investment in medical research at NIH that was included as part of in the American Recovery and Reinvestment Act (ARRA, Public Law 111–5) as well as the $938 million increase in NIH funding in the Omnibus Appropriations Act for fiscal year 2009 (Public Law 111–8). In particular, we are deeply grateful to the chairman and this subcommittee for your long-standing leadership in support of NIH. These are difficult times for our Nation and for people all around the globe, but the affirmation of science is the key to a better future is a strategic step forward.

The recent history of the NIH budget has hindered scientific discovery and limited the capacity of a key engine for today's innovation-based economy. The additional funding in the ARRA and the fiscal year 2009 omnibus are critical first steps to returning the NIH to a course for even greater discovery. These investments give patients, their families and researchers renewed hope for the future, and will help ensure the success of America's medical research enterprise and leadership.

The funding increases in the ARRA and the fiscal year 2009 omnibus will provide an immediate infusion of funds into the Nation's proven and highly competitive medical research enterprise to sustain the pursuit of improved diagnostics, better prevention strategies and new treatments for many devastating and costly diseases as well as support innovative research ideas, state-of-the-art scientific facilities and instrumentation, and the scientists, technicians, laboratory personnel, and administrators necessary to maintain the enterprise. These funds will are also reinvigorating this Nation's ability to produce the human and intellectual capital that will continue to drive scientific discovery, transform health, and improve the quality of life for all Americans. Moreover, we see this as the first step in renewing a national commitment to sustained, predictable growth in NIH funding, which we believe is an essential element in restoring and sustaining both national and local economic growth and vitality as well as maintaining this Nation's prominence as the world leader in medical research.

As a result of this subcommittee's prior investment in NIH, we have made critical advances in understanding basic science, saved and improved the lives of millions of Americans and provided doctors with tools to prevent and treat costly and devastating diseases including:

—*Cardiovascular Disease*.—New results from multiple studies provided the strongest evidence to date that a simple blood test for high-sensitivity C-reactive protein (hsCRP), whose characterization was funded by NIH, is a useful marker for cardiovascular disease. Furthermore, scientists have discovered that a daily dose of a commonly used statin, rosuvastatin (Crestor), reduced the risk of heart attack, stroke, and death by nearly half (44 percent) in individuals with high levels of hsCRP but with normal or low levels of low density lipoprotein (LDL), the so-called "bad cholesterol." These developments show great promise in helping clinicians better identify and treat individuals at risk for cardiovascular disease—potentially saving millions more lives.

—*Cancer*.—For the first time in a decade, incidence rates for all cancers combined are decreasing, driven largely by declines in some of the most common types of cancer, including breast cancer (2.2 percent decline among women) and prostate cancer (4.4 percent decline). Death rates declined for 10 of the top 15 causes of cancer death among both men and women.

—*Alzheimer's*.—Researchers isolated a toxic substance that appears to be a key to understanding Alzheimer's disease, suggesting a possible new target for developing drug therapies to combat the irreversible and progressive disorder. In addition, further insights into the early stages of Alzheimer's may answer questions not only about the disease, but also about age-related memory impairments.

—*Type 2 Diabetes*.—An international team that included NIH-funded scientists identified six new genetic variants associated with increased risk of type 2 diabetes. By pinpointing particular pathways involved in diabetes risk, this discovery can empower new approaches to understanding environmental influences and to the development of better, more precisely targeted drugs.

INVESTMENT IN NIH IS CRITICAL TO TAKING ADVANTAGE OF EMERGING SCIENTIFIC OPPORTUNITIES

Prior investment in NIH has begun to unlock the secrets of the human genome and allowed scientists to gain new insight into how disease works at the most basic levels within our bodies. Scientists are working tirelessly to translate research results into interventions for our most debilitating medical conditions. NIH also serves an invaluable role in communicating research findings to patients and their families, healthcare providers, and the general public in critical areas such as increasing knowledge about infectious diseases, improving cognitive health, and reducing health disparities.

THE CONSEQUENCES OF STAGNANT FUNDING FOR RESEARCH

The re-emergence of previously eradicated diseases such as mumps, the development of new health threats, a rapidly aging population, and significant increases in longevity lends a sense of urgency to the need to expedite scientific discovery. Yet even as our need to prevent disease becomes greater and the opportunities to succeed become more numerous, our national commitment to medical research has stagnated:

—"Success rates" dropped to an estimated 18 percent in fiscal year 2009. This means that more than 80 percent of the highly qualified, peer-reviewed research proposals go unfunded. With every unfunded idea, we risk missing or delaying critical discoveries leading to therapies for our most debilitating health conditions.

—The competition for funding is coming at a time when both the interest in careers in the science field and the number of newly trained researchers entering the workforce is increasing. Doctorates in the critical fields of engineering and biological sciences increased 10 percent and 11 percent respectively, in 1 year.[1]

—The medical schools, teaching hospitals, universities, and research institutes where NIH research takes place are among the largest employers in their respective communities. In fiscal year 2007, NIH grants and contracts created and supported more than 350,000 jobs that generated wages in excess of $18 billion in the 50 States.[2]

---

[1] Council of Graduate Schools. 2008. *Graduate Enrollment and Degrees: 1997–2007*. http://www.cgsnet.org/portals/0/pdf/N__pr__ED2007.pdf

[2] Families USA. 2008. *In your own backyard: How NIH funding helps your state's economy*. http://www.familiesusa.org/assets/pdfs/global-health/in-your-own-backyard.pdf

THE IMPORTANCE OF SUSTAINED, PREDICTABLE FUNDING FOR RESEARCH

The research engine needs a predictable, sustained investment in science to maximize our return on investment. The discovery process—while it produces tremendous value—often takes a lengthy and unpredictable path. Recent experience has demonstrated how cyclical periods of rapid funding growth followed by periods of stagnation is disruptive to training, to careers, long-range projects, and ultimately to progress. NIH needs sustainable and predictable budget growth to achieve the full promise of medical research to improve the health and longevity of all Americans. We must ensure that after the stimulus money is spent we do not have to dismantle our newly built capacity and terminate valuable, on-going research.

The fiscal year 2009 omnibus and the ARRA provided $38.5 billion for NIH to provide more than 16,000 new research grants for live-saving research into diseases such as cancer, diabetes, and Alzheimer's. Keeping up with the rising cost of medical research in the 2010 appropriations will help NIH begin to prepare for the "post-stimulus" era. In 2011 and beyond we need to make sure that the total funding available to NIH does not decline and that we can resume a steady, sustainable growth that will enable us to complete the President's vision of doubling our investment in basic research. Consistent with the President's proposal, we respectfully urge this subcommittee to increase funding for NIH in fiscal year 2010 by at least 7 percent more than the fiscal year 2009 level.

The Federal commitment to biomedical research is profoundly transforming medical practice, preventing disease, and creating better therapies but additional resources are needed to pursue the historic level of scientific opportunity that is available today. We recognize this subcommittee has the especially difficult task of providing funding for a wide range of critical human service programs and thank you for recognizing that prosperity and quality of life are increasingly shaped by investments in science and technology.

PREPARED STATEMENT OF THE FRIENDS OF THE HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Friends of the Health Resources and Services Administration (HRSA) is a nonprofit and nonpartisan alliance of more than 140 national organizations, collectively representing millions of public health and healthcare professionals, academicians, and consumers. The coalition's principal goal is to ensure that HRSA's broad health programs have continued support in order to reach the populations presently underserved by the Nation's patchwork of health services.

Through its programs in every State and thousands of communities across the country, HRSA is a national leader in providing a health safety net for medically underserved individuals and families, including 86.7 million Americans who were uninsured for some or all of 2007–2008; 50 million Americans who live in neighborhoods where primary health services are scarce; more than 1 million people living with HIV/AIDS, and 34 million vulnerable mothers and children, including children with special health needs. In the best professional judgment of the members of the Friends of HRSA, to respond to this challenge, the agency will require an overall funding level of at least $8.5 billion for fiscal year 2010.

For several years, HRSA has suffered from relatively level funding, undermining the ability of its successful programs to grow. Our request reflects the minimum amount necessary for HRSA to adequately meet the needs of the populations they serve in fiscal year 2010, especially during these difficult economic times that are causing an increase in demand for HRSA programs and funding. Much more is needed for the agency to achieve its ultimate mission of ensuring access to culturally competent, quality health services for all; eliminating health disparities; and rebuilding the public health and healthcare infrastructure.

The coalition is very appreciative of the $2.5 billion HRSA received in the American Recovery and Reinvestment Act of 2009 for community health centers and health professions workforce development to prepare our health infrastructure for health system reform. This investment recognizes the critical role HRSA plays in building the foundation for health service delivery. However, we urge the subcommittee to support adequately funding all of HRSA's broad health programs and ensure that vulnerable populations transition smoothly into a new health system and receive continued, quality health services. By supporting, planning for and adapting to change, we can build on the successes of the past and address the new gaps that emerge as a result of health system reform.

Our $8.5 billion funding request is based on recommendations provided by coalition members for the various programs they focus on. It includes $2.602 billion for the Health Centers program, the fully authorized level under the Health Care Safe-

ty Net Act of 2008, as part of a long-term plan to provide care to 30 million Americans by 2015. Thanks to the leadership of the subcommittee, more than 7,000 health centers in every State and territory provide a healthcare home for more than 18 million medially underserved and low-income patients, and demand for their services continues to grow. The Health Centers program targets populations with special needs, including migrant and seasonal farm workers, homeless individuals and families, and those living in public housing. Health centers provide access to high-quality, family-oriented, culturally and linguistically competent primary care and preventive services, including mental and behavioral health, vision, and dental services. While recent growth in the health centers program has been substantial, a significant need remains in underserved communities across the country. We strongly encourage the subcommittee to continue its support of existing health centers and efforts to expand the reach and scope of the Health Centers program into new communities.

Coalition members recommend $235 million for the National Health Service Corps (NHSC), the amount authorized under the Health Care Safety Net Amendments of 2002. Approximately 50 million Americans live in communities with a shortage of health professionals, lacking adequate access to primary care. The Corps supports the recruitment and retention of primary care clinicians to practice in underserved communities in exchange for scholarships and loan repayment. The Corps supports more than 4,000 clinicians, with over half working in community health centers. Growth in the Health Centers program must be complemented with growth in the recruitment and retention of primary care clinicians to ensure adequate staffing.

Coalition members recommend $550 million for health professions programs under title VII and VIII of the Public Health Service Act. These programs are an essential component of America's health safety net and work in concert with the Health Centers Program and National Health Service Corps to enhance the supply, distribution and diversity of the health professions workforce. They are the only Federal programs that support the education and training of primary care providers in interdisciplinary settings to work in underserved communities and increase minority representation in the health professions workforce. Through loans, scholarships, and grants to academic institutions and nonprofit organizations, these programs provide support for the training of primary care physicians, nurses, dentists, optometrists, physician assistants, nurse practitioners, public health personnel, mental and behavioral health professionals, pharmacists, health educators, and other allied health providers. Adequate funding will reduce provider shortages in rural, medically underserved and federally designated health professions shortage areas and strengthen the pipeline of new providers that Health Centers and other safety-net health facilities need to meet the long-term needs of underserved communities. In addition, we recommend funds be appropriated to re-establish the National Center for Health Workforce Analysis to conduct and support statistical and epidemiological activities for assessing and improving decisionmaking to enhance the supply, distribution, diversity, and development of the current and future public health workforce. Finally, we urge the subcommittee to provide funding for the grant program under section 758 of the Public Health Service Act to develop interdisciplinary training and education programs on domestic violence and other types of violence and abuse as authorized by the Violence Against Women and Department of Justice Reauthorization Act of 2005.

We recommend $330 million for the Children's Hospital Graduate Medical Education (GME) Program, the amount authorized under the Children's Hospital GME Support Reauthorization Act of 2006. This program provides funds to freestanding children's hospitals to support the training of pediatric and other residents in GME programs. This program ensures that pediatric hospitals receive Federal funding comparable to other types of hospitals. We also request a significant investment in the Patient Navigator program that places navigators in underserved communities to help people with cancer and/or other chronic diseases make their way through the health systems and utilize community services that will help them beat chronic disease for longer, healthier lives.

We recommend $850 million for the Maternal and Child Health (MCH) block grant, the fully authorized level under title V of the Social Security Act. For more than 70 years, the MCH block grant has provided a source of flexible funding for States and territories to address their unique needs related to improving the health of mothers, infants, children, adolescent, and children with special healthcare needs. Today, this program provides prenatal services to more than 2 million mothers—almost half of all mothers who give birth annually—and primary and preventive care to more than 17 million children, including almost 1 million children with special needs. Fully funding the MCH block grant will enable States to expand critical health services and cope with ever increasing medical costs.

Newborn screening is a vital public health activity used to identify and treat genetic, metabolic, hormonal, and functional conditions in newborns. Screening detects heritable disorders in newborns that, if left untreated, can cause disability, mental retardation, serious illnesses, or even death. While nearly all babies born in the United States undergo newborn screening for genetic birth defects, the number of these tests varies from State to State. We recommend $30 million for the Heritable Disorders Program to support State efforts to improve programs, to acquire innovative testing technologies, and to increase capacity to reach and educate health professionals and parents on newborn screening programs and follow-up services. These activities and the funding level are authorized by the Newborn Screening Saves Lives Act.

We recommend $16 million for the Traumatic Brain Injury (TBI) program in order to better serve the 5.3 million Americans with a long-term or lifelong need for help to perform daily activities as a result of a TBI, including many of our returning war veterans. The TBI Program provides grants to States to coordinate, expand, and enhance service delivery systems in order to improve access to services and support for persons with TBI and their families. The TBI program also provides funds to State protection and advocacy programs that work to ensure that people with TBI get access to the supports and services they need.

We recommend $25 million for the Emergency Medical Services for Children (EMSC) program to address significant shortcomings in pediatric emergency care. The EMSC program is a national initiative designed to reduce child and youth disability and death due to severe illness and injury. EMSC grants provide funding for States and territories to improve existing emergency medical services systems and develop better procedures and protocols for treating children. Additional funding is needed to maintain and improve the program's activities, take advantage of important opportunities and address emerging threats such as terrorism.

We recommend $2.816 billion for the Ryan White HIV/AIDS programs, which is the estimated amount necessary to provide health services to all eligible individuals. The Ryan White programs provide the largest source of Federal discretionary funding to support health services for more than 500,000 low-income, uninsured, and underinsured people living with HIV/AIDS. Through grants to State and local governments and community-based organizations, the Ryan White HIV/AIDS programs support comprehensive care, drug assistance and support services for people living with HIV/AIDS; provide training for health professionals treating people with HIV/AIDS; provide assistance to metropolitan and other areas most severely affected by the HIV/AIDS epidemic; and address the disproportionate impact of HIV/AIDS on women and minorities. A significant funding increase is needed to meet growing medical costs and incidence of HIV, particularly among underserved populations.

The Office of Rural Health Policy promotes better health services for the 60 million Americans who live in rural communities. These communities suffer from inadequate access to quality health services and experience the higher rates of illness associated with lower socioeconomic status. Rural Health Outreach and Network Development Grants, and other programs are designed to support community-based disease prevention and health promotion projects, help rural hospitals and clinics implement new technologies and strategies, and build health system capacity in rural and frontier areas. In addition, Rural Health Research Centers help policymakers better understand the challenges that rural communities face in assuring access to health services and improving the health of their residents. Finally, the Rural and Community Access to Emergency Devices Program provides States with grants to train lay rescuers and first responders to use automated external defibrillators (AEDs) and purchase and place them in public areas where sudden cardiac arrests are likely to occur. We encourage the subcommittee to adequately fund these important programs that address the many unique health service needs of rural communities.

We recommend $700 million for the Family Planning programs under title X of the Public Health Service Act. Title X programs provide comprehensive, voluntary, and affordable family planning services to nearly 5 million low-income women at more than 4,500 clinics nationwide. Title X funded clinics help improve access to contraceptives, which help women plan the number and timing of their pregnancies, improve maternal and infant health, and help to prevent approximately 1.94 million unintended pregnancies each year, including nearly 400,000 teenage pregnancies. The Guttmacher Institute estimates that unintended pregnancies prevented each year would have resulted in 810,000 abortions and without publicly funded family planning programs, the U.S. abortion rate would be nearly two-thirds higher than the current level. Family planning is also cost-saving and for every public dollar invested in family planning, $3.80 is saved in costs associated with unintended births to women who are eligible for Medicaid. Today, almost 17 million women need pub-

licly supported contraceptive care—a number which continues to grow. Title X programs require a substantial increase in investment to meet the growing demand.

The Healthcare Systems Bureau provides national leadership on the transplantation of organs, bone marrow and cord blood. The recently passed Budget Resolution Conference Agreement calls for increased funding for "the organ transplant program." Coalition members recommend $35 million for the Division of Transplantation in order to meet the Office of Management and Budget's goal of doubling the number of transplants by 2013 and reduce the waiting list of 101,951 people in need of a life saving organ transplant. We recommend $38 million for the C.W. Bill Young Cell Transplantation Program, the amount authorized by the Stem Cell Therapeutic and Research Act of 2005. This program helps patients who need a potentially life-saving bone marrow or cord blood transplant, including patients with diseases like leukemia, lymphoma, sickle cell anemia, or other inherited metabolic or immune system disorders. We also recommend the fully authorized $15 million for the National Cord Blood Inventory, which collects and maintains high-quality cord blood units and makes them available for transplantation through the C.W. Bill Young Cell Transplantation Program.

Poison Control Centers, also administered by the Healthcare Systems Bureau, are a critical resource for people, health professionals, and organizations. Poisoning can happen to anyone, at anytime in any place and can lead to serious illness or even death. Each year, more than 2 million possible poisonings are reported to the nation's poison centers. On average, poison centers handle one possible poisoning every 13 seconds. These critical centers cannot afford to lose any resources and we encourage the subcommittee to fully fund this program.

Finally, we recommend a significant funding increase for HRSA's program management and staffing needs. Since 2001, HRSA has experienced a decline of almost 600 full-time equivalent employees. While HRSA has continued to administer its many programs effectively, the agency if facing ever growing demands as a result of the economic crisis and a changing health system. We strongly urge the subcommittee to increase program management funds to provide the agency with the necessary human and other resources to ensure the programs it administers are effective and improve the health of the American public.

We appreciate the subcommittee's hard work in advocating for HRSA's programs in a climate of competing priorities. The members of the Friends of HRSA thank you for considering our fiscal year 2010 request for $8.5 billion for HRSA and are grateful for this opportunity to present our views to the subcommittee.

We the undersigned organizations, thank you for your attention to this matter.

Academic Pediatric Association; Advocates for Youth; AIDS Action; AIDS Alliance for Children, Youth and Families; AIDS Foundation of Chicago; AIDS Project Los Angeles; The Alan Guttmacher Institute; Allergy and Asthma Network Mothers of Asthmatics; Alliance for Academic Internal Medicine; American Academy of Family Physicians.

American Academy of Nurse Practitioners; American Academy of Nursing; American Academy of Ophthalmology; American Academy of Pediatrics; American Academy of Physician Assistants; American Association of Colleges of Podiatric Medicine; American Association for Dental Research; American Association of Colleges of Nursing; American Association of Colleges of Osteopathic Medicine; American Association of Colleges of Pharmacy; American Association of Family and Consumer Services.

American Association of Nurse Anesthetists; American Association of Orthopedic Surgeons; American Association on Intellectual and Developmental Disabilities; American Cancer Society; American College of Nurse-Midwives; American College of Obstetricians and Gynecologists; American College of Physicians; American College of Preventative Medicine; American Counseling Association; American Dental Association.

American Dental Education Association; American Dental Hygienists' Association; American Dietetic Association; American Federation of State, County and Municipal Employees; American Foundation for AIDS Research; American Heart Association; American Hospital Association; American Medical Student Association; American Medical Women's Association; American Nephrology Nurses' Association.

American Nurses Association; American Occupational Therapy Association; American Optometric Association; American Pediatric Society; American Physical Therapy Association; American Podiatric Medicine Association; American Psychiatric Association; American Psycho-

logical Association; American Public Health Association; American Red Cross.

American School Health Association; American Society for Microbiology; American Society for Reproductive Medicine; Americans for Democratic Action; The Arc; Asian and Pacific Islander American Health Forum; Association for Prevention Teaching and Research; Association of Academic Health Centers; Association of American Medical Colleges; Association of American Veterinary Medical Colleges.

Association of Clinicians for the Underserved; Association of Departments of Family Medicine; Association of Family Medicine Residency Directors; Association of Maternal and Child Health Programs; Association of Medical School Pediatric Department Chairs; Association of Minority Health Professions Schools; Association of Organ Procurement Organizations; Association of Professors of Medicine; Association of Public Health Laboratories; Association of Reproductive Health Professionals.

Association of Schools of Allied Health Professionals; Association of Schools of Public Health; Association of State and Territorial Directors of Nursing; Association of State and Territorial Health Officials; Association of University Centers on Disabilities; Association of Women's Health, Obstetric and Neonatal Nurses; Avancer Health Policy; CAEAR Coalition; Catholic Health Association of the U.S.; Center for Health Policy Research and Ethics, GMU.

Center for the Advancement of Health; Center for Women Policy Studies; Center on Disability and Health; Charles Drew University; Children's Defense Fund; Coalition for American Trauma Care; Coalition for Health Funding; Coalition for Health Services Research; Consortium of Social Science Associations; Council of Accredited MPH Programs.

Easter Seals; Emergency Nurses Association; Epilepsy Foundation; Families USA; Family Violence Prevention Fund; Health and Medicine Counsel of Washington; HIV Medicine Association; Human Rights Campaign; Infectious Diseases Society of America; Institute for Children's Environmental Health.

Latino Council on Alcohol and Tobacco; Legal Action Center; March of Dimes; Meharry Medical College; Morehouse School of Medicine; NAADAC, the Association for Addiction Professionals; National AHEC Organization; National Alliance of State and Territorial AIDS Directors; National Assembly on School-Based Health Care; National Association of Addiction Treatment Providers; National Association of Community Health Centers.

National Association of Councils on Developmental Disabilities; National Association of County and City Health Officials; National Association of Local Boards of Health; National Association of People with AIDS; National Association of Public Health Statistics and Information Systems; National Association of Public Hospitals and Health Systems; National Association of Rural Health Clinics; National Association of Social Workers; National Associations of Children's Hospitals; National Black Nurses Association.

National Coalition for the Homeless; National Council for Diversity in the Health Professions; National Council of La Raza; National Disability Rights Network; National Episcopal AIDS Coalition; National Family Planning and Reproductive Health Association; National Health Care for the Homeless Council; National Hemophilia Foundation; National Hispanic Medical Association; National League for Nursing.

National Marrow Donor Program; National Medical Association; National Minority AIDS Council; National Network for Youth; National Rural Health Association; North American Primary Care Research Group; Oncology Nursing Society; Organizations of Academic Family Medicine; Partnership for Prevention; Planned Parenthood Federation of America.

Sexuality Information and Education Council of the United States; Society for Adolescent Medicine; Society for Pediatric Research; Society for Public Health Education; Society for the Psychological Study of Social Issues; Society of General Internal Medicine; Society of Teachers of Family Medicine; The AIDS Institute; Trust for America's Health; U.S. Conference of Mayors.

LETTER FROM THE FRIENDS OF THE NATIONAL INSTITUTE ON AGING

DEAR CHAIRMAN HARKIN AND MEMBERS OF THE SUBCOMMITTEE: I am writing to request the opportunity to testify at the fiscal year 2010 public witness hearing on behalf of The Friends of the National Institute on Aging regarding the important role that the National Institute on Aging (NIA) plays among the National Institutes of Health and the need for increased appropriations to ensure sustained, long-term growth in aging research in the fiscal year 2010 budget and beyond.

The Friends of the NIA is a coalition of 50 academic, patient-centered and not-for-profit organizations that conduct, fund, or advocate for scientific endeavors to improve the health and quality of life for Americans as we age. We support the continuation and expansion of NIA research activities and seek to raise awareness about important scientific progress in the area of aging research currently guided by the Institute. I serve as Chair of the Friends of the NIA and as such, am respectfully requesting permission to testify on behalf of the Friends of the NIA before the subcommittee.

Our testimony highlights the relevance of the work of the NIA to each and every American, as well as opportunities for future progress that are dependent on Congressional action to build upon the unprecedented $10.4 billion in the American Recovery and Reinvestment Act for NIH research and training activities in fiscal year 2010. I have attached a copy of our testimony for your review.

Mr. Chairman, The Friends of the NIA thanks you in advance for this opportunity to outline the challenges and opportunities that lie ahead as you consider the fiscal year 2010 appropriations for the NIH.

Regards,

KIMBERLY D. ACQUAVIVA,
Chair.

PREPARED STATEMENT OF THE FSH SOCIETY, INC.

Mr. Chairman, it is a great pleasure to submit this testimony to you today.

My name is Daniel Paul Perez, of Bedford, Massachusetts, and I am testifying today as President and CEO of the FSH Society, Inc. (facioscapulohumeral muscular dystrophy) and as an individual who has this common and most prevalent form of muscular dystrophy.

THE NEED FOR NATIONAL INSTITUTE OF HEALTH (NIH) FUNDING FOR FSHD

My testimony is about the profound and devastating effects of a disease known as facioscapulohumeral muscular dystrophy which is also known as facioscapulohumeral muscular disease, FSH muscular dystrophy or FSHD, and the urgent need for increased NIH funding for research on this disorder.

According to our research, only a limited amount of work is going on across all the Institutes at the NIH. In fact, only 3 of the 27 Institutes at the NIH are funding FSHD research, e.g., the National Institute of Neurological Disorders and Stroke (NINDS), the National Institute of Arthritis, Musculoskeletal and Skin Disease (NIAMS), and the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). Currently, the level of funding from NINDS, NICHD, and NIAMS for FSHD research is approximately $3,093,269.

Since 1994, I have submitted testimony before both House and Senate Appropriations Committees' Subcommittee on Labor, Health and Human Services, and Education and Related Agencies which stated that NIH and Congress with modest investments could help bring about a significant research and scientific opportunity which would benefit hundreds of thousands of people worldwide.

Today, I am asking Congress to communicate to the Public Health Service and National Institutes of Health the need for research funding on the FSHD disorder at a level of $10,000,000 annually in fiscal year 2010.

LIVING WITH FSHD

As a man with facioscapulohumeral muscular dystrophy, I will tell you that it is a hard way to live, and that FSHD is a strong fort—it will last a lifetime. Unless Congress mandates that the NIH ensure that it receives sufficient grant applications of highest quality on FSHD and to spend an equitable ratio of NIH muscular dystrophy dollars on FSHD, which is now conservatively $10 million.

At 47 years of age, I consider myself a lifelong survivor of the severe trauma and tension of FSHD, and I do not say this lightly. I have dealt with the continuing, unrelenting, and unending loss caused by FSHD from the first second, into the first minute, hour, day, week, over the months and through the years. Not for a moment

is there a reprieve from continual loss of my physical ability; not for a moment is there a time for me to mourn; not for a moment is there relief from the physical and mental pain that is a result of this disease. There is no known treatment and no known cause for this disease.

Look at what this disease does to people. Look at me. Look at what I see—a child with a profound hearing loss, the broken innocence of a child, alienation at an early age, a decision not to marry, a decision not to have biological children, disability in the prime of life, incapacitation in middle age, the guilt of a parent, a lifetime of physical challenge, a suicide, a premature death, anxiety caused by uncontrollable loss, decades spent somewhere between the able and the disabled, the loss of ambulating, the unstoppable atrophy and loss of muscle and the humiliation endured in the process.

For men, women, and children the major consequence of inheriting the most prevalent form of muscular dystrophy, FSHD, is a lifelong progressive and severe loss of all skeletal muscles. FSHD is a terrible, crippling and life shortening disease. No one is immune, it is genetically and spontaneously (by mutation) transmitted to children and it affects entire family constellations.

THE MOST PREVALENT FORM OF MUSCULAR DYSTROPHY IS NOW MARKEDLY UNDERFUNDED AT NIH

It is a fact that FSHD is now published in the scientific literature as the most prevalent muscular dystrophy in the world. The incidence of the disease is conservatively estimated to be 1 in 14,285. The prevalence of the disease, those living with the disease ranges to two or three times as many as that number based on our increasing experiences with the disease and more available and accurate genetic diagnostic tests.

The French Government research agency INSERM (Insitut National de la Santé et de la Recherche Medicale) is comparable to the NIH, and it recently published prevalence data for hundreds of diseases in Europe. Notable is the "Orphanet Series" reports covering topics relevant to all rare diseases. The "Prevalence or reported number of published cases listed in alphabetical order of disease". This update contains new epidemiological data and modifications to existing data for which new information has been made available. This new information ranks facioscapulohumeral muscular dystrophy (FSHD) as the most prevalent muscular dystrophy followed by Duchenne (DMD) and Becker Muscular dystrophy (BMD) and then, in turn, myotonic dystrophy (DM). FSHD is historically presented as the third-most prevalent muscular dystrophy in the Muscular Dystrophy Community Assistance, Research and Education Amendments of 2001 and 2008 (the MD–CARE Act). This new data ranks FSHD as the first and most prevalent.

Estimated prevalence	Cases/100,000
Facioscapulohumeral muscular dystrophy (FSHD)	7/100,000
Duchenne (DMD) and Becker Muscular dystrophy (BMD) types	5/100,000
Steinert myotonic dystrophy (DM)	4.5/100,000

NIH MUSCULAR DYSTROPHY FUNDING HAS TRIPLED SINCE THE INCEPTION OF THE MD CARE ACT ($21 MILLION TO $56 MILLION)

Between fiscal year 2006 and 2007, NIH overall funding for muscular dystrophy increased from $39,913,000 to $47,179,000, an 18 percent increase.

Between fiscal year 2007 and 2008, NIH overall funding for muscular dystrophy decreased as shown in the "Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC)" report on the new Research Portfolio Online Reporting Tool (RePORT) from $58 million to $56 million, a 3 percent decrease. These figures are from the new "2007/2008 NIH Revised Method" columns. The same RCDC RePORT system report shows $47 million as the 2007 figure under the "2007 NIH Historical Method" column, a 23 percent increase and restatement when converting to the new system.

Figures from the RCDC RePORT and the NIH Appropriations History for Muscular Dystrophy report historically provided by NIH/Office of the Director (OD) Budget Office and NIH OCPL show that from the inception of the MD CARE Act 2001, funding has nearly tripled from $21 million to $56 million for muscular dystrophy.

NIH FSHD FUNDING HAS REMAINED LEVEL SINCE THE INCEPTION OF THE MD CARE ACT ($3 MILLION/$56 MILLION)

Between fiscal year 2006 and 2007, NIH funding for FSHD increased from $1,732,655 to $4,108,555. In fiscal 2007, FSHD was 8.7 percent of the total muscular dystrophy funding ($4.109 million/$47.179 million).

Between fiscal year 2007 and 2008, NIH funding for FSHD decreased from $4,108,555 to $3 million under the "2007 and 2008 NIH Revised Method." The "2007 NIH Historical Method" was restated to $3 million. In fiscal 2008 under "NIH Revised Method," FSHD was 5.3 percent of the total muscular dystrophy funding ($3 million /$56 million). The previous years 2006/2007 figures are revised and restated under "2007 NIH Historical Method" as ($3 million/$58 million) which is 5.1 percent of the total muscular dystrophy funding. FSHD funding has merely kept its ratio in the NIH funding portfolio and has not grown in the last 7 years.

We highly commend the Director of the NIH on the ease of use and the accuracy of the Research Portfolio Online Reporting Tool (RePORT) report "Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC)" with respect to reporting projects on facioscapulohumeral muscular dystrophy.

NATIONAL INSTITUTES OF HEALTH (NIH) APPROPRIATIONS HISTORY

[Dollars in millions]

Fiscal year	FSHD research dollars	FSHD percentage of muscular dystrophy
2002	$1.3	5
2003	1.5	4
2004	2.2	6
2005	2	5
2006	1.7	4
2007	3	5
2008	3	5

The MD CARE Act 2008 mandates the NIH Director to intensify efforts and research in the muscular dystrophies, including FSHD, across the entire NIH. It should be very concerning that in the last 7 years muscular dystrophy has tripled to $56 million and that FSHD has remained at 5 percent of the NIH muscular dystrophy portfolio or $3 million. Only three of the Institutes at the NIH are funding FSHD. OD, National Heart, Lung, and Blood Institute, National Institute of General Medical Sciences, National Institute of Biomedical Imaging and Bioengineering, National Institute on Deafness and Other Communication Disorders, National Human Genome Research Institute , NEI, National Institute on Aging, National Cancer Institute, and National Center for Research Resources are all aware of the high impact each could have on FSHD. FSHD is certainly still far behind when we look at the breadth of research coverage NIH-wide.

Now, FSHD is published as the most prevalent muscular dystrophy, and given the extraordinary interest of the scientific and clinical communities in its unique disease mechanism, it defies gravity that it still remains the most prevalent and one of the most underfunded dystrophies at the NIH and in the Federal research agency system (Centers for Disease Control and Prevention, Department of Defense, and Food and Drug Administration). In 2008, the third most prevalent dystrophy, Duchenne (DMD) and Becker Muscular dystrophy (BMD) type, received $22 million from NIH. In 2008, the second most prevalent dystrophy myotonic dystrophy (DM), received $9 million from NIH. In 2008, the most prevalent dystrophy, FSHD, received $3 million from NIH. It is now time to flip the stack and to make sure that FSHD with its equal burden of disease and highest prevalence gets more funding, stimulus and that NIH program staff initiates request for applications specifically in FSHD. It is crystal clear, if not completely black and white, that the open mechanism program announcement and investigator driven model are not achieving the goal mandated by the MD CARE Acts 2001/2008 and by the NIH Action Plan for the Muscular Dystrophies as submitted to the Congress by the NIH. Efforts of excellent program staff and leadership at NIH, excellent reviewers and study sections, excellent and outstanding researchers working on FSHD and submitting applications to the NIH, and extraordinary efforts of the volunteer health agencies working in this area have not yet enabled FSHD funding to increase at the NIH. It is time for NIH requests, contracts, and calls for researcher proposals on FSHD to bootstrap existing FSHD research worldwide.

I am here once again to remind you that FSHD is taking its toll on your citizens. FSHD illustrates the disparity in funding across the muscular dystrophies and recalcitrance in growth over 20 years despite consistent pressure from appropriations language and Appropriations Committee questions, and an authorization and a reauthorization from Congress mandating research on FSHD.

OUR REQUEST TO THE NIH APPROPRIATIONS SUBCOMMITTEE

We request this year in fiscal year 2010, immediate help for those of us coping with and dying from FSHD. We ask NIH to fund research on FSHD at a level of $10 million in fiscal year 2010.

We implore the Appropriations Committee to request that the Director of NIH, the chairman/chairwoman, and executive secretary of the Federal advisory committee Muscular Dystrophy Coordinating Committee mandated by the MD CARE Act of 2008, to increase the amount of FSHD research and projects in its portfolios using all available passive and pro-active mechanisms and interagency committees. Given the knowledge base and current opportunity for breakthroughs in treating FSHD it is inequitable that only 3 of the 12 NIH Institutes covering muscular dystrophy have a handful of research grants for FSHD. We request that the Director of the NIH be more proactive in facilitating grant applications (unsolicited and solicited) from new and existing investigators and through new and existing mechanisms, special initiatives, training grants and workshops—to bring knowledge of FSHD to the next level.

Thanks to your efforts and the efforts of your subcommittee, Mr. Chairman, the Congress, the NIH and the FSH Society are all working to promote progress in FSHD. Our successes are continuing and your support must continue and increase.

We ask you to fund NIH research on FSHD at a level of $10 million in fiscal year 2010.

Mr. Chairman, thank you for this opportunity to testify before your subcommittee.

PREPARED STATEMENT OF THE FAMILY VIOLENCE PREVENTION FUND

The Family Violence Prevention Fund (FVPF) works to end violence against women and children around the world, because every person has the right to live free of violence. The FVPF's National Health Resource Center on Domestic Violence provides critical information to thousands of healthcare providers, institutions, domestic violence service providers, Government agencies, researchers, and policy makers each year. Its public education campaigns, conducted in partnership with The Advertising Council, have shaped public awareness and changed social norms for 15 years.

STRENGTHENING THE HEALTHCARE SYSTEM'S RESPONSE TO DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT, AND STALKING

Through our work as the National Health Resource Center on Domestic Violence, I know the critical role healthcare providers can play in preventing and responding to violence against women and children, particularly during this difficult economic time when rates of abuse in families seem to be rising. But it is not simply a moral imperative that we try to reduce violence and abuse in this country; it is an economic necessity that Congress supports prevention and intervention efforts in the healthcare system. The Centers for Disease Control and Prevention (CDC) classifies violence and abuse as a "substantial public health problem in the United States," noting the long-term impact of violence and abuse has huge implications for health outcomes and costs.

Children who experience childhood trauma, including witnessing incidents of domestic violence, are at a greater risk of having serious adult health problems including tobacco use, substance abuse, cancer, heart disease, depression and a higher risk for unintended pregnancy. Twenty years of research links childhood exposure to violence with chronic health conditions including obesity, asthma, arthritis, and stroke. It is worth noting that victims, particularly of sexual violence, are linked with obesity. A meta-analysis of research on the impact of adult intimate partner violence finds that victims of domestic violence are at increased risk for conditions such as heart disease, stroke, hypertension, cervical cancer, chronic pain including arthritis, neck and pain, and asthma. In addition to injuries, adult intimate partner violence also contributes to a number of mental health problems including depression and PTSD, risky health behaviors such as smoking, alcohol and substance abuse, and poor reproductive health outcomes such as unintended pregnancy, pregnancy com-

plications, postpartum depression, poor infant health outcomes and sexually transmitted infections including HIV.

According to a CDC survey, women who have experienced domestic violence are 80 percent more likely to have a stroke, 70 percent more likely to have heart disease, 60 percent more likely to have asthma and 70 percent more likely to drink heavily than women who have not experienced intimate partner violence.

When Congress joined together to reauthorize the Violence Against Women Act (VAWA) of 2005 (Public Law 109–162), the law included new provisions to educate and train healthcare providers and public health professionals on how to safely screen and intervene in cases of domestic and sexual violence. These provisions were added after years of work by medical associations, health professionals, advocates and a National Health Care Standards Campaign on Domestic Violence funded by the U.S. Department of Health and Human Services. These collaborations successfully developed strategies, tools, and policies to identify and help victims in health settings.

We know that most women seek healthcare services regularly, either for routine, emergency, perinatal, or pediatric care. As a result, healthcare providers are in a unique position to identify and reach out to victims of violence, long before they may seek help from a domestic violence shelter, rape crisis center, law enforcement agency, or family member. However, fewer than 10 percent of primary care physicians routinely screen patients for domestic violence during regular office visits, according to a study published by the Journal of the American Medical Association.

Research on the most effective interventions in the healthcare setting and prevention messages would have significant public health benefits and cost savings to the healthcare system. While we do not know the full cost of violence and abuse to the healthcare system, previous studies have shown that those who experience abuse access healthcare 2 to 2.5 times more frequently than those without that history. Research shows that intimate partner violence alone costs a health plan $19.3 million each year for every 100,000 women between the ages of 18 and 64 enrolled.

Far more important is the cost of violence and abuse over time. Even 5 years after abuse has ended, healthcare costs for women with a history of intimate partner violence remain 20 percent higher than those for women with no history of violence. A study by the CDC in 2003 estimated the direct medical costs of only injuries and mental health services related to intimate partner violence at $4.1 billion alone, this does not include any evaluation of costs associated with chronic health issues or reproductive health issues discussed above and known to be highly prevalent among victims of abuse. A recent report by the Academy on Violence and Abuse estimated the actual cost to the healthcare system of violence and abuse may be nearly 17 percent of the total healthcare dollar or $333 billion in 2008.

But early identification and treatment of victims can financially benefit the healthcare system. Initial and unpublished findings from one study found that hospital-based domestic violence interventions may reduce healthcare costs by at least 20 percent. Preventing abuse or associated health risks and behaviors clearly could have long term implications for decreasing chronic disease and costs. Because of the long-term impact of abuse on a patient's health, I recommend integrating assessment for current and lifetime physical or sexual violence exposure and interventions into routine care. Regular, face-to-face screening of women by skilled healthcare providers markedly increases the identification of victims of intimate partner violence (IPV), as well as those who are at risk for verbal, physical, and sexual abuse. Routine inquiry of all patients, as opposed to indicator-based assessment, increases opportunities for both identification and effective interventions, validates IPV as a central and legitimate healthcare issue, and enables providers to assist both victims and their children.

When victims or children exposed to IPV are identified early, providers may be able to break the isolation and coordinate with domestic violence (DV) advocates to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Expert opinion suggests that such interventions in adult health settings may lead to reduced morbidity and mortality. Assessment for exposure to lifetime abuse has major implications for primary prevention and early intervention to end the cycle of violence.

Just as the healthcare system has always played an important role in identifying and preventing other serious public health problems, I believe it can and must play a pivotal role in domestic and sexual violence prevention and intervention. It is clear that by funding these innovative and life-saving health provisions established by title V in VAWA 2005, we can help save the lives of victims of violence and greatly reduce healthcare expenses.

In order to advance necessary and needed health goals, I urge you to provide $13 million to the Department of Health and Human Services to fully fund the Violence

Against Women Act's Health Care Programs for fiscal year 2010, and specifically fund the following Labor, Health and Human Services, and Education, and Related Agencies programs accordingly:

—*Training and Education of Health Professionals Program*.—$3 million to train healthcare providers and students in health professional schools how to identify and screen victims of domestic and sexual violence; ensure immediate safety; document their injuries; and refer them to appropriate services;

—*Fostering Public Health Responses*.—$5 million to promote public health programs that integrate domestic and sexual violence assessment and intervention into basic care, as well as encourage collaborations between healthcare providers, public health programs, and domestic and sexual violence programs; and

—*Research on Effective Interventions*.—$5 million to support research and evaluation on effective interventions in the healthcare setting to improve abused women's health and safety and prevent initial victimization.

PROTECT NONABUSIVE PARENTS AND CHILDREN

Another area of concern is the intersection of domestic violence and child abuse, which often occur in the same family. Approximately 45 percent of female caregivers of children reported for child maltreatment have experienced intimate partner violence in their lifetime and 29 percent in the past year. In a study of families investigated for child maltreatment, 31 percent of female caregivers reported experiencing intimate partner violence in the past year; however child welfare workers only identified this abuse in 12 percent of the families.

When child welfare agencies work alone in responding to child maltreatment, they may not understand the complexity of the domestic violence situation and "preemptively" remove the child without offering services to the adult victim. This can have a devastating result for both the child and the nonabusive caretaker. In addition, the opposite approach may also be taken. Frequently, the child protective system fails to take seriously the threat posed by an abusive husband or partner and fails to take any action to support the mother's efforts to keep her and her children safe and hold him accountable for his actions.

By supporting agencies in cooperative efforts to provide services to victims—both children and their nonabusive caretakers—it is possible to keep families safe and united during the difficult process of ending abuse.

THE SOLUTION: IMPROVE COOPERATION BETWEEN CHILD WELFARE AND DOMESTIC VIOLENCE ADVOCATES

Building on what was commonly known as the "Greenbook Project," a federally funded demonstration grant program, VAWA 2005 authorized a program to create grants for training and collaboration on the intersection between domestic violence and child maltreatment. The intent is to ensure that nonabusive family members receive the services they need to keep their families safe, and community services can deal with both problems simultaneously, allowing for a better use of our limited resources. As the two problems often occur together, dealing with one problem and not the other is at the peril of our children.

I urge you to fully fund Training and Collaboration on the Intersection Between Domestic Violence and Child Maltreatment Program at $5 million to help serve families experiencing violence.

In addition, I ask that you continue to support full funding for the Family Violence Prevention and Services Act, the Nation's only designated Federal funding source for domestic violence shelters and services. As leaders committed to both the prevention of intimate partner violence and to the health and safety of victims, I urge you to fund these critical programs.

PREPARED STATEMENT OF THE HIV MEDICINE ASSOCIATION

The HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA) represents more than 3,600 physicians, scientists, and other healthcare professionals who practice on the frontline of the HIV/AIDS pandemic. Our members provide medical care and treatment to people with HIV/AIDS throughout the United States, lead HIV prevention programs and conduct research to develop effective HIV prevention and treatment options. As medical providers and researchers dedicated to the field of HIV medicine, we work in communities across the country and around the globe. We appreciate the fiscal challenges that you currently face, but the state of the economy makes it imperative that our Nation has

a strong healthcare safety net, effective programs for preventing infectious diseases like HIV and a vibrant scientific research agenda.

The U.S. investment in HIV/AIDS programs has revolutionized HIV care globally making HIV treatment one of the most effective medical interventions available. A robust research agenda and rapid public health implementation of scientific findings have transformed the HIV epidemic reducing morbidity and mortality due to HIV disease by nearly 80 percent in the United States. The Ryan White program has played a critical role in ensuring that many low-income people with HIV have access to lifesaving HIV treatment. However, the impact of our diminished investment in public health and research programs over the last several years has taken its toll in communities across the country. HIV clinics are cutting hours and services while new HIV cases are increasing by at least 15 percent.

We face a critical juncture when we must either shore up our healthcare safety net, public health infrastructure, and research programs or risk serious regression in our fight against this deadly disease. The funding requests in our testimony largely reflect the consensus of the Federal AIDS Policy Partnership (FAPP) a coalition of HIV organizations from across the country, and are estimated to be the amounts necessary to sustain and strengthen our investment in combating HIV disease.

CENTER FOR DISEASE CONTROL AND PREVENTION'S (CDC) NATIONAL CENTER FOR HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION (NCHHSTP)

HIVMA strongly supports an increase of $1.27 billion in funding for the CDC's NCHHSTP with an increase of $878 million for HIV prevention and surveillance, an increase of $31.7 million for viral hepatitis and $66.1 million for Tuberculosis prevention.

Every 9½ minutes a new HIV infection happens in the United States with more than 60 percent of new cases occurring among African Americans and Hispanic/Latinos. While new HIV cases have increased, the CDC's HIV prevention budget has declined 19 percent compared to inflation since 2002. A failure to invest now in HIV prevention will be costly. The CDC estimates that the 56,300 new HIV infections each year in the United States may result in $56 billion in medical care and lost productivity.

We strongly support the CDC initiative to integrate HIV screening into medical care and remain seriously concerned about the lack of Federal resources available to State health departments, medical institutions, community health centers, and other community-based organizations for implementing these programs. Increased HIV screening with linkage to care and treatments will help lower HIV incidence and prevalence in the United States. Effective treatment reduces the virus to very low levels in the body and greatly reduces the risk of HIV transmission. Furthermore through education, counseling and treatment, individuals who are aware that they have HIV are less likely to transmit the virus. The transmission rates among people who know their status is 1.7 percent to 2.4 percent compared to transmission rates of 8.8 percent to 10.8 percent for those who are unaware they are infected with HIV.

Despite the known benefit of effective treatment, 21 percent of people living with HIV in the United States are still not aware of their status and as many as 36 percent of people newly diagnosed with HIV progress to AIDS within 1 year of diagnosis. Identifying people with HIV earlier through routine HIV testing and linking them to HIV care saves lives and is more cost effective for the healthcare system. One study found that people living with HIV disease receiving care at the later stages of the disease expended 2.6 times more in healthcare dollars than those receiving treatment according to the standard of care recommended in the Federal HIV treatment guidelines.

An infusion of HIV prevention funding is critical to restore and enhance HIV prevention cooperative agreements with State and local health departments; to optimize core surveillance cooperative agreements with health departments and to expand HIV testing in key healthcare venues by funding testing infrastructure, the purchase of approved testing devices, including rapid HIV tests and confirmatory testing.

Finally, we also must increase support for science-based, comprehensive sex education programs. We strongly urge Congress to discontinue funding for unproven abstinence-only sex education programs and shift these funds to support comprehensive, age-appropriate sex education programs.

CDC—TUBERCULOSIS

Tuberculosis is the major cause of AIDS-related mortality worldwide. Congress passed landmark legislation—the Comprehensive Tuberculosis Elimination Act of 2008—Public Law 110–873 last year that authorizes a number of actions that will shore up State TB control programs, enhance U.S. capacity to deal with the serious threat of drug-resistant tuberculosis and escalate our efforts to develop urgently needed new "tools" in the form of drugs, diagnostics, and vaccines. It is critical that the $210 million in funding authorized for fiscal year 2010 in this important new law is appropriated for the CDC Division of TB Elimination. This represents an increase of $66.1 million more than current funding levels. Funding to support the prevention, control, and elimination of tuberculosis must increase substantially if we are going to make headway against this deadly disease and to address the emerging threat of highly drug resistant tuberculosis.

CDC—VIRAL HEPATITIS

Funds are urgently needed to provide core public health services and to track chronic cases of hepatitis. Hepatitis is a serious co-infection for nearly one-third of our HIV patients. We strongly urge you to boost funding for viral hepatitis at the CDC by $31 million for a total funding of $50 million.

HIV/AIDS BUREAU OF THE HEALTH RESOURCES AND SERVICES ADMINISTRATION

We strongly urge you to increase funding for the Ryan White program by $577 million in fiscal year 2010 with at least an increase of $68.4 million for part C for a total appropriation of $270,254,000. We also strongly support the $4 million included in the President's budget to support in-depth, long-term HIV training opportunities for primary care clinicians.

Ryan White part C funds comprehensive HIV care and treatment—the services that are directly responsible for the dramatic decreases in AIDS-related mortality and morbidity over the last decade. While the patient load in part C programs has been rising in number, funding for part C has effectively decreased. Part C programs expect a continued increase in patients due to higher diagnosis rates and declining insurance coverage. During this economic downturn people with HIV across the country will rely on part C comprehensive services more than ever. An increase in funding is critical to ensure that clinics are able to prevent staffing cuts, as well as, to ensure the public health of our communities. Part C of the Ryan White program has been under-funded for years, but new pressures are creating a crisis in communities across the country. The HIV medical clinics funded through part C have been in dire need of increased funding for years. Years of near flat funding, combined with large increases in the patient population, are negatively impacting the ability of part C providers to serve their patients.

With the rapid cost increases in all aspects of healthcare delivery, despite small funding increases, programs are still operating at a funding deficit because they are serving more patients than ever. In 2008, part C programs will treat an estimated 248,070—a dramatic 30 percent increase in less than 10 years. Part C clinics are laying off staff, discontinuing critical services such as laboratory monitoring, creating waitlists, and operating on a 4-day work week just to get by. HIVMA strongly supports the effort led by the Ryan White Medical Providers Coalition to double funding for Ryan White part C programs by fiscal year 2012. These funds are urgently critical to meet the needs of HIV patients served by part C around the country.

The $4 million proposed in the President's budget to support longer-term training opportunities in HIV medicine or clinical HIV fellowships for primary care practitioners is vital to drawing clinicians into the field of HIV medicine and ensuring new HIV clinicians have the skills and expertise to provide effective HIV care. More that a one-quarter of a century into the HIV epidemic, we are seeing the graying of our Nation's HIV clinical workforce, and we have serious concerns about ensuring a new generation of HIV medical providers to care for Americans with HIV. In a recent survey of Ryan White part C clinics—nearly 70 percent reported difficulty recruiting and retaining HIV clinicians. One of the top barriers identified to retention and to recruitment was lack of a qualified workforce. We must promptly and swiftly address this issue before its effects are felt in increases in morbidity and mortality from HIV and the proposed $4 million for more intensive training in HIV medicine would be an important first step.

We also respectfully urge you to include at least $1 million in this year's Labor, Health and Human Services, and Education, and Related Agencies appropriations bill for a study to evaluate the capacity of the HIV medical workforce as well as

potential strategies to increase the numbers of young physicians, nurse practitioners and physician assistants entering HIV medicine.

NATIONAL INSTITUTES OF HEALTH (NIH)—OFFICE OF AIDS RESEARCH

HIVMA strongly supports an increase of at least $3.7 billion for all research programs at the NIH, including at least a $500 million increase for the NIH Office of AIDS. This level of funding is vital to sustain the pace of research that will improve the health and quality of life for millions of Americans.

HIVMA strongly supported the infusion of NIH research dollars included in the economic recovery bill. The desperately needed funding came at a critical time to sustain our Nation's scientific research capacity while stimulating the economy in communities across the country.

Prior to the boost in NIH funding, the declining U.S. investment in biomedical research had taken its toll in deep cuts to clinical trials networks and significant reductions in the numbers of high-quality, investigator-initiated grants that were approved. With only 1 in 4 research applications receiving funding, the pipeline for critical discoveries and HIV scientists has been dwindling and our role as a leader in biomedical research is at serious risk.

Our past investment in a comprehensive portfolio was responsible for the dramatic gains that we made in our HIV knowledge base, gains that resulted in reductions in mortality from AIDS of nearly 80 percent in the United States and in other countries where treatment is available. Gains that also helped us to reduce the mother to child HIV transmission rate from 25 percent to nearly 1 percent in the United States and to very low levels in other countries where treatment is available.

A continued robust AIDS research portfolio is essential to sustain and to accelerate our progress in offering more effective prevention technologies; developing new and less toxic treatments; and supporting the basic research necessary to continue our work developing a vaccine that may end the deadliest pandemic in human history. The sheer magnitude of the number of people affected by HIV—more than 1 million people in the United States; more than 33 million people globally—demands a continued investment in AIDS research if we are going to truly eradicate this devastating disease. We believe a high priority should be research to discover novel prevention strategies, to improve available treatment strategies, to aid prevention and to maximize the benefits of antiretroviral therapy, especially in the populations disproportionately affected by HIV in the United States and in resource-limited settings.

We also continue to support the NIH's Fogarty International Center (FIC) and recommend an expansion of its programs and funding. The FIC training programs play a critical role in developing self-sustaining healthcare infrastructures in resource-limited countries. These important programs offer invaluable training and mentoring to indigenous physicians from the countries hardest hit by the HIV pandemic and other deadly infectious diseases, such as malaria and tuberculosis. Physicians trained through the FIC are able to develop research programs that more effectively address the healthcare, cultural and resource needs of their country's residents while also fostering the development of ongoing, robust research and clinical programs.

Historically, our Nation has made significant strides in responding to the HIV pandemic here at home and around the world, but we have lost ground in recent years, particularly domestically, as funding priorities have shifted away from public health and research programs. We appreciate the many difficult decisions that Congress faces this year but urge you to recognize the importance of investing in HIV prevention, treatment, and research now to avoid the much higher cost that individuals, communities, and broader society will incur if we fail to sustain these programs now. We have the opportunity to limit the toll of this deadly infectious disease on our planet and to save the lives of millions who are infected or at risk of infection here in the United States and around the globe.

LETTER FROM THE HIV LAW PROJECT

New York, NY, May 22, 2009.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health, and Human Services, and Education, and Related Agencies, Washington, DC.

DEAR CHAIRMAN HARKIN: We respectfully request that you eliminate all funding for abstinence-only-until-marriage programs (in particular the Community-Based Abstinence Education Program as well as the Title V Abstinence Education Pro-

grams), and instead fund programs that provide medically accurate, age-appropriate comprehensive sex education.

President Obama has recently released a budget that zeroes out these funding streams for abstinence-only-until-marriage programs. We applaud his leadership in stopping the flow of dollars that has funded these ineffective and inaccurate programs for too long. Yet the President's budget proposes to replace these programs with a new Teen Pregnancy Prevention Initiative that falls short of the needed comprehensive sexuality education programming, and opens the door to again funding ineffectual abstinence-only programs with new dollars.

Moving forward, we ask that you follow President Obama's lead in advancing public health over ideology by embracing evidence- and science-based educational programs through the elimination of funding for abstinence-only programs. But we believe that new funds to protect the sexual and reproductive health of adolescents through educational programming must be comprehensive in nature, and not limited to the single issue of teen pregnancy prevention.

WHAT IS COMPREHENSIVE SEXUALITY EDUCATION?

Comprehensive sexuality education programs include age-appropriate, medically accurate information on a wide range of topics related to sexuality including relationships, decisionmaking, abstinence, contraception, and disease prevention. They provide students with opportunities for developing interpersonal and relationship skills as well as learning accurate information. Comprehensive sexuality education programs help young people exercise responsibility regarding sexual relationships by addressing abstinence, pressures to engage in sexual intercourse prematurely, and the use of contraception. Comprehensive sexuality education also addresses prevention against the triple threats of unwanted teen pregnancies, sexually transmitted infections, and HIV in order to preserve the sexual and reproductive health of our young people.

ABSTINENCE-ONLY PROGRAMS ARE INEFFECTIVE AND INACCURATE

Contrary to the claims of abstinence-only proponents, these programs have had no positive impact on teen sexuality. A study commissioned by the U.S. Department of Health and Human Services found that youth who participated in abstinence-only programs were no more likely than their peers to abstain from sex, and participants reported having similar numbers of sexual partners and having initiated sex at the same average age as their counterparts who did not participate in the programs.[1]

Teaching abstinence is appropriate if discussed as one among many possible approaches to staying healthy, and avoiding unintended pregnancy. The problem is teaching abstinence only. Abstinence-only-until-marriage programs are prohibited from teaching about contraceptives, except to emphasize their failure rates. Many of the most popular federally funded, abstinence-only curricula are rife with false and misleading information, including that condoms fail to prevent the spread of HIV approximately 31 percent of the time in heterosexual sex, and that HIV is spread through sweat and tears. By their very definition, abstinence-only programs perpetuate ignorance as well as homophobia by teaching that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity, and that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.

COMPREHENSIVE SEXUALITY EDUCATION PROGRAMS ARE EFFECTIVE

A rigorous review of 48 studies evaluating the efficacy of domestic comprehensive sexuality education programs found numerous positive outcomes, and debunked all the myths that serve to hamper governmental support of comprehensive sexuality education:[2]

—Comprehensive sexuality education program participants were found to delay sexual initiation in 40 percent of the programs reviewed, and no study found that comprehensive sexuality education programs hasten the initiation of sex.

[1] Trenholm, Christopher, Barbara Devaney, Ken Fortson, et al. for Mathematica Policy Research. "Impacts of Four Title V, Section 510 Abstinence Education Programs. Final Report." April 2007. Available at http://www.mathematica-mpr.com/publications/PDFs/impactabstinence.pdf

[2] Douglas Kirby, Ph.D. et al. "Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases." November 2007. Available at http://www.thenationalcampaign.org/EA2007/EA2007__full.pdf

—Of the studies that measured the programs' impact on frequency of sexual activity among participants, 30 percent found that programs reduced the frequency of sexual activity, and none found an increase in frequency.
—A decrease in the number of sexual partners was documented by 41 percent of those studies measuring for this.
—An increase in condom use among program participants was found by 41 percent of the studies.
—56 percent of the programs found that sexuality and STD/HIV education programs significantly reduced sexual risk-taking. Reducing risk-taking reduces the transmission of STIs and HIV, and helps to prevent unwanted pregnancies. None of the programs increased sexual risk-taking.
—One of the studies estimated the cost-effectiveness of a sex education program, and found that for every $1 invested in the comprehensive sexuality program studied, $2.65 was saved in medical and social costs, attributable to pregnancy prevention and prevention of the transmission of sexually transmitted infections, including HIV.

THE PUBLIC SUPPORTS COMPREHENSIVE SEX EDUCATION

A 2004 poll by Harvard's Kennedy School of Government, the Kaiser Family Foundation, and National Public Radio found that 77 percent of Americans believe that giving teens information about how to obtain and use condoms makes it more likely that teens will practice safe sex now or in the future. Further, a mere 7 percent of Americans said sex education should not be taught in schools.[3]

YOUTH ARE SEXUALLY ACTIVE

One of the fundamental problems with abstinence-only programs is that they ignore the reality of teenage sexuality. According to the Centers for Disease Control and Prevention, in 2007, 47 percent of high school students had sex at some time. In addition, nearly 15 percent of students had sex with four or more sexual partners.[4] Further, that same year 38 percent of high school students who were then sexually active had not used a condom during last sexual intercourse. In other words, sexually active youth are engaging in risky sexual behaviors.

NEGATIVE HEALTH OUTCOMES ARE PREVALENT AMONG YOUTH

—Almost half of all new STD infections are among youth aged 15 to 24.
—Approximately 14 percent of the persons diagnosed with HIV/AIDS in 2006 were young people, between the ages of 13 and 24.
—In 2002, there were approximately 757,000 pregnancies among adolescents aged 15–19.[5]

Comprehensive sex education has great potential to influence safer sexual behavior among youth and reduce the risk of HIV and STI transmission, as well as prevent unwanted pregnancies. Yet many young people still lack both the knowledge and the skills to minimize their risk. Prevention is not possible without knowledge of risk and appropriate risk-reduction strategies.

SCHOOLS ARE FAILING TO EDUCATE STUDENTS ABOUT SEXUAL AND REPRODUCTIVE HEALTH

Unfortunately, recent history indicates that young people are becoming less able to protect themselves due to their schools' failure to provide comprehensive sexuality education. In 2006, only 38.5 percent of high schools provided students with information regarding proper condom use,[6] a decrease from 2000 when 55.1 percent of high schools provided this information.[7] Additionally, while 96 percent of States

[3] National Public Radio, Kaiser Family Foundation, and Kennedy School of Government, "Sex Education in America: General Public/Parents Survey." January 2004. Available at http://www.kff.org/newsmedia/upload/Sex-Education-in-America-Summary.pdf
[4] Centers for Disease Control and Prevention. "Youth Risk Behavior Surveillance—United States, 2007". June 6, 2008. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5704a1.htm
[5] Centers for Disease Control and Prevention, "Sexual Risk Behaviors". Available at http://www.cdc.gov/healthyyouth/sexualbehaviors/index.htm
[6] SHPPS 2006. "HIV Prevention". Available at: http://www.cdc.gov/HealthyYouth/SHPPS/2006/factsheets/pdf/FS_HIVPrevention_SHPPS2006.pdf
[7] SHPPS 2000. "Fact Sheet: HIV Prevention". Available at: http://www.cdc.gov/HealthyYouth/SHPPS/2000/factsheets/pdf/hiv.pdf

provided funding for or offered staff development on HIV prevention to health educators in 2000, only 84 percent did so in 2006.[8]

In sum, young people need prevention information and skills in order to make healthy decisions. Funding for abstinence-only programming, which has been proven ineffective, must be eliminated and replaced with funds for comprehensive sexuality education. We cannot afford to continue to spend money on ineffective programs. Our young people deserve, and it is Government's obligation to provide, programs that give them the information they need to make responsible decisions to maintain their own sexual and reproductive health.

Sincerely yours,

ADAP Advocacy Association; African Services Committee; AIDS Alabama; AIDS Alliance for Children, Youth and Families; AIDS Law Project of Pennsylvania; Alliance of AIDS Services—Carolina; Cascade AIDS Project; Center for HIV Law & Policy; Center for Women & HIV Advocacy at HIV Law Project; CHAMP.

Christie's Place; Colorado AIDS Project; Community Access National Network; Global Life Works; HIVictorious, Inc.; Housing Works; Positive Women's Network; Latino Commission on AIDS; Lifelong AIDS Alliance; National Alliance of State and Territorial AIDS Directors.

New York City AIDS Housing Network (NYCAHN); Sisterlove; SMART (Sisterhood Mobilized for AIDS/HIV Research & Treatment); The Women's Collective; Women's HIV Collaborative of New York; Women's Initiative to Stop HIV—NY of the Legal Action Center; Women's Lighthouse Project; Women Organized to Respond to Life-Threatening Diseases (WORLD); Young Women of Color HIV/AIDS Coalition.

PREPARED STATEMENT OF HONOREFORM

Mr. Chairman and members of the subcommittee: As president and cofounder of Hepatitis Outbreaks National Organization for Reform (HONOReform), I want to take this opportunity to thank you for the leadership role this subcommittee has played on healthcare acquired infections (HAIs). HONOReform is a nonprofit foundation that advances the lessons learned in hepatitis outbreaks and seeks to prevent future healthcare-associated hepatitis epidemics through education and policy reform.

The Centers for Disease Control and Prevention (CDC) estimates there are 1.7 million infections resulting in approximately 99,000 deaths annually in the United States, making HAIs the fourth-leading cause of death. Beyond the human toll, there is an enormous financial burden to our healthcare system.

We are deeply concerned with the rise in the number of disease outbreaks related to the reuse of syringes and misuse of multidose vials in the outpatient setting. In the January 2009 edition of the Annals of Internal Medicine, an article by the CDC, revealed the occurrence of 33 outbreaks of viral hepatitis in healthcare settings over the last decade. All of these documented outbreaks occurred in nonhospital settings and involved failure on the part of healthcare providers to adhere to basic infection control practices, most notably by reusing syringes and other equipment intended for single use.

I am a victim of what was the largest single source outbreak of Hepatitis C in U.S. history, until last year's Las Vegas, Nevada outbreak that potentially exposed more than 63,000 patients to hepatitis C. In 2001, I contracted hepatitis C through an oncology clinic (nonhospital setting), in Fremont, Nebraska as I was fighting to survive breast cancer for the second time. Ninety-eight other patients from the oncology clinic became infected with hepatitis C. The nurse would reuse the syringe for port flushes, which would then contaminated a 500cc saline bag. The saline bag was used for other patients, which in turn became the source of infection for multiple cancer patients. This improper practice was repeated on a regular basis over a 2-year period.

I utilized my malpractice settlement to establish HONOReform in 2007 to put an end to these completely preventable outbreaks. More than 100,000 patients seeking healthcare and treatment have received letters notifying them of potential exposure to hepatitis and HIV due to improper injection practices in the last 10 years. In April 2009, two outbreaks in New Jersey—a cancer clinic and hospital—and an outbreak at a South Dakota outpatient urology clinic, conducted large patient notifica-

---

[8] SHPPS 2006. "HIV Prevention".

tions which further illustrates that this problem requires immediate action to protect the citizens that are accessing our healthcare system each day.

Moreover, these hepatitis outbreaks are entirely preventable when healthcare providers adhere to proper infection control procedures. A 2002 study by the American Association of Nurse Anesthetists (AANA) found that 1 percent of practitioners felt it was acceptable to reuse a syringe for multiple patients and more than 30 percent of healthcare providers believed it was acceptable to reuse a syringe on the same patient if the needle is changed.

Mr. Chairman, beyond the significant risk posed to the physical health of patients, even the receipt of a notification of potential exposure can cause significant mental anguish and lead to an even greater danger—a loss of faith in the medical system by the public. Victims feel that they have been personally violated and betrayed by those to whom they entrusted their health. We, as a Nation, can not afford to ignore the issue and hope it goes away.

Through its foundation, HONOReform has joined forces with the Accreditation Association for Ambulatory Health Care, AANA, Association for Professionals in Infection Control and Epidemiology, Ambulatory Surgery Foundation, Becton, Dickinson and Company, CDC, CDC Foundation, Nebraska Medical Association, and the Nevada State Medical Association, to establish the One & One Campaign. The One & Only Campaign is an effort aimed at re-educating healthcare providers that syringes and other medical equipment must not be reused and empowering patients to ask the right questions when seeking healthcare. If patients are knowledgeable about injection safety, they will be empowered to speak up in their provider's office to ask if they are getting "One Needle, One Syringe, and Only One Time.

In fiscal year 2009, the CDC received $2.5 million to establish a pilot campaign in Nevada for the launch of the One & Only Campaign, which we hope will be expanded to the national campaign with your support for continued and expanded funding in fiscal year 2010.

Each of these requests will have a profound impact on all patients and consumers. They are aimed at reducing the knowledge gap for providers, empowering patients, tracking HAIs to limit the spread of disease, and improving the quality and standards of care in our Nation's ambulatory care facilities. By focusing on prevention, this subcommittee can realize savings for healthcare systems and promote increased patient safety for all Americans.

Mr. Chairman, we respectfully request that the subcommittee continue supporting prevention efforts at CDC, HHS, and the Agency for Healthcare Research and Quality (AHRQ) to help prevent future hepatitis and HIV outbreaks through the following fiscal year 2010 appropriations requests:

HONOReform requests $26 million for CDC's Division of Healthcare Quality and Promotion to build infrastructure for complete and consistent adherence to injection safety and infection control guidelines in the delivery of outpatient care.

As you know, the migration of healthcare delivery from primarily acute care hospitals to other nonhospital settings (e.g., home care, ambulatory care, free-standing specialty care sites, long-term care, etc.) requires that common principles of infection control practice be applied to the spectrum of healthcare delivery settings. The CDC needs additional resources to use the knowledge gained through these activities to detect infections and develop new strategies to prevent healthcare-associated transmission of blood borne pathogens. This request includes the following elements:

—*Provider Education and Awareness*.—Nine million dollars to be used to support CDC's efforts around provider education and patient awareness activities. Currently, the CDC along with patient advocacy organizations, foundations, provider associations and societies and industry partners have established the Safe Injection Practices Coalition. The requested funding would be used to roll out a national public health campaign focused on safe injection practices. Additionally, funds will be used to develop and disseminate safe practice materials and develop related tools designed for inpatient and outpatient settings. Innovative tools will be developed in conjunction with key partners and stakeholders for use by providers and healthcare personnel, including training tools to be used by professional organizations and accreditation and licensing groups to increase adherence to recommendations

—*Engineering and Innovation*.—Eight million dollars would be used to support CDC in promoting private-sector healthcare solutions to injection safety and infection control problems by engage and incentivizing the private sector to innovate and create fast track engineering solutions to injection safety and infection control problems through the development of innovative products to reduce infection transmission for inpatient and outpatient healthcare settings. With this funding, CDC will convene a roundtable with industry, conduct a study on available technology, assess opportunities for investment in research and devel-

opment, and examine incentives required for adoption of equipment designed with engineering controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needless systems, etc.). CDC will also pursue mechanisms such as grants or CRADAs with industry to accelerate the development of products that have the potential for eliminating the opportunity for human error from process of administering injections.

—*Detection and Tracking*.—Nine million dollars would be used for detection and tracking in order to enable States to investigate outbreaks of hepatitis and other potential pathogens related to injection safety. In addition, this funding would provide support to CDC for emergency response to assist States in responding to hepatitis outbreaks (i.e., Nevada), including genetic sequencing tests. Funding would support efforts including training at health departments related to safe injection practices and recognition of errors, and to enable rapid investigation and intervention when errors are detected. The funding would also support the augmentation of survey capacity in outpatient settings to strengthen State capacity to detect infections that indicate systemic patient safety errors. The funding will enable CDC to provide support to States by providing training tools for surveyors, health department staff and epidemiologists to improve methods of monitoring adherence to correct practices and to provide tools for investigation, response and intervention strategies. Funds will also enable CDC to provide data analysis and feedback to States.

HONOReform requests $1 million for the Department of Health and Human Services (HHS) to expand its current focus for reducing healthcare acquired infections (HAIs) from hospitals to all healthcare settings, including outpatient facilities. We are deeply concerned with the number of HAIs occurring in office-based settings, such as ambulatory care centers, infusion centers, and endoscopy clinics, due to a lack of adherence to basic infection control procedures. In the past year, more than 100,000 patients across the country have been exposed to hepatitis and HIV from healthcare providers failing to adhere to proper safe injection practices and infection control.

HONOReform requests $10 million in general patient safety funds for the AHRQ's Ambulatory Patient Safety Program. While much is known about risk and hazards in the hospital setting, the same cannot be said of ambulatory care setting. Few safety practices have been identified, and there is limited data on the nature of risk and hazards to patients and the threat to quality in the ambulatory care setting. As part of the overall AHRQ patient safety and quality improvement efforts, the identification, assessment, and modeling of risk and hazards prior to designing or implementing intervention strategy in ambulatory care is critical. In light of the growing number of incidents involving syringe reuse and hepatitis C transmission, this funding would enable AHRQ to expand its ambulatory safety and quality program "to identify the inherent risks in ambulatory settings and to develop potential solutions for protecting patients."

Mr. Chairman, on behalf of HONOReform, I would like to express my appreciation for this opportunity to present written testimony before the subcommittee. The growing number of incidents involving syringe reuse and hepatitis C transmission in non-hospital settings across the country highlights the need for enhancing education, awareness and public health activities related to proper infection control and safe injection practices.

PREPARED STATEMENT OF THE HEALTH PROFESSIONS AND NURSING EDUCATION COALITION

The members of the Health Professions and Nursing Education Coalition (HPNEC) are pleased to submit this statement for the record in support of $550 million in fiscal year 2010 for the health professions education programs authorized under titles VII and VIII of the Public Health Service Act and administered through the Health Resources and Services Administration (HRSA). HPNEC is an informal alliance of more than 60 national organizations representing schools, programs, health professionals, and students dedicated to ensuring the healthcare workforce is trained to meet the needs of our diverse population.

As you know, the title VII and VIII health professions and nursing programs are essential components of the Nation's healthcare safety net, bringing healthcare services to our underserved communities. These programs support the training and education of healthcare providers to enhance the supply, diversity, and distribution of the healthcare workforce, filling the gaps in the supply of health professionals not met by traditional market forces. Through loans, loan guarantees, and scholarships

to students, and grants and contracts to academic institutions and nonprofit organizations, the title VII and VIII programs are the only Federal programs designed to train providers in interdisciplinary settings to meet the needs of special and underserved populations, as well as increase minority representation in the healthcare workforce.

We are thankful to the subcommittee for the $200 million provided for the health professions programs in the American Recovery and Reinvestment Act (Public Law 111–5). We also greatly appreciate that the recently enacted fiscal year 2009 Omnibus Appropriations bill (Public Law 111–8) provides some increases for most title VII and VIII programs. These investments provide a crucial springboard to begin to wholly reverse chronic underfunding of these programs and address existing and looming shortages of health professionals.

According to HRSA, an additional 30,000 health practitioners are needed to alleviate existing health professional shortages. Combined with faculty shortages across health professions disciplines, racial/ethnic disparities in healthcare, and a growing, aging population, these needs strain an already fragile healthcare system. Because of the time required to train health professionals, we must make appropriate investments today. Yet, despite some increases in recent years, many of the health professions programs remain well below their comparable fiscal year 2005 funding levels. HPNEC's $550 million recommendation will help sustain the health workforce expansion supported by funding in the recovery package. Further, this appropriation will restore funding to critical programs that sustained drastic funding reductions in fiscal year 2006 and remain well below fiscal year 2005 levels.

We are grateful to President Obama for highlighting the need to strengthen the health professions workforce as a national priority. This strategy is in line with numerous recent, highly regarded recommendations. In a December 2008 Institute of Medicine (IOM) report, HRSA's health professions programs were characterized as "an undervalued asset" and the Department of Health and Human Services was encouraged to support additional investments in the programs. Another IOM report on the future workforce for older Americans from April 2008 also called for increased funding for the health professions programs. The November 2008 issue of the peer-reviewed journal Academic Medicine chronicles the effectiveness of the programs, and the primary care programs in particular, while the December 2008 issue of the Mt. Sinai Journal of Medicine highlights the impact of the diversity programs. These most recent publications showcase the network of title VII and VIII initiatives across the country supporting the education and training of the full range of health providers. Together, the programs work in concert with other programs at the Department of Health and Human Services—including the National Health Service Corps and Community Health Centers (CHCs)—to strengthen the health safety net for rural and medically underserved communities.

The Health Professions Education Partnerships Act of 1998 (Public Law 105–392) consolidated the programs into seven general categories:

—The purpose of the Minority and Disadvantaged Health Professionals Training programs is to improve healthcare access in underserved areas and the representation of minority and disadvantaged healthcare providers in the health professions. Minority Centers of Excellence support programs that seek to increase the number of minority health professionals through increased research on minority health issues, establishment of an educational pipeline, and the provision of clinical opportunities in community-based health facilities. The Health Careers Opportunity Program seeks to improve the development of a competitive applicant pool through partnerships with local educational and community organizations. The Faculty Loan Repayment and Faculty Fellowship programs provide incentives for schools to recruit underrepresented minority faculty. The Scholarships for Disadvantaged Students (SDS) make funds available to eligible students from disadvantaged backgrounds who are enrolled as full-time health professions students. Nurses received $15.1 million in fiscal year 2007 from SDS grants, 32 percent of funds appropriated for SDS.

—The Primary Care Medicine and Dentistry programs, including General Pediatrics, General Internal Medicine, Family Medicine, General Dentistry, Pediatric Dentistry, and Physician Assistants, provide for the education and training of primary care physicians, dentists, and physician assistants to improve access and quality of healthcare in underserved areas. Two-thirds of all Americans interact with a primary care provider every year. Approximately one- half of primary care providers trained through these programs go on to work in underserved areas, compared to 10 percent of those not trained through these programs. The General Pediatrics, General Internal Medicine, and Family Medicine programs provide critical funding for primary care training in community-based settings and have been successful in directing more primary care physi-

cians to work in underserved areas. They support a range of initiatives, including medical student training, residency training, faculty development and the development of academic administrative units. The General Dentistry and Pediatric Dentistry programs provide grants to dental schools and hospitals to create or expand primary care dental residency training programs. Recognizing that all primary care is not only provided by physicians, the primary care cluster also provides grants for Physician Assistant programs to encourage and prepare students for primary care practice in rural and urban Health Professional Shortage Areas. Additionally, these programs enhance the efforts of osteopathic medical schools to continue to emphasize primary care medicine, health promotion, and disease prevention, and the practice of ambulatory medicine in community-based settings.

—Because much of the Nation's healthcare is delivered in areas far removed from health professions schools, the Interdisciplinary, Community-Based Linkages cluster provides support for community-based training of various health professionals. These programs are designed to provide greater flexibility in training and to encourage collaboration between two or more disciplines. These training programs also serve to encourage health professionals to return to such settings after completing their training. The Area Health Education Centers (AHECs) provide clinical training opportunities to health professions and nursing students in rural and other underserved communities by extending the resources of academic health centers to these areas. AHECs, which have substantial State and local matching funds, form networks of health-related institutions to provide education services to students, faculty and practitioners. Geriatric Health Professions programs support geriatric faculty fellowships, the Geriatric Academic Career Award, and Geriatric Education Centers, which are all designed to bolster the number and quality of healthcare providers caring for our older generations. Given America's burgeoning aging population, there is a need for specialized training in the diagnosis, treatment, and prevention of disease and other health concerns of the elderly. The Quentin N. Burdick Program for Rural Health Interdisciplinary Training places an emphasis on long-term collaboration between academic institutions, rural healthcare agencies, and providers to improve the recruitment and retention of health professionals in rural areas. This program has received no funding since fiscal year 2006. The Allied Health Project Grants program represents the only Federal effort aimed at supporting new and innovative education programs designed to reduce shortages of allied health professionals and create opportunities in medically underserved and minority areas. Health professions schools use this funding to help establish or expand allied health training programs. The need to address the critical shortage of certain allied health professionals has been acknowledged repeatedly. For example, this shortage has received special attention given past bioterrorism events and efforts to prepare for possible future attacks. The Graduate Psychology Education Program provides grants to doctoral, internship and postdoctoral programs in support of interdisciplinary training of psychology students with other health professionals for the provision of mental and behavioral health services to underserved populations (i.e., older adults, children, chronically ill, and victims of abuse and trauma, including returning military personnel and their families), especially in rural and urban communities.

—The Health Professions Workforce Information and Analysis program provides grants to institutions to collect and analyze data on the health professions workforce to advise future decisionmaking on the direction of health professions and nursing programs. The Health Professions Research and Health Professions Data programs have developed a number of valuable, policy-relevant studies on the distribution and training of health professionals, including the Eighth National Sample Survey of Registered Nurses, the Nation's most extensive and comprehensive source of statistics on registered nurses. However, the Workforce Information and Analysis program has received no appropriation since fiscal year 2006.

—The Public Health Workforce Development programs are designed to increase the number of individuals trained in public health, to identify the causes of health problems, and respond to such issues as managed care, new disease strains, food supply, and bioterrorism. The Public Health Traineeships and Public Health Training Centers seek to alleviate the critical shortage of public health professionals by providing up-to-date training for current and future public health workers, particularly in underserved areas. Preventive Medicine Residencies, which receive minimal funding through Medicare GME, provide training in the only medical specialty that teaches both clinical and population medicine to improve community health. Dental Public Health Residency pro-

grams are vital to the Nation's dental public health infrastructure. The Health Administration Traineeships and Special Projects grants are the only Federal funding provided to train the managers of our healthcare system, with a special emphasis on those who serve in underserved areas. However, the traineeships have received no appropriation since fiscal year 2006.

—The Nursing Workforce Development programs under title VIII provide training for entry-level and advanced degree nurses to improve the access to, and quality of, healthcare in underserved areas. These programs provide the largest source of Federal funding for nursing education, providing loans, scholarships, traineeships, and programmatic support to 51,657 nursing students and nurses in fiscal year 2008. Healthcare entities across the Nation are experiencing a crisis in nurse staffing, caused in part by an aging workforce and capacity limitations within the educational system. Each year, nursing schools turn away between 50,000 and 88,000 qualified applications at all degree levels due to an insufficient number of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. At the same time, the need for nursing services and licensed, registered nurses is expected to increase significantly over the next 20 years. Congress responded to this dire national need by passing the Nurse Reinvestment Act (Public Law 107–205) in 2002, which increases nursing education, retention, and recruitment. The Advanced Education Nursing program awards grants to train a variety of advanced practice nurses, including nurse practitioners, certified nurse-midwives, nurse anesthetists, public health nurses, nurse educators, and nurse administrators. For example, this funding has been instrumental in doubling nurse anesthesia graduates in the last 8 years. However, even though the number of graduates doubled, the vacancy rate for nurse anesthetists has remained the same at 12 percent, due to a retiring nursing profession and an aging population requiring more care. Workforce Diversity grants support opportunities for nursing education for disadvantaged students through scholarships, stipends, and retention activities. Nurse Education, Practice, and Retention grants are awarded to help schools of nursing, academic health centers, nurse-managed health centers, State and local governments, and other healthcare facilities to develop programs that provide nursing education, promote best practices, and enhance nurse retention. The Loan Repayment and Scholarship Program repays up to 85 percent of nursing student loans and offers full-time and part-time nursing students the opportunity to apply for scholarship funds. In return these students are required to work for at least 2 years of practice in a designated nursing shortage area. The Comprehensive Geriatric Education grants are used to train RNs who will provide direct care to older Americans, develop and disseminate geriatric curriculum, train faculty members, and provide continuing education. The Nurse Faculty Loan program provides a student loan fund administered by schools of nursing to increase the number of qualified nurse faculty.

—The loan programs under Student Financial Assistance support needy and disadvantaged medical and nursing school students in covering the costs of their education. The Nursing Student Loan (NSL) program provides loans to undergraduate and graduate nursing students with a preference for those with the greatest financial need. The Primary Care Loan (PCL) program provides loans covering the cost of attendance in return for dedicated service in primary care. The Health Professional Student Loan (HPSL) program provides loans covering the cost of attendance for financially needy health professions students based on institutional determination. The NSL, PCL, and HPSL programs are funded out of each institution's revolving fund and do not receive Federal appropriations. The Loans for Disadvantaged Students (LDS) program provides grants to health professions institutions to make loans to health professions students from disadvantaged backgrounds.

These programs work collectively to fulfill their unique, three-pronged mission of improving the supply, diversity, and distribution of the health professions workforce. HPNEC members respectfully urge support for funding of at least $550 million for the title VII and VIII programs, an investment essential not only to the development and training of tomorrow's healthcare professionals but also to our Nation's efforts to provide needed healthcare services to underserved and minority communities. We greatly appreciate the support of the subcommittee and look forward to working with Members of Congress and the new administration to reinvest in the health professions programs in fiscal year 2010 and into the future.

PREPARED STATEMENT OF THE HOME SAFETY COUNCIL

INTRODUCTION

Chairman Harkin, Ranking Member Cochran, and members of the subcommittee, thank you for the opportunity to submit testimony on the fiscal year 2010 appropriations for the Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control (NCIPC).

I am Patricia Adkins, chief operating office and director of public policy for the Home Safety Council which is located in Washington, DC.

ABOUT THE HOME SAFETY COUNCIL (HSC)

The mission of the HSC is to help prevent and reduce the nearly 20,000 deaths and 21 million medical visits each year from such hazards as falls, poisoning, fires and burns, choking and suffocation, and drowning. Through national programs, partnerships and the support of volunteers, HSC educates people of all ages to help keep them safer in and around their homes.

Our vision for our Nation is safer homes that provide the opportunity for all individuals to lead healthy, active, and fulfilling lives.

INCREASED FUNDING FOR CDC'S NCIPC

CDC's NCIPC has the mission of preventing injuries and violence, and reducing their consequences. It strives to help every American live his or her life to its fullest potential. Funds are utilized by NCIPC for intramural and extramural research and in assisting State and local health agencies in implementing injury prevention programs.

HSC and a coalition of 30 like-minded nonprofit organizations are requesting an increase of $10 million to the "Unintentional Injury Prevention" account to begin to comprehensively address the large-scale growth of older adult falls.

Ultimately, success in reducing the number and severity of older adult falls will be reached through partnerships with Federal, State, and local agencies along with the cooperation of many nongovernmental organizations.

WHY INJURY PREVENTION IS A CRITICAL ELEMENT OF HEALTHCARE REFORM

In 1998, the National Academy of Sciences stated, "Injury is probably the most under-recognized public health threat facing the nation today."

Each year, injuries resulting from a wide variety of physical and emotional causes—motor vehicle crashes, sports trauma, violence, poisoning, fires, and falls—keep millions of children and adults from achieving their goals and making the most of their talents and abilities.

This is what we know:

—Nationally and in every State in the United States, injuries are the leading cause of death in the first 44 years of a person's life.

—In a single year, more than 50 million injuries required medical attention, with an estimated total lifetime cost of $406 billion.

—This total lifetime cost includes $80 billion in medical care costs and $326 billion in productivity losses, including lost wages and benefits and the inability to perform normal household functions.

These three statistics clearly show the consequences of injuries and its major burden on the healthcare system.

Fortunately, injury research has proven that there are steps that can be taken to prevent injuries and increase the likelihood for full recovery when they do occur. By incorporating these strategies into our communities and everyday activities, we can help to ensure that Americans remain healthy and live their lives to the fullest potential.

PROTECTING OLDER ADULTS FROM INJURY

We all want a society where people, including our older citizens, can live healthy and productive lives. A key component of achieving this is helping older adults avoid injuries. There are actions we can take to prevent injuries and premature death to our parents, grandparents, and friends. Some of the most important include preventing older adults from falling and being injured in fires or motor vehicle crashes.

One of the injuries affecting the quality of life for older adults is falls. Falls are the leading cause of fatal and nonfatal injuries for those 65 and older. Each year, 1.8 million older adults are treated in emergency departments. Every day, 5,000 adults 65 and older are hospitalized due to fall-related injuries, and every 35 minutes, an older adult dies from a fall-related injury.

We know one of the greatest financial challenges facing the U.S. Government, its citizens, and their employers is the rising cost of healthcare services needed by older Americans. CDC reports that $80.2 billion is spent annually for medical treatment of injuries, of which fully $19.2 billion ($12 billion for hospitalization, $4 billion for emergency department visits, and $3 billion for outpatient care) is for treating older adults injured by falls. That's almost one-quarter of all healthcare expenses for injuries each year spent on older adult falls and the majority of these expenses are paid by CMS through Medicare. If we cannot stem this rate of increase, it is projected that the direct treatment costs will reach $54.9 billion annually in 2020, at which time the cost to Medicare would be $32.4 billion.

While falls are a threat to the health and independence of older adults and can significantly limit their ability to remain self-sufficient, the opportunity to reduce falls among older adults has never been better. Today there are proven interventions and strategies that can reduce falls and in turn help older adults live better and longer. Studies show that prescription medications have an effect on balance. A medication review and adjustment is a simple, cost-effective way to help prevent a fall. Additionally, older adults who actively participate in physical exercise and receive vision exams are at a lower risk for falling. These evidence-based interventions can help save healthcare costs and greatly improve the lives of older adults. The costs are small compared to the potential for savings. For every $1 invested in a comprehensive falls prevention program for an older adult, it returns close to a $9 benefit to society.

HOW CONGRESS CAN HELP

Congress took a major step forward in preventing older adult falls with passage of the Safety of Seniors Act of 2007 (S. 845 and Public Law 110–202) which authorized increased research, education, and demonstration projects. Further evidence of support included the passage of S. Res. 674 and the introduction of H. Res. 1478 for the first National Falls Prevention Awareness Day in September 2008. For the good intentions of Congress to bear fruit, an appropriation of $10 million is needed for fiscal year 2010 for CDC's NCIPC.

NCIPC's funding in this area is severely inadequate to address the scale of human suffering and the impact of falls on our healthcare system. Additional funding would enable NCIPC to expand research, evaluation of demonstrations, public education, professional education, and policy analysis. At present, CDC can only allocate $2 million per year to address a problem costing $19.2 billion a year. The benefits of increased funding would be enormous, vastly improving the quality of life for those 65 and older and greatly reducing healthcare costs for falls and related disabilities.

Increased funding for older adult falls prevention efforts is supported by a broad-based coalition of nonprofit organizations and a growing number of State falls prevention coalitions that are dedicated to improving the safety and health of older Americans.

CDC ACTIVITY IN FALLS PREVENTION AMONG OLDER ADULTS

If the CDC NCIPC's falls prevention budget is increased by $10 million, the next steps would be to:

—Develop additional program demonstrations to test and replicate the most cost effective interventions to reduce the risk of falls;
—Undertake additional extramural research into the causes of falls; and
—Develop more public education programs to raise awareness about falls and what individuals, family members, professionals, nonprofit organizations, and the private sector can do to reduce them.

On behalf of HSC and our supporting organizations, thank you for the opportunity to share our fiscal year 2010 appropriations request for the CDC NCIPC on the very costly, but often preventable problem of falls among older adults.

PREPARED STATEMENT OF THE HUMANE SOCIETY LEGISLATIVE FUND

The Humane Society Legislative Fund (HSLF) supports a strong commitment by the Federal Government to research, development, standardization, validation, and acceptance of nonanimal and other alternative test methods. We are also submitting our testimony on behalf of The Humane Society of the United States and Doris Day Animal League, representing more than 11 million members and supporters. Thank you for the opportunity to present testimony relevant to the fiscal year 2010 budget request for the National Institute of Environmental Health Sciences (NIEHS) for activities of the National Toxicology Program Center for the Evaluation of Alternative

Toxicological Test Methods (NICEATM), the support center for the Interagency Coordinating Committee for the Validation of Alternative Test Methods (ICCVAM).

Function of the ICCVAM

The ICCVAM performs a valuable function for regulatory agencies, industry, public health and animal protection organizations by assessing the validation of new, revised, and alternative toxicological test methods that have interagency application. After appropriate independent peer review of the test method, the ICCVAM recommends the test to the Federal regulatory agencies that regulate the particular endpoint the test measures. In turn, the Federal agencies maintain their authority to incorporate the validated test methods as appropriate for the agencies' regulatory mandates. This streamlined approach to assessment of validation of new, revised, and alternative test methods has reduced the regulator burden of individual agencies, provided a "one-stop shop" for industry, animal protection, public health, and environmental advocates for consideration of methods and set uniform criteria for what constitutes a validated test methods. In addition, from the perspective of animal protection advocates, ICCVAM can serve to appropriately assess test methods that can refine, reduce and replace the use of animals in toxicological testing. This function will provide credibility to the argument that scientifically validated alternative test methods, which refine, reduce or replace animals, should be expeditiously integrated into Federal toxicological regulations, requirements, and recommendations.

History of the ICCVAM

The ICCVAM is currently composed of representatives from the relevant Federal regulatory and research agencies. It was created from an initial mandate in the NIH Revitalization Act of 1993 for NIEHS to "(a) establish criteria for the validation and regulatory acceptance of alternative testing methods, and (b) recommend a process through which scientifically validated alternative methods can be accepted for regulatory use." In 1994, NIEHS established the ad hoc ICCVAM to write a report that would recommend criteria and processes for validation and regulatory acceptance of toxicological testing methods that would be useful to Federal agencies and the scientific community. Through a series of public meetings, interested stakeholders, and agency representatives from all 14 regulatory and research agencies, developed the National Institutes of Health (NIH) Publication No. 97–3981, "Validation and Regulatory Acceptance of Toxicological Test Methods." This report, and subsequent revisions, has become the sound science guide for consideration of new, revised, and alternative test methods by the Federal agencies and interested stakeholders.

After publication of the report, the ad hoc ICCVAM moved to standing status under the NIEHS' NICEATM. Representatives from Federal regulatory and research agencies and their programs have continued to meet, with advice from the NICEATM's Advisory Committee and independent peer review committees, to assess the validation of new, revised and alternative toxicological methods. Since then, several methods have undergone rigorous assessment and are deemed scientifically valid and acceptable.

Request for Committee Report Language

In 2006, the NICEATM/ICCVAM at the request of the U.S. Congress began a process of developing a 5-year roadmap for assertively setting goals to prioritize ending the use of antiquated animal tests for specific endpoints. The HSLF and other national animal protection organizations provided extensive comments on the process and priorities for the roadmap.

While the stream of methods forwarded to the ICCVAM for assessment has remained relatively steady, it is imperative that the ICCVAM take a more proactive role in isolating areas where new methods development is on the verge of replacing animal tests. These areas should form a collective call by the Federal agencies that compose

ICCVAM to fund any necessary additional research, development, validation, and validation assessment that is required to eliminate the animal methods. We also strongly urge the NICEATM/ICCVAM to closely coordinate research, development, and validation efforts with its European counterpart, the European Centre for the Validation of Alternative Methods (ECVAM) to ensure the best use of available funds and sound science. This coordination should also reflect a willingness by the Federal agencies comprising ICCVAM to more readily accept validated test methods proposed by the ECVAM to ensure industry has a uniform approach to worldwide chemical safety evaluation.

We respectfully request the subcommittee consider the following report language for the fiscal year 2010 Senate Labor, Health and Human Services, and Education, and Related Agencies appropriations bill:

"The Committee acknowledges the publication of the NICEATM/ICCVAM Five-Year Plan but remains concerned by the slow pace at which federal agencies have moved to adopt regulations that would replace, reduce or refine the use of animals in testing. The Committee therefore requests that NICEATM/ICCVAM hold an initial workshop, based upon input received from a workshop steering committee with representation of scientists from academia, federal government, animal welfare organizations and industry, on "Challenges to Incorporating Alternative Methods into US Federal Agency Programs." The Committee also requests that NICEATM/ICCVAM convene a workshop in fiscal year 2010 to assess the difficulty of obtaining high-quality relevant data for validating alternative methods, which is a significant barrier to validation and acceptance. NICEATM/ICCVAM are also urged to establish timetables for completion of all validation reviews that are currently under way."

National Institutes of Health Support for—"Toxicity Testing in the 21st Century: A Vision and a Strategy"

NIH has launched an ambitious collaboration with the Environmental Protection Agency (EPA) to dramatically transform the way drugs, consumer products, pesticides, and other chemicals are assessed for safety. The new approach will use isolated cells, molecular targets, and lower organisms such as roundworms, instead of laboratory animals. According to the NIH, the research collaboration is expected "to generate data more relevant to humans; expand the number of chemicals that are tested; and reduce the time, money and number of animals involved in testing."

The tripartite arrangement is designed to capitalize on the NIH Chemical Genomics Center's high-speed, automated screening robots to test compounds for toxicity; the experimental toxicology expertise of the National Toxicology Program, which is headquartered at the NIH's NIEHS; and the computational toxicology capabilities at the EPA's National Center for Computational Toxicology.

The Government collaboration seeks to implement a June 2007 report by the National Research Council (NRC) entitled Toxicity Testing in the 21st Century: A Vision and a Strategy, which calls for a sustained, well-funded effort across the toxicology community to shift the traditional toxicity-testing paradigm away from its heavy reliance on animal testing and towards high-throughput systems that monitor perturbations in toxicity pathways.

The Government project could be seen as a successor, with equally visionary possibilities for biology, to Dr. Collins and NHGRI's highly successful Human Genome Project. In order for the new vision to be fully realized within a decade, what is needed is a well-funded Government effort that would attract additional partners and resources from interested industries and overseas governments. We urge the subcommittee to support the efforts of the NIH to implement the NRC report.

PREPARED STATEMENT OF THE HUMANE SOCIETY OF THE UNITED STATES

On behalf of The Humane Society of the United States (HSUS) and our 11 million supporters nationwide, we appreciate the opportunity to provide testimony on our top funding priority for the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee in fiscal year 2010. We are also submitting our testimony on behalf of The Humane Society Legislative Fund (HSLF) and the Doris Day Animal League. Thank you for the opportunity to present testimony relevant for the fiscal year 2010 budget request.

The HSUS requests that no Federal funding be appropriated for (1) the breeding of chimpanzees for research, or (2) the transfer of Government-owned chimpanzees to private hands (including endowments for their maintenance) unless for retirement to appropriate sanctuary. The basis of our request can be found below.

BREEDING OF CHIMPANZEES FOR RESEARCH

The National Center for Research Resources (NCRR) of the National Institutes of Health (NIH), responsible for the oversight and maintenance of federally owned chimpanzees, has announced a permanent end to funding the breeding of federally owned and supported chimpanzees primarily due to the excessive costs of lifetime care of chimpanzees in laboratory settings. We recently discovered that the Government has provided millions of dollars in recent years for chimpanzee breeding. Therefore, we seek to ensure that neither the NIH nor any other Federal agency provides funding for breeding of Government-owned chimpanzees due to the future financial implications to the Government and taxpayers of continuing to do so, particularly during this difficult economic time.

The cost of maintaining chimpanzees in laboratories is exorbitant, totaling up to $8.5 million each year for the current population of approximately 500 federally

owned or supported chimpanzees (approximately $54 per day per chimpanzee; more than $1,000,000 per chimpanzee's 60-year lifetime). Breeding of additional chimpanzees into laboratories will only perpetuate a number of burdens on the Government.

The United States currently has a surplus of chimpanzees available for use in research due to overzealous breeding for HIV research and subsequent findings that they are a poor HIV model.[1]

Expansion of the chimpanzee population in laboratories only creates more concerns than presently exist about their quality of care.

Use of chimpanzees in research raises strong public concerns.

TRANSFER OF OWNERSHIP OF GOVERNMENT-OWNED CHIMPANZEES

If the Government-owned and supported chimpanzees leave the Federal system and are transferred into private hands with an accompanying federally funded endowment, their lifetime support will not be guaranteed as required now by the CHIMP Act and their transfer to a suitable sanctuary will be highly unlikely. These chimpanzees will instead of warehoused and/or used for research for their entire lifetime—with the backing of the Government through an endowment. This will surely lead to a public outcry.

—If private industry breeds and uses chimpanzees in invasive research with Federal endowment money, the private sector would be unfairly, and perhaps illegally, benefiting from federally owned "resources" meant for the betterment of the American public, not for the profit of private industry.

—To date, the private sector has been less than fiscally responsible for the lifetime care of chimpanzees who they have used for private profit. Even in the situations where they eventually retire their chimpanzees, private users rarely offer financial compensation for their chimpanzees' lifetime care and on the few occasions that they have offered some financial compensation, it falls far short of what is actually needed.

We instead urge the Government to transfer all 500 Government-owned chimpanzees to the national sanctuary system and appropriate a portion of the funding currently being given to chimpanzee laboratories to the sanctuary system. A transfer of the chimpanzees to sanctuary would: (1) consolidate and lessen chimpanzee maintenance costs, (2) provide the chimpanzees with better care, and (3) offer the public the humane solution they are asking for.

BACKGROUND AND HISTORY

Beginning in 1995, the National Research Council (NRC) confirmed a chimpanzee surplus and recommended a moratorium on breeding of federally owned or supported chimpanzees[1], who now number approximately 500 of the more than 1,000 total chimpanzees available for research in the United States. On May 22, 2007, the NCRR of NIH announced a permanent end to the funding of chimpanzee breeding, which applies to all federally owned and supported chimpanzees as well as NIH-funded research. Further, it has also been noted that "a huge number" of chimpanzees are not being used in active research protocols and are therefore "just sitting there."[2] If no breeding is allowed, it is projected that the Government will have almost no financial responsibility for the chimpanzees it owns within 30 years due to the age of the population—any breeding today will extend this financial burden to 90 years.

There is no justification for breeding of additional chimpanzees for research; therefore lack of Federal funding for breeding will ensure that no breeding of federally owned or supported chimpanzees for research will occur in fiscal year 2010.

CONCERNS REGARDING CHIMPANZEE CARE IN LABORATORIES

A 9-month undercover investigation by the HSUS at University of Louisiana at Lafayette New Iberia Research Center (NIRC)—the largest chimpanzee laboratory in the world—revealed some chimpanzees living in barren, isolated, conditions and documented more than 100 alleged violations of the Animal Welfare Act at the facility in regards to chimpanzees. The U.S. Department of Agriculture (USDA) and NIH's Office of Laboratory Animal Welfare (OLAW) have since launched formal investigations into the facility and NIRC was cited for several violations of the Animal Welfare Act during an initial site visit.

---

[1] NRC (National Research Council) (1997) Chimpanzees in research: strategies for their ethical care, management and use. National Academies Press: Washington, D.C.

[2] Cohen, J. (2007) Biomedical Research: The Endangered Lab Chimp. Science. 315:450–452.

Aside from the HSUS investigation, inspections conducted by the USDA demonstrate that basic chimpanzee housing requirements are often not being met. Inspection reports for two other federally funded chimpanzee facilities reported housing of chimpanzees in less than minimal space requirements, inadequate environmental enhancement, and/or general disrepair of facilities. These problems add further argument against the breeding of even more chimpanzees.

CHIMPANZEES HAVE OFTEN BEEN A POOR MODEL FOR HUMAN HEALTH RESEARCH

The scientific community recognizes that chimpanzees are poor models for HIV because chimpanzees do not develop AIDS. Similarly, chimpanzees do not model the course of the human hepatitis C virus yet they continue to be used for this research, adding to the millions of dollars already spent without a sign of a promising vaccine. According to the chimpanzee genome, some of the greatest differences between chimpanzees and humans relate to the immune system,[3] calling into question the validity of infectious disease research using chimpanzees.

ETHICAL AND PUBLIC CONCERNS ABOUT CHIMPANZEE RESEARCH

Chimpanzee research raises serious ethical issues, particularly because of their extremely close similarities to humans in terms of intelligence and emotions. Americans are clearly concerned about these issues: 90 percent believe it is unacceptable to confine chimpanzees individually in Government-approved cages (as we documented during our investigation at NIRC); 71 percent believe that chimpanzees who have been in the laboratory for more than 10 years should be sent to sanctuary for retirement;[4] and 54 percent believe that it is unacceptable for chimpanzees to "undergo research which causes them to suffer for human benefit."[5]

We respectfully request the following bill or subcommittee report language:

"The Committee directs that no funds provided in this Act be used to support the breeding of chimpanzees for research, research that requires breeding of chimpanzees, or the transfer of ownership of federally owned chimpanzees to private entities, including endowments for their maintenance, with the exception of a transfer to an appropriate sanctuary that meets the national chimpanzee sanctuary system standards."

We appreciate the opportunity to share our views for the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act for fiscal year 2010. We hope the subcommittee will be able to accommodate this modest request that will save the Government a substantial sum of money, benefit chimpanzees, and allay some concerns of the public at large. Thank you for your consideration.

PREPARED STATEMENT OF THE HARLEM UNITED COMMUNITY AIDS CENTER, INC.

FUNDING REQUEST OVERVIEW

Harlem United Community AIDS Center, Inc. (Harlem United) appreciates the opportunity to submit written comments for the record regarding fiscal year 2010 funding for HIV/AIDS related programs. Harlem United was founded in 1988 as a community-based, nonprofit organization providing comprehensive, integrated care in a healthy and healing environment. We serve individuals and families living with HIV and AIDS in the greater Harlem and South Bronx neighborhoods of New York City. Touching the lives of more than 6,000 people each year through our programs, Harlem United offers its clients an array of evidence-based, outcomes-driven, culturally sensitive medical and support services, including: primary healthcare and dental care; mental health and substance use counseling; individual psychotherapy and case management; and supportive housing.

For far too long, Federal funding for domestic HIV/AIDS programs has been inadequate, leaving communities struggling to meet the prevention, care, and treatment needs of people at risk for and living with HIV/AIDS. Harlem United values working with policymakers at the local, State, and Federal levels to advance policies and programs that support HIV prevention, care, and treatment. We respectfully request

[3] The Chimpanzee Sequencing and Analysis Consortium/Mikes, TS, et al.,(1 September 2005) Initial sequence of the chimpanzee genome and comparison with the human genome, Nature 437, 69–87.

[4] 2006 poll conducted by the Humane Research Council for Project Release & Restitution for Chimpanzees in laboratories.

[5] 2001 poll conducted by Zogby International for the Chimpanzee Collaboratory.

the subcommittee provide the following allocations in fiscal year 2010 to promote HIV prevention and HIV related research and treatment innovations:

—$1.57 billion for HIV prevention and surveillance at the Centers for Disease Control and Prevention (CDC) to help stem the tide of the Nation's HIV/AIDS epidemic, particularly among individuals and communities of color.

—At least $2.81 billion in overall funding for the Ryan White Program, including the AIDS Drug Assistance Program, to provide essential services for more than 530,000 uninsured and underinsured low-income individuals and families impacted by HIV/AIDS.

—A minimum of $610 million for the Minority AIDS Initiative, which funds programs across 8 Federal agencies to address HIV infection-related disparities among racial and ethnic groups.

—At least $34 billion for the National Institutes of Health (NIH), with $3.35 billion allocated to HIV/AIDS research to help identify and deliver new therapies.

INTRODUCTION AND OVERVIEW

Despite ongoing prevention efforts, approximately 56,300 new HIV infections occur each year, and an estimated 21 percent of infected individuals are unaware of their HIV status. Moreover, CDC estimates that there are 430,000 people with HIV in the United States, who are not currently receiving HIV-related medical care. In 2004, the Institute of Medicine estimated that more than 50 percent of Americans living with HIV had no reliable access to the care they needed to stay alive. Evidence has shown that new infections have been driven in large part by (1) people who were unaware of their status and unwittingly transmitted the virus, and (2) individuals who were diagnosed, but who were not treatment eligible and who were engaging in risk behaviors.[1] Prevention programs, routine HIV testing and universal access to care are essential to stemming the tide of the HIV/AIDS epidemic nationwide.

To prevent the incidence of HIV and ensure that all people living with HIV/AIDS have access to comprehensive and quality care that they need and deserve, Harlem United advocates ongoing and significant Federal funding for domestic HIV/AIDS programs.

BOLSTER CDC HIV PREVENTION AND SURVEILLANCE EFFORTS

The CDC estimates that there are more than 1.1 million people living with HIV/AIDS in the United States and an estimated 56,300 new infections occur each year. With these staggering statistics, it becomes clear that a sustained Federal investment in and commitment to HIV/AIDS initiatives are essential to advancing efforts to prevent and treat HIV infections. However, over the past 6 years, as the number of people living with HIV/AIDS has increased, Federal funding for HIV prevention programs at CDC has decreased by 19.3 percent. In fiscal year 2009, CDC HIV related prevention and surveillance programs were flat-funded after facing a $3.5 million cut in fiscal year 2008. Harlem United calls upon the subcommittee to provide a specific allocation of $1.57 billion, an increase of $877 million, for HIV prevention efforts at CDC.

The current body of knowledge and research surrounding HIV prevention provides evidence for effective interventions, yet CDC and State and local public health departments do not always have the resources to implement them. With increased Federal funding, gaps in resources and fiscal needs will be alleviated and prevention efforts can be scaled up. Specifically, additional funding will allow CDC to expand HIV testing efforts and prevention outreach, particularly among high-risk populations and communities of color, where the epidemic is disproportionately concentrated. CDC also would be able to assist State and local health departments fund prevention programs that go beyond just testing for HIV. Furthermore, additional funding would allow CDC to continue to build the capacity of community-based organizations to implement evidenced-based interventions and provide technical assistance, Lastly, CDC would also be able to improve HIV monitoring and surveillance activities to ensure that accurate data on the disease is captured.

PRESERVE ACCESS TO HIV TREATMENT FOR LOW-INCOME INDIVIDUALS THROUGH THE RYAN WHITE PROGRAM

Each year, the Ryan White Program provides care and treatment to more than half a million low-income individuals living with HIV/AIDS. This program is vital

[1] Federal guidelines do not allow for treatment until an individual's viral load reaches 350 or lower.

to those who have no medical coverage or face coverage limits, as it steps in as the "payer of last resort." While the Ryan White Program was initially implemented as an emergency measure, it has become an integral part of the Nation's response to HIV, providing treatment for individuals who would otherwise not have access to care.

The AIDS Drug Assistance Program (ADAP), a critical component of the Ryan White Program that exists under part B, provides HIV medications to program participants and funds for purchasing health insurance for eligible participants and services that enhance drug treatment therapies.

Unfortunately, growing caseloads and costs of treatment have left current funding levels inadequate. As such, Harlem United calls upon the subcommittee to allocate at least $2.81 billion in overall funding for the Ryan White Program, including the AIDS Drug Assistance Program.

STRENGTHEN THE MINORITY AIDS INITIATIVE

The HIV/AIDS epidemic in the United States has hit racial and ethnic minority communities hard. While only 12 percent of the U.S. population is African American, this racial group accounts for 49 percent of all new AIDS cases. Hispanics account for 19 percent of new AIDS diagnoses, yet comprise only 12 percent of the total U.S. population. Combined, minorities represent 71 percent of new AIDS cases, 67 percent of all people living with HIV/AIDS, and 70 percent of deaths caused by AIDS. These grim statistics demonstrate the critical need for the Minority AIDS Initiative (MAI).

MAI provides funding to community-based organizations and healthcare providers to implement prevention and treatment programs specifically tailored to racial and ethnic minority populations. The Initiative, designed to complement other HIV efforts, strengthens the capacity of organizations serving communities of color to implement culturally appropriate HIV prevention programs and treatment services, in order to reduce the incidence of HIV and improve HIV related health outcomes among these communities.

Given the urgent need to reduce HIV/AIDS disparities among racial and ethnic communities in the United States, Harlem United urges the subcommittee to allocate a minimum of $610 million for the Minority AIDS Initiative.

ENHANCE HIV TREATMENT AND THERAPEUTICS RESEARCH

Despite breakthroughs in HIV treatment and prevention research, currently, no vaccine or cure exists for HIV/AIDS. With approximately 56,300 new HIV cases each year, it is crucial that the United States increase its commitment to research aimed at the prevention and treatment of this disease.

The NIH is the global leader in AIDS research. It conducts research on drug therapies, vaccines, and evidenced-based behavior and biomedical prevention interventions. Previous breakthroughs in NIH AIDS research include advances in antiretroviral therapy and drug regimens that have decreased HIV-related morbidity and mortality and reduced the risk of mother-to-child transmission of HIV. While NIH research has significantly contributed to HIV prevention and treatment programs that have improved the quality-of-life for many, additional and on-going research is needed to advance existing HIV/AIDS treatments. Therefore, Harlem United calls upon the subcommittee to allocate at least $34 billion for NIH, with $3.35 billion allocated to HIV/AIDS research.

CONCLUSION

Harlem United maintains a strong commitment to working with Members of Congress, other community-based organizations, and stakeholders to curtail the HIV epidemic and ensure that individuals living with HIV/AIDS have access to quality care and treatment. By providing the fiscal year 2010 funding levels detailed above, we believe the subcommittee will be taking the necessary steps towards accomplishing the goals of HIV prevention and universal access to care, ensuring that this disease will no longer threaten our Nation.

LETTER FROM THE INTERSTITIAL CYSTITIS ASSOCIATION

MAY 22, 2009.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

Hon. THAD COCHRAN,
Ranking Member, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

DEAR SENATOR HARKIN AND COCHRAN: Thank you very much for your continued leadership in advancing healthcare policy.

Interstitial cystitis (IC) is pelvic pain, pressure, or discomfort related to the bladder typically associated with high urinary frequency and urgency, in the absence of infection or other pathology. IC is also called chronic pelvic pain syndrome, painful bladder syndrome (PBS), and bladder pain syndrome (BPS).

The Interstitial Cystitis Association (ICA) is a nonprofit organization committed to finding more effective treatments and a cure for interstitial cystitis. ICA promotes IC research; educates the medical community and public; advocates for IC patients, healthcare providers and researchers; and offers support for IC patients and their families. In this capacity the ICA requests the following funding considerations for the fiscal year 2010 Labor, Health and Human Services, and Education, and Related Agencies bill:

—A 7 percent increase for the National Institutes of Health (NIH) for fiscal year 2010. A 7 percent increase will allow NIH to continue to expand basic biomedical research on all diseases, and take advantage of the explosion of opportunities that exist in reducing suffering from debilitating medical disorders.

—A 7 percent increase for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). NIDDK is the key NIH agency funding research on interstitial cystitis (IC). ICA urges that NIDDK continue to expand the research portfolio on IC, so millions of American women and men can benefit from advances and breakthroughs in medical care and treatments. NIDDK supports the Multidisciplinary Approach to Chronic Pelvic Pain clinical trial-a critical priority of ICA.

—A 7 percent increase for the NIH Office of Research on Women's Health. Located in the NIH Office of the Director, the NIH Office of Women's Health supports research and program activities that contribute to the understanding of interstitial cystitis which primarily affects women.

—$1 million for the Centers for Disease Control and Prevention (CDC) interstitial cystitis program. A funding level of $1 million will allow the modest expansion of IC program activities at CDC and continue the critical CDC/ICA cooperative agreement on public and professional awareness on interstitial cystitis.

Thank you for the opportunity to present the views of the IC community. Please do not hesitate to contact me if there is any more information you would like us to provide for your consideration.

Sincerely,

BARBARA GORDON,
Executive Director.

PREPARED STATEMENT OF THE INFECTIOUS DISEASES SOCIETY OF AMERICA

The Infectious Diseases Society of America (IDSA) appreciates this opportunity to speak in support of Federal efforts to prevent, detect, and respond to infectious diseases in the United States and abroad as part of the fiscal year 2010 funding cycle. IDSA represents more than 8,500 infectious diseases physicians and scientists devoted to patient care, prevention, public health, education, and research. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis (TB), antibiotic-resistant bacterial infections such as methicillin-resistant Staphylococcus aureus (MRSA), and those with cancer or transplants who have life-threatening infections caused by unusual microorganisms, food poisoning, and HIV/AIDS, as well as emerging infections like the 2009 H1N1 virus (swine influenza) and severe acute respiratory syndrome (SARS).

2009 H1N1 Virus (Swine Influenza)

IDSA's leadership strongly commends the administration's efforts to date in managing and responding to the 2009 H1N1 outbreak. Of critical importance, experts and scientists are driving key decisions. The leadership of the Centers for Disease Control and Prevention (CDC) and the Department of Health and Human Services

(HHS) has been strong, and their coordination with other Federal, State, and local governments is clear. Undeniably, the investments and subsequent preparations the country has made since the National Strategy for Pandemic Influenza was issued in November 2005 are paying off. As the 2009 H1N1 virus outbreak unfolds, we are witnessing firsthand the important role a robust public health infrastructure plays in rapidly detecting and containing disease outbreaks. Yet, additional resources are needed to adequately respond to the 2009 H1N1 outbreak as well as to continue to prepare our Nation for other bioemergencies.

We thank the subcommittee for providing funding for pandemic influenza preparedness and response activities in the recent fiscal year 2009 supplemental bill. IDSA supports a funding level of $2.05 billion to complete the funding to implement the National Strategy for Pandemic Influenza, as well as to develop a 2009 H1N1 virus vaccine and replenish the Strategic National Stockpile, support grants to State and local health departments so they may adequately prepare for and respond to the 2009 H1N1 virus and other infectious diseases outbreaks, and provide additional funding for global pandemic preparedness activities. IDSA further believes that funding is needed annually to adequately maintain State and local pandemic preparedness activities. IDSA also strongly supports strengthening funding for ongoing pandemic influenza preparedness activities at CDC, the Food and Drug Administration (FDA), National Institutes of Health (NIH), and HHS' Office of the Secretary.

Congress also must fully fund the Biomedical Advanced Research and Development Authority (BARDA) within HHS so that the United States can begin to realize goals envisioned under the Pandemic and All-Hazards Act enacted in 2006 to address a broad spectrum of biological threats in addition to pandemic influenza. IDSA recommends that $1.7 billion of multi-year appropriations be allocated to BARDA in fiscal year 2010 to fund biological therapeutics, diagnostics, vaccines, and other technologies. Such funding would help ensure the availability of resources throughout the stages of development and the flexibility for BARDA to partner effectively with industry.

CDC

A strong CDC is essential to the United States' efforts to rapidly detect and control infectious diseases as witnessed by the current H1N1 outbreak. CDC is the primary Federal agency responsible for conducting and supporting public health protection through health promotion, prevention, preparedness, and research. IDSA recommends increasing funding for CDC's core programs to $8.6 billion, to enable it to maintain a strong public health infrastructure and protect Americans from public health threats and emergencies.

IDSA is especially concerned about CDC's Infectious Diseases program budget, which supports critical management and coordination functions for infectious diseases science, program, and policy, including related specific epidemiology and laboratory activities. IDSA recommends an fiscal year 2010 funding level of $2.7 billion for CDC's Infectious Diseases programs.

Within the Infectious Disease programs' proposed budget, the agency's already severely strapped Antimicrobial Resistance budget stands at $16.9 million. This vital program is necessary to help combat the rising tide of drug resistance, a critical medical problem marked most publicly by the upsurge in methicillin-resistant Staphylococcus aureus (MRSA) and other drug-resistant bacterial infections. Antimicrobial resistance also has serious implications for our collective response to the 2009 H1N1 virus. Viruses are unpredictable, and should the 2009 H1N1 virus develop resistance to oseltamivir and zamamir, our ability to respond effectively to the influenza outbreak will significantly diminish. For these reasons, IDSA recommends increasing fiscal year 2010 funding for resistance programs at CDC by $48 million, to a total of $65 million. Such funding increases will enable CDC to more effectively gather morbidity and mortality data related to resistance, track the development of dangerous resistant bugs as they develop, educate physicians, patients and the public about the need to protect the long-term effectiveness of antimicrobial drugs, and strengthen infection control activities across the United States. This recommended level coincides well with an internal CDC professional judgment prepared last year which, unfortunately, was not provided to Congress.

The Emerging Infectious Diseases (EI) budget line boosts the agency's capacity to nimbly identify and respond to emerging infections, such as the 2009 H1N1 virus. Much of CDC's infectious diseases funding is highly disease-targeted, making it difficult to fund cross-cutting or emergent needs. Unique in its flexibility, the EI line supports dozens of research and surveillance programs that address new and unpredictable threats. Such threats have included rabies, rotavirus, food-borne diseases, Ebola and SARS. Inadequate funding would severely affect CDC's laboratory capac-

ity, research grants to academic partners, and support for State public health departments and public health laboratories and would reduce CDC's flexibility in setting priorities and taking action against new infections that may emerge throughout the year. IDSA recommends, at a minimum, that the Other Emerging Infectious Diseases line item be increased to $160 million for fiscal year 2010.

Immunizing our population against vaccine—preventable diseases is one of our country's greatest public health achievements. Through CDC's Section 317 Program, which funds State and local immunizations efforts, the United States has made significant progress toward eliminating vaccine-preventable diseases among children. IDSA applauds the actions by the Congress over the past year to increase funding for this program in the American Recovery and Reinvestment Act and in the fiscal year 2009 omnibus appropriations bill. At a time when new CDC-recommended vaccines are available and a greater commitment to immunizations for both children and adults is necessary, we need to continue to increase access to this critical intervention that saves lives and millions of dollars in unnecessary medical spending. To build on this important effort, IDSA recommends a funding level for the Section 317 Program of $802 million in fiscal year 2010.

IDSA also supports changes which will significantly strengthen the Section 317 Program's support for adult and adolescent immunization. Each year, more than 46,000 adults die of vaccine-preventable diseases. Costs related to illnesses from adult vaccine-preventable diseases are approximately $10 billion. IDSA recommends the establishment of distinct funding floors for adult vaccine purchase and infrastructure in amounts sufficient to cover immunization of the majority of under-insured and uninsured adults with all CDC-recommended vaccines.

Last year, Congress passed landmark legislation in the Comprehensive Tuberculosis Elimination Act of 2008. This bill authorizes a number of actions that will shore up State TB control programs, enhance U.S. capacity to deal with the serious threat of drug-resistant tuberculosis, and escalate our efforts to develop urgently needed "tools," such as drugs, diagnostics, and vaccines. Realizing these goals will require additional resources. At a minimum, it is critical that the funding authorized for fiscal year 2010 in this important law—$210 million—be appropriated for the CDC Division of TB Elimination. The bill also separately authorized $100 million for development of TB diagnostics, treatments and prevention tools, which IDSA also supports for inclusion in fiscal year 2010 appropriations.

HIV prevention and surveillance activities at CDC are critical to reducing the number of new cases occurring annually in the United States. Sufficient resources must be devoted to HIV prevention to support CDC's portfolio of prevention programs, including the initiative to identify people with HIV/AIDS earlier through routine HIV screening. This program will lead to lifesaving care sooner and will help to prevent further transmissions. IDSA supports funding in the amount of $1.57 billion for these programs in fiscal year 2010. We also support funding of $2.81 billion for the Ryan White CARE Act programs within the Health Resources and Services Administration and urge you to increase funding for critical part C medical care by $68.4 million, to a total of $270.3 million for part C programs. Ryan White programs provide a vital link in our healthcare safety net and are currently struggling to meet the need for HIV services in communities across the country.

NIH

NIH is the single-largest funding source for infectious diseases research in the United States and the life-source for many academic research centers. The NIH-funded work conducted at these centers lays the groundwork for advancements in treatments, cures, and other medical technologies. Between 2003 and 2009, NIH lost 13 percent of its purchasing power due to the rate of biomedical research inflation and stagnating annual budgets. Because of the flat budget, 3 out of 4 research proposals submitted to NIH were not funded. Peer reviewers were forced to become more risk averse, leading to a narrowing of scientific vision and a diminishing rate of medical advancement. Without medical advancements, thousands of Americans will have to wait longer for the cures they need.

IDSA is extremely pleased that the recently enacted American Recovery and Reinvestment Act provided $10 billion in additional funding to support NIH's research efforts in 2009 and 2010. Congress rightfully acknowledged the role of scientific research in stimulating the economy. It is vital, however, that this long overdue increase in funding be sustained and become part of NIH's baseline. Making this increase permanent ultimately will translate into long-term improvements in human health, both domestically and globally.

NIH's Fogarty International Center is at the forefront of global health and is a leader in extending the U.S. Federal biomedical enterprise abroad. It taps innovative thinking from all parts of the world and fosters important scientific partner-

ships. Through Fogarty, the United States has supported research and research training programs conducted by both U.S. and foreign investigators across a wide range of infectious diseases and needs, including HIV/AIDS, malaria, and tuberculosis. The Center's efforts have led to improved local health outcomes—but so much more can be done. For this reason, IDSA strongly supports increasing Fogarty's funding level in fiscal year 2010 to $100 million—an increase of $31.3 million. These additional resources will enable Fogarty to increase research training initiatives, forge new partnerships between U.S. and foreign research institutions, and conduct much-needed implementation research to increase the effectiveness of international programs.

IDSA also urges the National Institute of Allergies and Infectious Diseases (NIAID) at NIH to increase its antimicrobial resistance research funding by $100 million in fiscal year 2010, bringing overall funding in this area to $271 million. This will allow NIAID to strengthen clinical research and establish a clinical trials network to study resistant infections as well as antibacterial use and development. Well-designed, multi-center, randomized, controlled trials would create an excellent basis of evidence from which coherent and defensible recommendations could be developed.

FDA

Additionally, in the Agriculture Appropriations bill, IDSA supports a strengthening of antimicrobial resistance efforts at FDA. Specifically we support a $20 million increase in antimicrobial resistance funding for FDA in fiscal year 2010, bringing the agency's resistance funding to $44 million. This will allow FDA to establish and periodically update antibiotic susceptibility breakpoints based on testing and data collection, including through the purchase of vendor data; fund Critical Path initiatives for antibiotics; more aggressively review the safety of antibiotic use in food animals; and quicken its pace in developing critical guidance for industry on antibiotic clinical trial designs.

Today's investment in infectious diseases research, prevention, and treatments will pay significant dividends in the future by dramatically reducing healthcare costs and improving the quality of life of millions of Americans and others. It also will continue to enable Federal agencies to respond effectively and efficiently to the 2009 H1N1 virus and other potentially devastating outbreaks.

PREPARED STATEMENT OF THE INTERNATIONAL FOUNDATION FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2010

Provide a funding increase of at least 7 percent for the National Institutes of Health (NIH) and its Institutes and Centers.

Urge the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to prioritize and implement the recently released research recommendations of the National Commission on Digestive Diseases.

Urge NIH And NIDDK to expand the research portfolio on functional gastrointestinal and motility disorders, such as Irritable Bowel Syndrome (IBS).

Thank you for the opportunity to present this written statement regarding the importance of functional gastrointestinal and motility disorders research.

Since our establishment in 1991, the International Foundation for Functional Gastrointestinal Disorders (IFFGD) has been dedicated to increasing awareness of functional gastrointestinal and motility disorders among the public, health professionals, and researchers. We also work to bolster digestive disease research and generate new treatment option for patients. For example, IFFGD worked with the NIDDK, the National Institute of Child Health and Human Development (NICHD), and the Office of Medical Applications of Research (OMAR) to facilitate an NIH State-of-the-Science Conference on the Prevention of Fecal and Urinary Incontinence in Adults, which was held in December of 2007. Furthermore, I served on the National Commission on Digestive Diseases (NCDD) which recently released a long-range road map for digestive disease research, entitled Opportunities and Challenges in Digestive Diseases Research: Recommendations of the National Commission on Digestive Diseases

The majority of diseases and disorders we address have no cure and treatment options are often limited. We have yet to completely understand the mechanisms of the underlying conditions. Patients face a life of learning to manage a chronic illness that is accompanied by pain and an unrelenting myriad of gastrointestinal symptoms. The medical and indirect costs associated with these diseases are enormous; estimates range from $25 billion–$30 billion annually. Economic costs spill over into

the workplace, and are reflected in work absenteeism and lost productivity. Furthermore, the human toll is not only on the individual but also on the family. In essence, these diseases account for lost opportunities for the individual and society.

IBS

IBS strikes people from all walks of life. It affects 30 million to 45 million Americans and results in significant human suffering and disability. This chronic disease is characterized by a group of symptoms, which include abdominal pain or discomfort associated with a change in bowel pattern, such as diarrhea and/or constipation. Although the cause of IBS is unknown, we do know that this disease needs a multidisciplinary approach in research and treatment.

IBS can be emotionally and physically debilitating. Due to persistent pain and bowel unpredictability, individuals who suffer from this disorder may distance themselves from social events, work, and even may fear leaving their home.

Numerous research recommendations regarding IBS were included as components of the NCDD's Long-Range Research Plan for Digestive Diseases. For fiscal year 2010, IFFGD urges Congress to review the NCDD's Report, and provide NIH and NIDDK with the resources necessary to adequately implement the plan's recommendations.

FECAL INCONTINENCE

At least 12 million Americans suffer from fecal incontinence. Incontinence is neither part of the aging process nor is it something that affects only the elderly. Incontinence crosses all age groups from children to older adults, but is more common among women and in the elderly of both sexes. Often it is a symptom associated with various neurological diseases and many cancer treatments. Yet, as a society, we rarely hear or talk about the bowel disorders associated with spinal cord injuries, multiple sclerosis, diabetes, prostate cancer, colon cancer, uterine cancer, and a host of other diseases.

Damage to the anal sphincter muscles; damage to the nerves of the anal sphincter muscles or the rectum; loss of storage capacity in the rectum; diarrhea; or pelvic floor dysfunction can cause fecal incontinence. People who have fecal incontinence may feel ashamed, embarrassed, or humiliated. Some don't want to leave the house out of fear they might have an accident in public. Most attempt to hide the problem for as long as possible. They withdraw from friends and family, and often limit work or education efforts. Incontinence in the elderly burdens families and is the primary reason for nursing home admissions, an already huge social and economic burden in our increasingly aged population.

In November 2002, IFFGD sponsored a consensus conference entitled, Advancing the Treatment of Fecal and Urinary Incontinence Through Research: Trial Design, Outcome Measures, and Research Priorities. Among other outcomes, the conference resulted in six key research recommendations including more comprehensive identification of quality of life issues; improved diagnostic tests for affecting management strategies and treatment outcomes; development of new drug treatment compounds; development of strategies for primary prevention of fecal incontinence associated with childbirth; and attention to the process of stigmatization as it applies to the experience of individuals with fecal incontinence.

In December 2007, IFFGD collaborated with NIDDK, NICHD, and OMAR on the NIH State-of-the-Science Conference on the Prevention of Fecal and Urinary Incontinence in Adults. The goal of this conference was to assess the state-of-the-science and outline future priorities for research on both fecal and urinary incontinence; including, the prevalence and incidence of fecal and urinary incontinence, risk factors and potential prevention, pathophysiology, economic and quality of life impact, current tools available to measure symptom severity and burden, and the effectiveness of both short and long term treatment. For fiscal year 2010, IFFGD urges Congress to review the Conference's Report and provide NIH with the resources necessary to effectively implement the report's recommendations.

GASTROESOPHAGEAL REFLUX DISEASE (GERD)

Gastroesophageal reflux disease, or GERD, is a common disorder affecting both adults and children, which results from the back-flow of acidic stomach contents into the esophagus. GERD is often accompanied by persistent symptoms, such as chronic heartburn and regurgitation of acid. Sometimes there are no apparent symptoms, and the presence of GERD is revealed when complications become evident. One uncommon but serious complication is Barrett's esophagus, a potentially precancerous condition associated with esophageal cancer. Symptoms of GERD vary from person to person. The majority of people with GERD have mild symptoms,

with no visible evidence of tissue damage and little risk of developing complications. There are several treatment options available for individuals suffering from GERD. Nonetheless, treatment response varies from person to person, is not always effective, and long-term medication use and surgery expose individuals to risks of side-effects or complications.

Gastroesophageal reflux (GER) affects as many as one-third of all full term infants born in America each year. GER results from an immature upper gastrointestinal motor development. The prevalence of GER is increased in premature infants. Many infants require medical therapy in order for their symptoms to be controlled. Up to 25 percent of older children and adolescents will have GER or GERD due to lower esophageal sphincter dysfunction. In this population, the natural history of GER is similar to that of adult patients, in whom GER tends to be persistent and may require long-term treatment.

GASTROPARESIS

Gastroparesis, or delayed gastric emptying, refers to a stomach that empties slowly. Gastroparesis is characterized by symptoms from the delayed emptying of food, namely: bloating, nausea, vomiting, or feeling full after eating only a small amount of food. Gastroparesis can occur as a result of several conditions, including being present in 30 percent to 50 percent of patients with diabetes mellitus. A person with diabetic gastroparesis may have episodes of high and low blood sugar levels due to the unpredictable emptying of food from the stomach, leading to diabetic complications. Other causes of gastroparesis include Parkinson's disease and some medications, especially narcotic pain medications. In many patients the cause of the gastroparesis cannot be found and the disorder is termed idiopathic gastroparesis. Over the last several years, as more is being found out about gastroparesis, it has become clear this condition affects many people and the condition can cause a wide range of symptom severity.

CYCLIC VOMITING SYNDROME

Cyclic vomiting syndrome (CVS) is a disorder with recurrent episodes of severe nausea and vomiting interspersed with symptom-free periods. The periods of intense, persistent nausea, vomiting, and other symptoms (abdominal pain, prostration, and lethargy) lasts hours to days. Previously thought to occur primarily in pediatric populations, it is increasingly understood that this crippling syndrome can occur in a variety of age groups including adults. Patients with these symptoms often go for years without correct diagnosis. The condition leads to significant time lost from school and from work, as well as substantial medical morbidity. The cause of CVS is not known. Better understanding, through research, of mechanisms that underlie upper gastrointestinal function and motility involved in sensations of nausea, vomiting and abdominal pain is needed to help identify at risk individuals and develop more effective treatment strategies.

SUPPORT FOR CRITICAL RESEARCH

IFFGD urges Congress to provide the necessary funding for the expansion of the research activities at NIDDK and the Office of Research on Women's Health (ORWH) regarding functional gastrointestinal disorders and motility disorders. Additional funding will allow necessary growth of the research portfolios on functional gastrointestinal disorders and motility disorders at NIDDK and ORWH, and also facilitate implementation of the NCDD's research recommendations.

Recent years of near level-funding at NIH have negatively impacted the mission of its Institutes and Centers. For this reason, IFFGD applauds initiatives like Senator Arlen Specter's (R-PA) successful effort to provide NIH with $10.4 billion in stimulus funds. IFFGD urges this subcommittee to show strong leadership in pursuing substantial funding increase through the regular appropriations process in fiscal year 2010.

For fiscal year 2010, IFFGD recommends a funding increase of at least 7 percent for NIH and its Institutes and Centers.

PREPARED STATEMENT OF THE INTERNATIONAL MYELOMA FOUNDATION

The International Myeloma Foundation (IMF) appreciates the opportunity to submit written comments for the record regarding fiscal year 2010 funding for myeloma cancer programs. The IMF is the oldest and largest myeloma foundation dedicated to improving the quality of life of myeloma patients while working toward prevention and a cure.

To ensure that myeloma patients have access to the comprehensive, quality care they need and deserve, the IMF advocates on-going and significant Federal funding for myeloma research and its application. The IMF stands ready to work with policymakers to advance policies and programs that work toward prevention and a cure for myeloma and for all other forms of cancer.

MYELOMA BACKGROUND

Myeloma is a cancer in the bone marrow affecting production of red cells, white cells, and stem cells. It is also called "multiple myeloma," because multiple areas of bone marrow may be involved. Myeloma is the second most common blood cancer after lymphomas, affecting an estimated 750,000 people worldwide and its prevalence appears to be is increasing significantly.

No one knows the exact causes of myeloma. Doctors can seldom explain why one person develops this disease and another does not. Research has shown that people with certain risk factors such as age and race are more likely than others to develop myeloma. Growing older increases the chance of developing multiple myeloma as most people with myeloma are diagnosed after age 65. However, in recent years the diagnosis of myeloma in people 40 years of age and younger appears to have become more common as our ability to detect and diagnose this disease has improved. The risk of myeloma is highest among African Americans and lowest among Asian Americans.

Scientists are studying other possible risk factors for myeloma. Toxic chemicals (for example, agricultural chemicals and Agent Orange used in Vietnam), radiation (including atomic radiation), and several viruses (including HIV, hepatitis, herpes virus 8, and others) are associated with an increased risk of myeloma and related diseases.

According to the American Cancer Society, 19,920 Americans were expected to be diagnosed with myeloma and 10,690 would lose their battle with this disease in 2008. Even while they live with the disease, myeloma patients can suffer debilitating fractures and other bone disorders, severe side effects of their treatment, and other problems that profoundly affect their quality of life, and significantly impact the cost of their healthcare. Despite these grim statistics, significant gains in the battle against myeloma have been made through our Nation's investment in cancer research and its application. Research holds the key to improved myeloma prevention, early detection, diagnosis, and treatment, but such breakthroughs are meaningless unless we can deliver them to all Americans in need.

SUSTAIN AND SEIZE CANCER RESEARCH OPPORTUNITIES

Our Nation has benefited immensely from past Federal investment in biomedical research at the National Institutes of Health (NIH). The IMF advocates $33.3 billion for NIH in fiscal year 2010. This will allow NIH to sustain and build on its research progress resulting from the recent doubling of its budget while avoiding the severe disruption to that progress that would result from a minimal increase. Myeloma research is producing extraordinary breakthroughs—leading to new therapies that translate into longer survival and improved quality of life for myeloma patients. Although myeloma was once considered a death sentence with limited options for treatment, myeloma is an example of the progress that can be made and the work that still lies ahead in the war on cancer. Many myeloma patients are living proof of what innovative drug development and clinical research can achieve—sequential remissions, long-term survival and good quality of life. But these achievements are not a substitute for a cure and therefore the IMF calls upon Congress to allocate $6 billion to the National Cancer Institute in fiscal year 2010 to continue our battle against myeloma and its sequelae.

BOOST OUR NATION'S INVESTMENT IN MYELOMA PREVENTION, EARLY DETECTION, AND AWARENESS

As the Nation's leading prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in translating and delivering at the community level what is learned from research. Therefore, the IMF joins with our partners in the cancer community—including One Voice Against Cancer—in calling on Congress to provide additional resources for the CDC to support and expand much-needed and proven efforts in such areas as cancer prevention, early detection, and risk reduction. Specifically, the IMF advocates the appropriation of $471 million in fiscal year 2010 for CDC's cancer prevention and control initiatives.

Within that allocation, the IMF specifically advocates $6 million for the Geraldine Ferraro Blood Cancer Program. Authorized under the Hematological Cancer Re-

search Investment and Education Act of 2002, this program was created to provide public and patient education about blood cancers, including myeloma.

With grants from the Geraldine Ferraro Blood Cancer Program, the IMF has successfully promoted awareness of myeloma, particularly in the African-American community and other underserved communities. IMF accomplishments include the production and distribution of more than 4,500 copies of an informative video which addresses the importance of myeloma awareness and education in the African-American community to churches, community centers, inner-city hospitals, and Urban League offices around the country, increased African-American attendance at IMF Patient and Family Seminars (these seminars provide invaluable treatment information to newly diagnosed myeloma patients), increased calls by African-American myeloma patients, family members, and caregivers to the IMF myeloma hotline, and the establishment of additional support groups in inner city locations in the United States to assist underserved areas with myeloma education and awareness campaigns. Furthermore, the more than 90 IMF-affiliated patient support groups in the United States also made this effort their main goal during "Myeloma Awareness Week" in October 2005.

An allocation of $6 million in fiscal year 2010 will allow this important program to continue to provide patients—including those populations at highest risk of developing myeloma—with educational, disease management and survivorship resources to enhance treatment and prognosis.

CONCLUSION

The IMF stands ready to work with policymakers to advance policies and support programs that work toward prevention and a cure for myeloma. Thank you for this opportunity to discuss the fiscal year 2010 funding levels necessary to ensure that our Nation continues to make gains in the fight against myeloma.

PREPARED STATEMENT OF THE JEFFREY MODELL FOUNDATION

Thank you for the opportunity to present to you our testimony concerning the activities of the Jeffrey Modell Foundation (JMF) dedicated to Primary Immunodeficiency (PI). As you know, most of our programs are conducted in partnership with various governmental agencies under the jurisdiction of this subcommittee. We very much appreciate the support, generosity, and kindness of spirit that we have received from the members and staff of this subcommittee and look forward to continuing to work together closely in the future.

As a baseline, Mr. Chairman, please let me make clear the following four fundamental points:

—JMF programs always include our own investment of funds and resources, thereby assuring accountability.
—JMF programs improve patients' quality of life issues through prevention and earliest possible diagnosis.
—JMF programs, therefore, lower healthcare costs.
—JMF programs save lives as demonstrated in the 2008 Wisconsin newborn screening program.

All of the data concerning the impact of the education and awareness program that this subcommittee has long supported has been published in a leading scientific journal, "Immunologic Research", Humana Press, January 13, 2009 and is entitled, "From Genotype to Phenotype. Further Studies Measuring the Impact of a Physician Education and Public Awareness Campaign on Early Diagnosis and Management of Primary Immunodeficiencies".

PHYSICIAN EDUCATION AND PUBLIC AWARENESS CAMPAIGN ON PRIMARY IMMUNODEFICIENCIES

Five years ago, Mr. Chairman, this subcommittee set us on a path to work with the Centers for Disease Control and Prevention (CDC) to create a physician education and public awareness program. Today, that program has far exceeded even our most optimistic dreams.

JMF has now generated more than $100 million in donated media from television, radio, print, Web site, airport, and mall dioramas. This translates to more than $18 million annually and represents $7 donated to support this campaign for every $1 of Government support appropriated by this subcommittee. But all that visibility would be meaningless if there were not real impact on the health of these patients. And, there are.

The number of patients referred, tested, diagnosed, and treated has more than doubled every year for the past 5 years in which the campaign has been conducted.

The Jeffrey Modell Centers Network of Research, Diagnostic and Referral Centers now include 304 physicians, from 138 academic teaching hospitals and medical schools. Twenty-three of the 30 "Best Pediatric Hospitals" in the United States are designated Jeffrey Modell Centers. The physician-experts at these centers have provided JMF with data on more then 30,000 patients. And we can now pinpoint the specific disease, where the patient is treated, who is treating the patient, and how the patient is treated. This data can make an enormous contribution to registries not only in the United States, but on a global platform.

After diagnosis and treatment, physicians reported annual decreases of more than 70 percent in the number of severe infections, physician, hospital, and emergency room visits, pneumonias, school/work days missed, days in hospital, acute infections, and days with chronic infections.

The consequences of these changes in patient outcomes were assigned economic values. JMF's published study drew from the hospital accounting reports at the Centers for Medicare and Medicaid services. The specific hospital charges and length of stay data was obtained from the Hospital Cost and Utilization Project, Nationwide In-patient Sample, under the auspices of the Agency for Healthcare Research and Quality.

The study showed that each undiagnosed patient costs the healthcare system $102,736 annually in emergency room visits, hospitalizations, and medical treatment for severe complications. It costs $22,696 annually to treat patients after they have been diagnosed-a savings of more than $80,000 per patient per year.

The National Institutes of Helath (NIH) states that "while individual primary immunodeficiency diseases are somewhat rare, affecting 500,000 Americans, this group of diseases may affect 1–2 percent of the U.S. population or 3 million–6 million Americans." Using the most conservative estimate, the minimum cost to the U.S. healthcare system for undiagnosed PI patients is more than $40 billion annually. Ensuring that these patients are properly diagnosed makes enormous economic sense, not to mention their improved quality of life.

RESEARCH COLLABORATION WITH NIH

JMF established a $12 million research partnership with four of the U.S. National Institutes of Health. The RO1 research grants solicit investigations on Primary Immunodeficiency (PI) diseases. JMF also established the Robert A. Good/Jeffrey Modell International Fellowship Program, funding the brightest young investigators from around the world, focused on PI and stem cell transplantation. JMF awarded 4 Fellowships in 2008 under this program.

Finally, in 2008, JMF established Endowed Chairs in Pediatric Immunology Research at Children's Hospital Boston, Children's Hospital Seattle, as well as the Jeffrey Modell Endowed Fellowship in Immunology Research at the University of Washington.

NEWBORN SCREENING FOR PRIMARY IMMUNODEFICIENCIES

JMF and the State of Wisconsin launched the first newborn screening program for Severe Combined Immune Deficiency. Since January 2008, every baby born in the State of Wisconsin has been screened. The T Cell Receptor Excision Circles assay was utilized and the screening test identified a patient with a combined immunodeficiency disease. The baby received a life-saving bone marrow transplant. The screening protocol has picked up several other newborns with life threatening disorders including Complete Di George Syndrome, T-Cell lymphopenia, and a disorder where white blood cells are unable to migrate to sites of infection. We anticipate that Massachusetts, Illinois, Connecticut, Texas, and New York will move forward with pilot programs in 2009.

At this date, the cost to screen for these life threatening diseases is $5 per child. It is anticipated that this cost will decrease. There are approximately 4 million newborns per year in the United States. Thus, the outside cost to screen every newborn in the United States is estimated to be less than $20 million.

SPIRIT—SOFTWARE FOR PRIMARY IMMUNODEFICIENCY RECOGNITION INTERVENTION AND TRACKING

JMF brought its 2008 data to the annual meeting of the Managed Care Network (MCN). Senior executives and medical directors of private and Medicare/Medicaid health plans nationwide, as well as the leadership of pharmacy groups representing more than 150 million covered lives, attended the 2-day meeting. JMF was asked to develop an early warning system software program matching the ICD–9 codes to

the 10 Warning Signs and Physician Algorithm. This software, known as SPIRIT, is now in development and will be piloted with National managed care carriers during 2009. The software protocol is being developed by JMF and its Medical Advisory Board, and the technology will be produced by Xcenda, a division of AmeriSource Bergen Corporation. Besides the listing of the ICD–9 codes, the program assigns relative weights for each code, identifies each code as a chronic or acute condition, and provides specific exclusion criteria.

SUMMARY

Mr. Chairman, I hope you will agree that the many programs run by the Jeffrey Modell Foundation are a "perfect fit" with the announced approach to reforming healthcare articulated by the President and currently being addressed by this Congress. Specifically we have focused our attention on:

—Prevention through physician education and public awareness;
—Quality of care through the JMF Network of specialized centers;
—Control of healthcare costs through early diagnosis and Newborn Screening; and
—Use of technology to streamline records and generate electronic data though new software developed by JMF for third-party payers.

For fiscal year 2010, we bring you what we consider to be a very modest agenda:

—We ask for no new appropriations or programs from the subcommittee.
—We ask for continuation of the successful programs that we are now operating.
—We ask for Government encouragement and support for these programs.

In exchange, we can assure you that we will continue to contribute our own funds to every program with which we are involved. We will continue to operate these programs by fully exercising good management and ever-cognizant of our responsibilities to this subcommittee and to the taxpayers who have supplied the funds that you pass on to us.

Mr. Chairman, we are at a critical time in our Nation's healthcare history. JMF is proud of the contributions we have made to the healthcare system and look forward to continuing to work with you and with all members of Congress to continue to serve the American people.

PREPARED STATEMENT OF THE MENTOR CONSULTING GROUP

"It must not for a moment be forgotten that the core of any social plan must be the child."

President Franklin Roosevelt
U.S. Committee on Economic Security, Report to the President, 1935

Senator Harkin and distinguished members of the subcommittee: Mentor Consulting Group (MCG) is pleased to submit testimony for the outside witness record to ask the subcommittee to direct its attention to the President's fiscal year 2010 proposed budget recommendation calling for the elimination of the U.S. Department of Education's (ED) mentoring program. MCG is seeking your help in restoring the funding for this important and much needed program to enable agencies from Storm Lake, Iowa, to McAllen, Texas, from Rhinelander, Wisconsin to Starkville, Mississippi, to continue supporting match relationships for a third year.

It is our understanding that the cost of restoring the third year of funding for 2008 mentoring program grantees is estimated at $17 million.

Mentoring is fundamentally predicated on creating healthy and meaningful relationships for youngsters who are in jeopardized circumstances with respect to their potential for achieving long-term educational and socio-emotional success. Research demonstrates that youth who successfully transition from risk-filled backgrounds to responsible adulthood are consistently distinguished by the presence of a caring adult in their lives. Prematurely ending matches, such as those that have been recently established through the mentoring program grants, can be potentially harmful to mentees. MCG strongly urges the subcommittee to prevent this possibility from turning into a tragic reality for thousands of vulnerable children.

The ED mentoring program, authorized under the No Child Left Behind Act (NCLB) of 2002, section 4130, is a competitive Federal grant program managed by the Office of Safe and Drug Free Schools (OSDFS). It addresses the lack of supportive adults at critical turning points in the lives of youngsters in grades 4–8. The funding supports mentoring programs operating in local education agencies (LEAs); nonprofit community- and faith-based organizations; and partnerships between LEAs and local nonprofits. Funded programs are designed to:

—improve interpersonal relationships with peers, teachers, family members, and other adults;
—increase personal responsibility and community involvement;
—discourage the use of drugs and alcohol;
—discourage the use of weapons;
—reduce delinquency;
—improve academic achievement; and,
—reduce school dropout.

Since 2004, MCG has worked on-site with 57 ED mentoring program grantees serving in the capacity of overall technical assistance provider, e.g., mentor/mentee training, mentor recruitment, marketing, sustainability planning, and/or as the external evaluator. Our client sample is rich with diversity both with respect to the size and scope of their grants, e.g., we work with the agency receiving the smallest of the 2008 awards, as well as their experience in operating a formal mentoring program. Another of our clients, also a 2008 grantee, is among the 30 largest school districts in Texas and is working with 17 partnering school campuses. This grantee exceeded their 1 to 1 match goal of 150 matches before the end of the first year of the grant. The potential impact on 150 youngsters, in this one community alone, should this program be eliminated, is unimaginable.

A key "lesson learned" based on our experience with all of these clients is that the complexities of operating a mentoring program cannot be overstated. Building safe and secure relationships between youngsters and caring adults requires the attention and involvement of trained, committed, and competent staff who understand the quality assurance standards of the mentoring field.

Beyond the potential benefits for the youth, the ED mentoring program has enabled grantees to forge strategic community partnerships between concerned citizens and multiple youth serving organizations to maximize the use of community resources. Also negatively affected by this proposed termination of funds is those staff hired to work with the ED mentoring program who have worked diligently over the past 13 months to introduce and promote these programs in their community and to build these vital new mentor/mentee relationships. Premature termination of this grant program would, of course, force layoffs in 110 communities across the country. By contrast, the economic stimulus package is working hard to counter just such layoffs.

Research over the past decade has demonstrated that mentoring is a viable intervention strategy that holds considerable promise. Studies of structured mentoring programs, including those that have received Federal funding, suggest that the programs are likely to be more successful when they include a strong infrastructure and facilitate caring relationships. Infrastructure refers to a number of activities including identifying the youth population to be served and the activities to be undertaken, screening and training mentors, supporting and supervising mentoring relationships, collecting data on youth outcomes, and creating strategies for long-term sustainability. (Ref. Jean Balwin Grossman, ed., Contemporary Issues in Mentoring, Public/Private Ventures, p.6). The ED mentoring program is providing much needed funding to ensure the integrity of the requisite infrastructure and facilitation of caring relationships in programs that would otherwise be severely marginalized.

Another signal research finding is that mentoring relationships are likely to promote positive outcomes for youth and avoid harm when they are close, consistent, and enduring. (Ref. Rhodes and DuBois, "Understanding and Facilitating the Youth Mentoring Movement," p. 9). Closeness is the bond that is created between the youth and mentor. The characteristics of the volunteer mentors (no mentors in ED mentoring program matches are able to be remunerated) have also proven to be important in shaping the relationships and strengthening the bond. For example, individuals with prior experience in helping roles or occupations, an ability to understand and respect cultural differences, and an overall sense of commitment to mentoring all appear to contribute positively to the relationship and overall match quality. Further, it appears that relationships may be especially beneficial when they remain part of the youth's life for multiple years (Klaw, Fitzgerald & Rhodes, 2003: McLearn et al., 1998) and have the opportunity to facilitate adaptation throughout significant portions of their development (DuBois & Silverthorn, 2005b; Werner, 1995). These findings are of particular importance to the 4th through 8th grade population served by the ED mentoring program.

The ED mentoring program garnered national attention recently following publication of the Impact Evaluation of the U.S. Department of Education's Student Mentoring Program report prepared by Abt Associates for the Institute of Education Sciences (March 2009). ED contracted with Abt in 2005 to conduct the study which used an experimental design in which students were randomly assigned to a treatment or control group. The study involved 32 ED Mentoring Program grantee sites

that were funded beginning in 2004 or 2005. Grantees selected for participation in the Impact Study were required to meet three criteria:

—Be operational so that it could recruit and match students to mentors in the fall of 2005 for the first group of grantees and fall 2006 for the second group;

—Able to oversubscribe or identify excess demand supporting experimental study needs for an unserved control group (i.e., able to provide tangible evidence of a pool of 4th through 8th grade students referred to the mentoring program) of adequate size to support study requirements; and

—Willing and able to cooperate with the data collection and logistical needs of the national evaluation, including random assignment.

While the findings of the impact evaluation study are indeed mixed, MCG is encouraged that this study has captured several of the inherent challenges that often confront early cohorts of federally funded mentoring initiatives. This study contributes to the growing body of research evidence, however, the field warrants additional comparative evaluation studies that look at different program models. Each and every cohort of a federally funded initiative should be evaluated and this study helps to make that very point. More recently funded ED mentoring program grantees, including those in 2008, have had the benefit of an expanded comprehensive technical assistance package that includes conference trainings, webinars, resource materials (available online), and site visits designed to help program coordinators with all aspects of program implementation, data tracking, and operation. In addition, grantees are now trained on specific aspects of program sustainability.

In closing, we would like to share with you a comment from a mentee who met with us during a recent site visit. When asked what having a mentor meant to him, Isaiah, a fourth grade student replied, "Having a mentor has been the best thing that has happened to me in my whole life."

MCG fully acknowledges and appreciates the widespread economic and social challenges facing our country at this time. However, reinstatement of the ED mentoring program funding in the 2010 budget is a clarion call for moral policymaking.

That call is befitting of your role as members of this august body and will ensure that youngsters like Isaiah will one day achieve their full potential and enjoy their opportunity to sit as a distinguished member of Congress.

Thank you for the opportunity to submit this testimony.

PREPARED STATEMENT OF THE MONTGOMERY COUNTY STROKE ASSOCIATION

I am Flora Ingenhousz, a psychotherapist in private practice in Silver Spring, Maryland. I have always been in excellent health and live an active, healthy lifestyle. Doctors always commented on my low blood pressure and my excellent cholesterol numbers. But I suffered a stroke 3 years ago. It was a shock to me and my family, friends, and clients.

One morning 3 years ago, when doing a load of laundry, I had no idea how to set the dials, despite the fact that I had used them weekly for the last 10 years. I stood there for what seemed an eternity before I figured out how to set the dials.

Next, I went to do yoga. In one of the poses, I noticed my right arm was hanging limp. When my husband asked me a question, my answer was just the opposite of what I wanted to say. I caught my error and tried again, but it soon became clear that something was wrong. My symptoms kept getting worse.

When we walked into the emergency room (ER), my right leg was weak, and I could not sign my name at the desk. Twelve hours later, I could not move my right side, and my speech was reduced to "yes" and "no". Not a good thing for a psychotherapist, where language is a primary tool.

In the emergency room, a CT scan showed a hemorrhagic or bleeding stroke where an artery burst, destroying millions of brain cells within minutes, affecting my speech and my ability to perform activities like dressing in the correct order. Also, my right arm and leg were extremely weak. However, I could understand everything, and I was never completely paralyzed. But, I was scared.

I was in intensive care for 4 days of observation and lots of testing, but the tests provided no answers. Two days after my stroke, while still in intensive care, I started occupational, physical, and speech therapy. It was extremely challenging to feed myself with my right hand, requiring all my concentration. After a meal or brushing my teeth, I was exhausted. Speaking was the hardest of all. My brain seemed devoid of words.

After being stabilized, I was transferred to the National Rehabilitation Hospital. For a week, I endured speech, physical, occupational and recreational therapies.

Speech therapy was the hardest, but also the most important given my profession. Several times, the speech therapist challenged me to the brink of tears.

After a week at the Rehabilitation Hospital, I went home and to outpatient therapies. Speech therapy lasted the longest. After being discharged from speech therapy, I still had deficits in my organizational skills and abstract thinking.

As I struggled with starting to see my clients again, I slid into a deep depression. I was not confident that I could continue to practice. For months, I saw no point in living. Recovery from my poststroke depression was harder than the recovery of my arms and legs and even speech.

Being a psychotherapist, I know how to treat depression, so I went to a psychiatrist who prescribed anti-depressant medication and, I also found a psychotherapist.

After months on anti-depressants and excellent psychotherapy, my depression began to lift. I continue on the drugs and to see my psychotherapist. Emotionally, the aftermath of my stroke cut deep.

I am fortunate that 3 years poststroke, I am back to my practice full time. I lead support groups for stroke survivors and caregivers through the Montgomery County Stroke Association and served on its Board. I now lecture on stroke, stroke prevention and stroke recovery. I founded "hope for stroke"—individual and family counseling for stroke survivors and caregivers. And I have developed, together with a colleague, a seminar for professionals in the stroke field on the role of mental health providers in stroke recovery. In addition, I have participated in a National Institutes of Health (NIH) study about stroke recovery.

Once again, I am in excellent health and have resumed my active lifestyle. I thank my brain for having the capacity to work around the dead cells. But most of all, I thank my therapists for my recovery. Their ability to zero in so effectively would not have been possible without NIH research.

Because stroke is a leading cause of death and disability and major cost to society, I urge you to provide stroke research with a significant funding increase. I am concerned that NIH continues to invest only 1 percent of its budget in stroke research.

Thank you.

PREPARED STATEMENT OF MENTOR

Chairman Harkin and Ranking Member Cochran, we thank you for the opportunity on behalf of MENTOR to submit written testimony in support of resources for youth mentoring.

Primarily, this includes $100 million in Federal funding for youth mentoring—$50 million for the Department of Health and Human Services' Mentoring for Children of Prisoners program and $50 million for the Department of Education's Mentoring Programs grants. MENTOR has appreciated the support of the subcommittee in previous years, in funding these programs at these levels since fiscal year 2004.

Mentoring has been recognized as an important form of service by the Obama administration and the 111th Congress, given its inclusion in several portions of the recently signed Edward M. Kennedy Serve America Act. The act, in its wide-ranging call to significantly increase service opportunities, will also augment the pool of volunteers who can become mentors to young people.

We would like to appeal that the Serve America Act be fully funded in fiscal year 2010 to ensure that this historical boost in national and community service is allowed to occur. We also are recommending that Congress continue to provide $50 million each for the U.S. Department of Education Mentoring Programs grants and the U.S. Department of Health and Human Services' Mentoring for Children of Prisoners program.

Background on MENTOR and Youth Mentoring.—MENTOR is the Nation's leading advocate and resource for mentoring, delivering the research, policy recommendations, advocacy, and practical performance tools that facilitate the expansion of mentoring initiatives. We believe that, with the help and guidance of an adult mentor, each child can unlock his or her potential.

For nearly two decades, MENTOR has worked to expand the world of quality mentoring. In cooperation with a national network of Mentoring Partnerships and with more than 4,100 mentoring programs nationwide, MENTOR helps connect young Americans who want and need caring adults in their lives with the power of mentoring.

We build the infrastructure that enables mentoring programs to flourish, and we leverage resources and provide tools that local mentoring programs need to operate high-quality mentoring. We also assist mentoring programs nationwide in building greater awareness of the need for mentors, and raising the profile of mentoring among corporate leaders, foundation executives, policymakers and researchers.

Three million young people are currently benefiting from the guidance of caring adult mentors under our system. And through the combined efforts of the mentoring

field, we seek to close the mentoring gap so that the 15 million children who currently need mentors also can benefit from caring mentors.

It is on behalf of these 4,100 mentoring programs, the national network of mentoring partnerships and 15 million children who need mentors all across our country that we submit this testimony today.

Benefits of Mentoring.—Youth mentoring is a simple, yet powerful concept: an adult provides guidance, support and encouragement to help a young person achieve success in life. Mentors serve as role models, advocates, friends and advisors.

Mentoring today offers many options—the traditional one-to-one format, team and group mentoring, peer mentoring, and even online mentoring. And mentoring programs are run by nonprofit community-based organizations, schools, faith-based organizations, local government agencies, workplaces, and more.

Numerous program evaluations have demonstrated that high-quality mentoring relationships can lead to a range of positive outcomes. A meta-analysis of 55 mentoring program evaluations found benefits of participation in the areas of emotional/psychological well-being, involvement in problem/high-risk behavior and academic outcomes. Looking at a broader range of outcomes, conducted a meta-analysis of 40 youth mentoring evaluations, and found that youth in mentoring relationships fared significantly better than nonmentored youth. Likewise, a recent, large randomized evaluation of Big Brothers Big Sisters of America's newer, school-based mentoring revealed improvements in mentored youth's academic performance, perceived scholastic efficacy, school misconduct, and attendance relative to a control group of nonmentored youth. In short, mentoring is an effective strategy that addresses both the academic and nonacademic needs of struggling young people. It can help ensure that students come to school and are ready and able to learn.

HIGH-QUALITY MENTORING GENERATES THE STRONGEST IMPACT

Like any youth-development strategy, mentoring works best when measures are taken to ensure quality and effectiveness. Money, personnel and resources are required to initiate and support quality mentoring relationships. The average per-child expenditure for a mentoring match that adheres to The Elements of Effective Mentoring Practice™—the mentoring industry standard—is between $1,000 and $1,500 per year, depending on the program model.

Successful mentoring programs must have well-trained staff familiar with the needs of the community. One-third of mentoring programs indicate that hiring and retaining quality staff can be a challenge due to low salaries. A recruitment campaign must be conducted to attract volunteers, as many programs have young people on their waiting lists for mentors.

Program staff must interview each potential volunteer, check references, and perform criminal background checks. Thorough background checks alone can cost as much as $50–$90 per volunteer. Once the screening process is complete, each mentor must receive first-rate training before being matched with a mentee. The work of the mentoring program does not end with the first meeting of the mentor and young person—both require ongoing support, monitoring, and guidance.

All of these elements are critical because research clearly links program quality with positive outcomes. According to Dr. Jean Rhodes, professor of psychology at University of Massachusetts at Boston, careful screening, training and ongoing support are essential to the longevity of mentoring relationships and to the ultimate success of mentoring relationships.

Rhodes also found that the longer a mentoring relationship lasts, the greater the positive, long-lasting effect it has on a young person. Other researchers in the field have substantiated her findings. In essence, when properly prepared and supported, a mentor is more likely to connect with the young person and to stick with the relationship when times get hard.

Need for Federal Dollars.—The mentoring field needs continued access to Federal funds if we are to be able to serve more children, and serve them well. Once again, America has a wide mentoring gap of nearly 15 million young people. The demand for mentoring far exceeds the current capacity of local mentoring programs and the number of adults who volunteer as mentors, and thousands of children sit on waiting lists for mentors. As noted above, it takes financial resources to be able to adhere to mentoring best practices and provide quality mentoring experiences to young people.

Since fiscal year 2004, Congress has devoted approximately $100 million annually for youth mentoring, split evenly between two critical grant programs:

—*Department of Education, Mentoring Programs Grants*.—These grants go to local mentoring organizations to establish or expand their mentoring program. It can support recruiting, screening, and training of mentors, as well as hiring

and professional development of mentoring coordinators and support staff. Community-based organizations, faith-based organizations, and schools are eligible to apply for funding.

—*Department of Health and Human Services, Mentoring for Children of Prisoners*.—This program provides funding to organizations that match mentors with young people whose parents are incarcerated. It also is open to community-based and faith-based organizations.

Both of these programs provide much-needed Federal dollars to help mentoring programs get established or to expand to serve more children. Both programs are competitive grant programs, with all funding being awarded to local organizations. The request for proposals for both programs require applicants to detail how they will be able to carry out key mentoring best practices. Since 2004, coinciding with this significant increase in Federal support, we have seen the number of young people in mentoring relationships grow from 2.5 million to the current level of 3 million. Clearly, this funding is having an impact on the mentoring gap.

President Obama stated in remarks about his fiscal year 2010 budget February 26, 2009, "Education Secretary Duncan is set to save tens of millions of dollars more by cutting an ineffective mentoring program for students, a program whose mission is being carried out by 100 other programs in 13 other agencies." Once again, we are not certain that this means the total elimination of school-based mentoring programs in the Department of Education, but even in the absence of a detailed budget justification, we feel that comment is warranted.

We understand that this decision may rest in large part on a recent evaluation that showed that school-based mentoring, as practiced by many programs around the country, failed to increase grades or test scores. However, just 2 years ago, another rigorous evaluation of school-based mentoring found that teachers reported the quality of the mentored students' school work improved.

To understand these apparently contradictory findings, it is important to note that the earlier evaluation answered the question, "What effect does a well-run, school-based mentoring program have?" The more recent evaluation answered the question, "What effect does the average school-based mentoring program have?" Findings from both studies reveal that strong programs can improve academic performance, while programs that do not incorporate best practices cannot. Interestingly, both types of programs have increased attendance.

School-based mentoring was never designed to be a program that primarily improved academic achievement. Mentoring aims more broadly to keep children on a constructive, responsible path (such as encouraging behaviors like coming to school and following the rules). Mentors are not supposed to be teachers, but friends and role models. Even so, the earlier evaluation did show that well-run programs improved academic performance and behavior by the end of the school year.

Mentoring addresses a particular challenge facing our Nation today: the high rate at which young people drop out of high school. Nearly one-third of all high school students drop out before receiving their diploma, a rate which approaches 50 percent for minority students. Research on the dropout rate shows that young people can fail to graduate for a wide variety of reasons, including: lack of connection to the school environment, lack of motivation or inspiration, chronic absenteeism, lack of parental involvement, personal reasons such as teen pregnancy, and failing in school.

We know that young people who drop out will face a future of unemployment, Government assistance, and even criminal involvement. We need to help these young people before they reach the point of dropping out of high school. Fortunately, youth mentoring can play in important role in addressing the issues young people face within the learning environment. Research demonstrates that many of the impacts of mentoring can directly address the underlying causes of our Nation's dropout crisis. Specific impacts of mentoring include:

—Mentored youth feel greater competence in completing their schoolwork, which is linked to higher levels of classroom engagement and higher grades.

—School-based mentoring enhances connectedness to schools, peers and society, and mentored youth have more positive attitudes toward school and teachers;

—Evaluations of mentoring programs indicated that both one-to-one mentoring and group mentoring result in better school attendance for mentored youth;

—Mentored youth experience improvements in parental relationships and their own sense of self-worth; and

—Mentored youth are significantly less likely to participate in high-risk behaviors, including substance abuse, carrying a weapon, unsafe sex, and violent behaviors.

Mentoring is an important tool to help address dropout risk factors and help ensure that young people are supported in their effort to graduate from high school and make a successful transition to adulthood.

These are tough economic times that warrant tough decisions. However, rather than eliminating or cutting funding for school-based mentoring, Congress and the administration could restrict the funding to programs that truly incorporate best practices—the kind of programs that have been shown to produce results. MENTOR recommends that the request for proposals issued for the program be revisited to ensure that it focuses on the key functions mentoring programs must perform and their adherence to The Elements of Effective Mentoring Practice—research-based industry standards now in their third edition. These standards work to ensure that programs do their utmost to ensure that mentoring does, in fact, work for America's young people by providing the best mentoring experience possible. Within the Elements, Program Design and Planning includes comprehensive guidelines to launch an effective new mentoring initiative. Program Management and Program Operations contain guidelines for managing and implementing the many elements of a new program or fine-tuning certain elements for an established program. Program Evaluation provides guidance for analyzing a program to ensure it is safe, effective and able to meet its goals. It is important to ensure that funding is going to high-quality programs with real potential to make a difference, rather than dismantle a strong infrastructure for service that is now in place in thousands of American schools.

Thus, MENTOR recommends that $50 million once again be provided to the Department of Education's Mentoring Programs grants in fiscal year 2010. Some of this funding is needed to simply support commitments already made to existing grantees. All grants awarded under this program are 3-year projects and require continued appropriations. We also expect new grants to be made out of fiscal year 2009 funding, approved at $48.5 million. Those organizations that see their funding terminate early would likely have to downsize or even close. This would likely result in the premature end to hundreds—if not thousands—of mentoring relationships. Research shows that when mentoring relationships terminate unexpectedly, it can have a detrimental impact on the child.

Besides the immediate 1-year impact, the elimination of this program will mean the end of the only authorized Federal program specifically focused on providing mentors for young people at risk of failing academically—this is not a function that is duplicated in many programs more than 13 different agencies as the President mentioned in February. In the 7 years the program has been in existence, more than 600 grants have been awarded to local mentoring programs in every State, including rural, suburban, and urban settings. These grants have totaled nearly $300 million. At the average per-child mentoring cost of $1,500 per year, this means that approximately 200,000 young people are benefiting from a mentoring relationship that otherwise likely would not have been possible.

To conclude this portion of my testimony, we respectfully request that Congress provide $50 million each for the Department of Education Mentoring Programs grants and the Department of Health and Human Services Mentoring Children of Prisoners program.

The Call to Fund Service.—MENTOR joined the strong ranks of community organizations delighted when the Edward M. Kennedy Serve America Act became law last week. With significant, bi-partisan support, this legislation provides for the largest expansion of national and community service since the 1930s and expands major initiatives, such as AmeriCorps and the Retired Senior Volunteer Program, which emerged during the course of the past 20 years. The legislation also includes key new provisions that recognize mentoring as an important form of national and community service and support its growth.

As enacted, the Serve America Act provides many more opportunities to support quality mentoring. For example, mentoring is an eligible activity for those engaged in the newly expanded AmeriCorps, Volunteers In Service To America (VISTA) and Retired and Senior Volunteer Programs, as well as the newly created Education Corps and Veterans' Corps. In addition, mentoring partnerships, which support the expansion of quality mentoring in many States throughout the country, are now eligible for funding through the National Service Trust Program and Volunteer Generation Fund.

Now that it is authorized, it is doubly important that the act's provisions be funded properly in fiscal year 2010 and beyond. mentoring programs and our national network of Mentoring Partnerships already rely on the tremendous contributions that AmeriCorps and VISTA volunteers make, as mentors to youth in need and staff support at those organizations. The boost in service represented by the Serve America Act would allow programs and Partnerships to make an even more meaningful

impact in our communities and help us close the gap of 15 million young people who want and need high-quality mentoring relationships.

CONCLUSION

On behalf of the thousands of mentoring programs and millions of mentored children across the country, we commend you for your past support of mentoring and national and community service funding. We strongly encourage you to continue this wise investment in our young people and in our country. Thank you for your consideration.

LETTER SUBMITTED BY MAUI FAMILY SUPPORT SERVICES

Wailuku, HI, May 12, 2009.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies, Washington, DC.

I write to express support for increased funding for the Child Abuse Prevention and Treatment Act (CAPTA) programs. We propose to increase CAPTA basic State grant funding to $84 million, community-based prevention grants funding to $80 million, and research and demonstration grants funding to $37 million in fiscal year 2010.

CAPTA's title II authorizes grants to States to help develop community-based prevention services to support families, including parenting education classes, home visiting services, respite care, as well as family resource centers to connect families and children to the services they need. While we spend billions of dollars every year on foster care to protect the children who have been the most seriously injured, we can do a much better job at protecting children before the damage is so bad that we have no other choice than to remove them from their homes. Community prevention services to at-risk families are far less costly than the damage inflicted on children from abuse and neglect. Increasing for CAPTA prevention grants to $80 million would help communities support proven, cost-effective approaches to preventing child abuse and neglect.

It is extremely important that we give the highest priority to the children of this Nation for they are the most vulnerable population that needs protection and support to grow into a well-balanced, healthy, and productive citizenry.

Thank you for your time and consideration.

AVE DIAZ,
Healthy Start Home Visiting Supervisor.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF ANOREXIA NERVOSA AND ASSOCIATED DISORDERS

Founded in 1976, the National Association of Anorexia Nervosa and Associated Disorders (ANAD) is our Nation's first nonprofit organization dedicated to education, early detection, and prevention of anorexia nervosa, bulimia nervosa, binge eating disorder, obesity, and related eating disorders.

Eating disorders are severe mental illnesses which often have significant physical health consequences for their victims, including malnutrition, obesity, and diabetes, as well as death due to cardiac arrest, organ failure, blood imbalances, and suicide. Anorexia nervosa has the highest mortality rate of any mental illness. An estimated 6 percent of those who have the disease die as a result. These disorders also frequently lead to or co-occur with other serious illnesses such as severe depression, alcoholism, and drug abuse.

Eating disorders are at epidemic levels in America. An estimated 7 million women and 1 million men have eating disorders. These illnesses affect all segments of society—the young and old, the rich and poor, and all races and ethnicities, including African Americans, Asian Americans, Latino Americans, and Native Americans. But this is an epidemic that can be averted with education and prevention programs, and cured with early diagnosis and appropriate treatment.

Data from an ANAD survey of 18 middle and high schools in 15 States indicates that eating disorders are almost as prevalent as alcohol or drug problems among female middle school and high school students. The survey also indicates that our schools are spending far less time on eating disorder prevention than on alcohol or drug prevention programs. Seventeen percent of the schools surveyed spent 1 hour

per year on eating disorder education. Eleven percent of the schools surveyed had no eating disorder prevention program of any kind.

The failure to fund eating disorder education and prevention in schools is especially troubling in light of the fact that eating disorders are often accompanied by or lead to alcoholism or drug addiction, as well as diabetes, severe depression, and suicide.

Tens of millions of dollars are spent each year at the local, State, and Federal levels to ensure that our children are properly educated to the dangers of alcohol and drugs. The value of such programs has been proven and accepted in schools throughout the country. With eating disorders almost as prevalent as alcohol and drug abuse in our schools, it is imperative that we provide more support for eating disorder prevention efforts in our middle schools and high schools. Millions of our youth can benefit from proven, low-cost educational and preventive measures that help faculty and students to understand and avoid the dangers of eating disorders.

Eating disorder research into the underlying causes and risk factors associated with eating disorders is just as important as education and prevention. As we continue to learn more about underlying causes, risk factors and predictors through medical research, it will undoubtedly improve the efficacy of our education and prevention efforts.

Based on the foregoing, ANAD respectfully makes this request of the subcommittee with regard to funding priorities for fiscal year 2010. Millions of our youth can benefit from proven, low-cost services that assist students to understand and avoid the dangers of eating disorders. Programs, such as those provided by ANAD's Eating Disorders and Obesity Education/Prevention Program for Middle and High Schools, promote the elements of a healthy lifestyle: self-acceptance, a good diet, adequate exercise and sufficient sleep.

Given the troubling lack of education and prevention in our schools, ANAD respectfully requests $4 million or $75.00 per school be allocated to place these life-enhancing programs in every middle and high school in the United States. This $4 million in funds is above and beyond the current request in the administration's proposed budget, for the Department of Education's Safe and Drug-Free Schools programs to provide grants for eating disorder prevention and education programs in our Nation's middle schools and high schools.

Eating disorders cause serious physical problems that can last a lifetime. They rob people of their ability to function as productive members of society because, if not properly treated, victims of these illnesses find themselves requiring more and more costly medical services throughout their lives. With early education and detection, eating disorders are treatable and at a much lower economic and personal cost to society.

SUMMARY OF ANAD EATING DISORDERS STUDY

Data from a 2005 ANAD study shows that eating disorders are almost as prevalent as alcohol or drug problems in middle and high school female students. The study also shows that far less time is spent on eating disorder prevention than on alcohol or drug prevention programs.

This is especially significant since eating disorders are often accompanied by or lead to severe depression, suicidal tendencies, self-mutilation, or diabetes. Many victims become alcohol or drug addicted.

Eating disorders cause great suffering for victims and families and are expensive to treat. Anorexia nervosa has the highest mortality rate of any mental illness. An estimated 6 percent of all anorexics die from an eating disorder or from complications from their disorder. However, these very dangerous illnesses can be cured and prevented.

Eight middle schools and 10 high schools from 15 States were surveyed for this study.

Incidence of Alcoholism, Drugs, and Eating Disorders in Schools

Nine point eight percent of girls have problems with alcohol; 8 percent of girls have problems with drugs; and 7.8 percent of girls have problems with eating disorders.

Time Devoted to Education/Prevention

Time devoted to Alcohol Education/prevention—12.3 percent; time devoted to Drugs Education/Prevention—13.8 percent; and time devoted to Eating Disorders Education/prevention—6.2 percent.

Three schools reported 1 hour per year was spent on eating disorders education and two schools reported that they did not have any program.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS

The National Association of County and City Health Officials (NACCHO) represents the Nation's approximately 2,860 local health departments (LHDs). These governmental agencies work every day in their communities to prevent disease, promote wellness, and protect health. They organize community partnerships and facilitate community conversations to create the conditions in which people can be healthy. The work of local health departments and NACCHO improves economic well-being, educational success, and nationwide competitiveness community by community.

The current H1N1 influenza cases in the United States could signal the onset of the next pandemic. State and local public health agencies are actively engaged in outbreak investigation, control and response activities to control the virus' spread and minimize illness and death. NACCHO appreciates the past support of the subcommittee for public health emergency preparedness and urges the subcommittee to provide the necessary resources so that State and local health departments are able to respond to all hazards, including a possible resurgence of pandemic influenza in the fall.

LHDs have a unique and distinctive role and set of responsibilities in the larger health system and within every community. The Nation depends upon the capacity of local health departments to play this role well. A LHD is the only local governmental entity that works from a population-wide perspective. LHDs have statutory powers which enable their role and enshrine a duty to serve every person and household in their jurisdiction.

Funding to local health departments continues to be inadequate and many people in the United States suffer from conditions whose causes are preventable, whose costs for treatment are unsustainable into the future, and whose treatment is of erratic quality, effectiveness and efficiency. One clear, measured result is that the United States is not the healthiest Nation in the world despite higher per capita expenditures than any other Nation.

The Nation's current recession further diminishes the ability of local health departments to measure population-wide illness and death, organize efforts to prevent disease and prolong quality of life, and to serve the public through organized programs not offered elsewhere. Repeated rounds of budget cuts and layoffs in LHDs continue to erode capacity. Reductions in local and State tax bases further undermine these sources of support. A NACCHO survey found that in 2008, at least 7,000 LHD jobs were lost in 46 States across the country. Far more are expected this year and many LHDs are currently reporting budget cuts in the 20 to 40 percent range.

Protections people take for granted—from enforcement of rules requiring safe food in restaurants and schools to early identification of disease outbreaks to the expectation that their LHD will examine, discover, and take action—are disappearing. In economic hard times, people are more dependent than ever on their local health departments. Programs offered by LHDs serve as a safety net for people in communities where the numbers of unemployed, uninsured, and underinsured are growing daily, compounding the numbers of formerly working adults who need care.

NACCHO's recommendations focus on the Centers for Disease Control and Prevention (CDC) and the Health Services and Resources Administration (HRSA). Consistent funding with growth over time is needed. NACCHO recommends an overall funding level for CDC of $8.6 billion not including funding for Vaccines for Children.

CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

Preventive Health and Health Services Block Grant

NACCHO recommends: Not less than fiscal year 2005 funding of $131 million. Local public health departments receive approximately 40 percent of the Preventive Health and Health Services block grant (PHHS) nationally. The proportion received by local health departments varies among states from less than five percent to almost 100 percent. Increasing the availability of flexible funds is particularly important as the gaps in public health protections grow.

PHHS funds enable States to address critical unmet public health needs. Improving chronic disease prevention through screening programs and programs that promote healthy nutrition and physical activity are prime examples of activities to which many jurisdictions devote PHHS funds. Population-based strategies which create the conditions in which people are more likely to be healthy are also supported with these funds. Flexible PHHS funds allow local priorities and unexpected problems to be addressed. West Nile virus, a fully preventable disease spread to humans by mosquitoes, is one good example. Finally, PHHS funds provide leverage for additional support from non-Federal sources.

NACCHO also recommends that the subcommittee include language with the appropriations bill which would require concurrence of LHDs with State public health officials in the uses for and distribution of these funds. Such language has been instrumental in the effective use of preparedness funds, assuring that a reasonable proportion of funds help local communities.

EMERGENCY PREPAREDNESS

Public Health Emergency Preparedness Cooperative Agreement

NACCHO recommends not less than fiscal year 2005 funding of $919 million. Federal funding for improving State and local public health emergency preparedness has stalled for the past several years and is substantially down from $919 million in fiscal year 2005 to $746 million in the fiscal year 2009 omnibus appropriations bill. Local health departments successfully responded to the outbreak of H1N1 influenza this spring, but a sustained epidemic would further tax resources and stretch the capacity of local health professionals to respond adequately to the influenza outbreak as well as other responsibilities in the areas of infectious and chronic disease.

Last year more than 25 percent of LHDs reduced their preparedness activities, delayed completion of plans, and/or delayed acquisition of equipment and supplies as a result. Constant readiness for both new and emerging threats requires staff, plans, training and practice, all of which require financial support. The benefits to safety and well-being of local communities are clear when LHDs are prepared and work effectively with their communities to be prepared for all hazards. Reduction in Federal financial support has reduced readiness and the capacity to respond to emergencies.

ADVANCED PRACTICE CENTERS

NACCHO recommends level funding of $5.3 million plus inflation adjustment. NACCHO appreciates the past support of the subcommittee for the Advanced Practice Centers program. The Advanced Practice Center (APC) program funded through CDC provides funds to seven local health departments to develop innovative field-tested tools and models to help other LHDs meet emergency preparedness goals. The APCs are located in Santa Clara County, California; Cambridge, Massachusetts; Montgomery County, Maryland; Twin Cities Metro, Minnesota; Western New York Public Health Alliance; Tarrant County, Texas and Public Health—Seattle and King County, Washington. The 70 unique preparedness tools produced to date by the APCs have become essential instruments that LHDs nationwide routinely employ to assess their vulnerability, strengthen their response capacity, and enhance the resilience of their communities and workforce. The APC network provides a national learning laboratory that creates tools, resources, and technical guidance that can be used for all LHDs and that align with public health preparedness priority areas.

PUBLIC HEALTH WORKFORCE

NACCHO recommends $10 million new funding. The shortages in the public health workforce have been well-documented, particularly in public health nursing, epidemiology, laboratory science, and environmental health. The Nation's wellness depends on a continuing supply of people for this workforce. Additional funding and leadership is required to support a program of training, continuing education, and education for the full range of public health professions and community workers. Section 765 of the Public Health Service Act authorizes grants that would allow State and local health departments to provide training and trainee support. Funds have never been appropriated for this purpose.

EMERGENCY PREPAREDNESS WORKFORCE

NACCHO recommends $10 million new funding. Workforce shortages also exist in the area of public health preparedness. In 2006, the Pandemic and All-Hazards Preparedness Act created two new programs within the National Health Service Corps (NHSC) in the Health Resources and Services Administration, yet no funding was appropriated for these programs. Funding would allow expansion of the NHSC on a trial basis to include loan repayment for individuals who complete their service in a State, local, or tribal health department that serves health professional shortage areas or areas at risk of a public health emergency. The second program establishes grants to States to create loan repayment programs. These programs are essential to ensure a workforce trained to carry out specialized tasks in preparedness.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE TO END HOMELESSNESS

The National Alliance to End Homelessness (the Alliance) is a nonpartisan, nonprofit organization that has several thousand partner agencies and organizations across the country. These partners include local faith-based and community-based nonprofit organizations and public sector agencies that provide homeless people with housing and services such as substance abuse treatment, job training, and physical health and mental healthcare. The Alliance represents a united effort to address the root causes of homelessness and challenge society's acceptance of homelessness as an inevitable byproduct of American life.

SUMMARY OF APPROPRIATIONS GOALS

Moving Forward To End Homelessness.—Communities are using Federal, State, and local funds to help homeless persons maintain housing. Especially during the current economic recession, it is important that this progress not be undermined. To this end, the Alliance recommends the following:

—Allocate $120 million for services for people experiencing homelessness within the Programs of Regional and National Significance accounts of both Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services and Center for Substance Abuse Treatment.
—Increase funding for the Projects for Assistance in Transition from Homelessness (PATH) program to $75 million.
—Increase funding for the Runaway and Homeless Youth Act (RHYA) Programs to $165 million.
—Provide $2.602 billion in the Community Health Center program within the Health Resource Services Administration (HRSA). This would result in $226.3 million for the Health Care for the Homeless (HCH) program, a $36 million increase from fiscal year 2009.
—Fund Education for Homeless Children and Youth (EHCY) services at $210 million.
—Increase funding for the Homeless Veterans Reintegration Program to $50 million, its authorized level.

Connecting Homeless Families, Individuals, and Youth to Mainstream Services

People experiencing homelessness also depend on mainstream programs. The Alliance recommends the following to meet this goal:

—Fund the Social Services Block Grant (SSBG) program at $2.3 billion.
—Fund the Community Services Block Grant (CSBG) program at $725 million.
—Appropriate $60 million in education and training vouchers for youth exiting foster care under the Safe and Stable Families Program.
—Fund the Community Mental Health Services Performance Partnership Block Grant at $486.9, a $66.1 million increase.
—Fund the Substance Abuse Prevention and Treatment Block Grant at $1.929 billion, a $150 million increase more than fiscal year 2009.

BACKGROUND

Our 2009 report, Homelessness Counts: Changes in Homelessness from 2005 to 2007, estimates that 671,859 people are homeless on any given night. This includes 248,511 persons in families and 423,348 individuals. Eighteen percent of all homeless people are defined as chronically homeless; these are people who have a disability and who have been homeless repeatedly or continuously for 12 months. These numbers are based on homeless counts performed in 2007, prior to the current economic recession. Compared to 2005, there were decreases across the country resulting in a 10 percent overall decline in homelessness. Anecdotal evidence suggests there could be increases in homelessness as communities report the results of their 2009 counts. To help stave off drastic increases in homelessness, we need Congress to invest in what we know works. Successful interventions for all homeless populations couple housing with an appropriate level of services for the family or individual. We call on Congress to adequately fund programs that assist States and local entities in developing permanent housing and the necessary social services to end homelessness for all Americans.

DETAILED PROGRAM DESCRIPTIONS

Goal No. 1—Moving Forward To End Homelessness

Support Services for Permanent Supportive Housing Projects

The Alliance recommends allocating $120 million for services in permanent supportive housing within SAMHSA's Center for Mental Health Services and Center for

Substance Abuse Treatment. Years of reliable data and research demonstrate that the most successful intervention to solve chronic homelessness is linking housing to appropriate support services. Current SAMHSA investments in homeless programs are highly effective and cost-efficient.

PATH

The Alliance recommends that Congress increase PATH funding to $75 million and adjust the funding formula to increase allocations for small States and territories.

PATH provides outreach to eligible consumers and ensures that those consumers are connected with mainstream services, such as Supplemental Security Income, Medicaid, and welfare programs. Under the PATH formula grant, approximately 30 States share in the program's annual appropriations increases. The remaining States and territories receive the minimum grant of $300,000 for States and $50,000 for territories. These amounts have not been raised since the program was authorized in 1991. To account for inflation, the minimum allocation should be raised to $600,000 for States and $100,000 for territories. Amending the minimum allocation requires a legislative change. If the authorizing committees do not address this issue, we hope that appropriators will explore ways to make the change through appropriations bill language.

RHYA PROGRAMS

The Alliance recommends funding the RHYA programs at $165 million. RHYA programs support cost effective, community- and faith-based organizations that protect youth from the harms of life on the streets. The RHYA programs can either reunify youth safely with family or find alternative living arrangements. RHYA programs end homelessness by engaging youth living on the street with Street Outreach Programs, quickly providing emergency shelter and family crisis counseling through the Basic Centers, or providing supportive housing that helps young people develop lifelong independent living skills through Transitional Living Programs. Recently, the Congressional Research Service issued a report complimenting the good work of RHYA programs but detailing the gaps in services due to limited funding. For example, only one-tenth of the youth who connect with a RHYA program are able to receive services. It is essential that Congress increase this program.

COMMUNITY HEALTH CENTERS AND HCH PROGRAMS

The Alliance recommends $2.602 billion in the Community Health Center program within HRSA. This would result in $226.4 million for the HCH program, a $36 million increase more than fiscal year 2009. Persons living on the street suffer from health problems resulting from or exacerbated by being homeless, such as hypothermia, frostbite, and heatstroke. In addition, they often have infections of the respiratory and gastrointestinal systems, tuberculosis, vascular diseases such as leg ulcers, and hypertension. Healthcare for the homeless programs are vital to prevent these conditions from becoming fatal. Congress allocates 8.7 percent of the Consolidated Health Centers account for HCH projects.

EDUCATION FOR HOMELESS CHILDREN AND YOUTH (EHCY)

The Alliance recommends funding EHCY at $210 million. The most important potential source of stability for homeless children is school. The mission of the EHCY program is to ensure that these children can continue to attend school and thrive. EHCY, within the Department of Education's Office of Elementary and Secondary Education, removes obstacles to enrollment and retention by establishing liaisons between schools and shelters and providing funding for transportation, tutoring, school supplies, and the coordination of statewide efforts to remove barriers.

HOMELESS VETERANS REINTEGRATION PROGRAM (HVRP)

The Alliance recommends that Congress increase HVRP funding to $50 million. HVRP, which is within the Department of Labor's Veterans Employment and Training Service (VETS), provides competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans. HVRP is the primary employment services program accessible by homeless veterans and is the only targeted employment program for any homeless subpopulation. It is estimated that this program only reaches about two percent of the overall homeless veteran population. An appropriation at the authorized level of $50 million would enable HVRP grantees to reach approximately 19,866 homeless veterans.

Goal No. 2—Connecting Homeless Families, Individuals and Youth to Mainstream Services

SOCIAL SERVICES BLOCK GRANT (SSBG)

The Alliance recommends that Congress increase SSBG funding to $2.3 billion. SSBG funds are essential for programs dedicated to ending homelessness. In particular, youth housing programs and permanent supportive housing providers often receive State, county, and local funds which originate from the SSBG. As the Department of Housing and Urban Development has focused its funding on housing, programs that provide both housing and social services have struggled to fund the service component of their programs. This gap is often closed using Federal programs such as SSBG.

COMMUNITY SERVICES BLOCK GRANT (CSBG)

The Alliance recommends that Congress rejects cuts and fund CSBG at $725 million. Funding cuts for CSBG will destabilize the progress communities have made toward ending homelessness by not only ending services directly provided by CSBG funds but limiting a community's ability to access other Federal dollars, such as those provided by the Department of Housing and Urban Development. Community Action Agencies (CAAs), which are the primary local recipients of CSBG funding, are directly involved in housing and homelessness services. In several communities, CAAs lead the Continuum of Care (CoC). CoCs coordinate local homeless service providers and the community's McKinney-Vento Homeless Assistance Grant application process with the Department of Housing and Urban Development.

In the fiscal year 2006 Community Services Block Grant Information Systems report published by the U.S. Department of Health and Human Services, CAAs reported expending approximately $42 million on housing-related services. In addition, approximately $50 million was spent nationwide on youth services, some of which related to housing. States reported that 180,000 clients served with CSBG funds were homeless.

FOSTER YOUTH EDUCATION AND TRAINING VOUCHERS

The Alliance recommends that Congress appropriate $60 million in education and training vouchers for youth exiting foster care under the Safe and Stable Families Program. The Education and Training Voucher Program offers funds to foster youth and former foster youth to enable them to attend colleges, universities, and vocational training institutions. Students may receive up to $5,000 a year for college or vocational training education. The funds may be used for tuition, books, housing, or other qualified living expenses. Given the large number of people experiencing homelessness who have a foster care history, it is important to provide assistance such as these education and training vouchers to stabilize youth, prevent economic crisis, and prevent future homelessness.

COMMUNITY MENTAL HEALTH PERFORMANCE PARTNERSHIP BLOCK GRANT

The Alliance recommends that Congress appropriate $486.9 million for the Community Mental Health Performance Partnership Block Grant. The Mental Health Block Grant provides flexible funding to states to provide mental health services. Ending homelessness requires Federal, State, and local partnerships. Additional mental health funds will give States the resources to improve their mental health system and serve all people with mental health disorders better, including homeless populations. For example, block grant funds can be used to pay for services linked to housing for homeless people, thereby meeting the match requirements for projects funded through Shelter Plus Care or the Supportive Housing Program.

SUBSTANCE ABUSE PREVENTION AND TREATMENT (SAPT) BLOCK GRANT

The Alliance recommends that Congress appropriate $1.929 billion for the SAPT Block Grant. The SAPT Block Grant is the primary source of Federal funding for substance abuse treatment and prevention for many low-income individuals, including those experiencing homelessness. Studies have shown that half of all people experiencing homelessness have a diagnosable substance use disorder. States need more resources to implement proven treatment strategies and work with housing providers to keep homeless populations, especially chronically homeless populations, stably housed.

CONCLUSION

Homelessness is not inevitable. As communities implement plans to end homelessness, they are struggling to find funding for the services that homeless and formerly homeless clients need to maintain housing. The Federal investments in mental health services, substance abuse treatment, employment training, youth housing, veterans' services, and case management discussed above will help communities create stable housing programs and change social systems which will end homelessness for millions of Americans.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE FOR EYE AND VISION RESEARCH

National Alliance for Eye and Vision Research (NAEVR) requests a fiscal year 2010 National Institute of Health (NIH) funding increase of at least 7 percent, to a level of $32.4 billion, which represents a modest 3 percent increase plus the biomedical inflation rate, estimated at 3.8 percent in fiscal year 2009. This increase is necessary to keep pace with inflation and rebuild the base, since NIH has lost 14 percent of its purchasing power during the past 6 funding cycles.

NAEVR commends the congressional leadership's actions in fiscal year 2008 and 2009 to increase NIH funding, including the $150 million in the fiscal year 2008 supplemental dedicated to investigator-initiated grants, the $10.4 billion in 2-year stimulative NIH funding within the American Recovery and Reinvestment Act (ARRA), and the final fiscal year 2009 appropriations inflationary increase of 3.2 percent. However, NIH needs sustained and predictable funding to rebuild its base and support multi-year, investigator-initiated research, which is the cornerstone of the biomedical enterprise. Annual increases of at least 7 percent put NIH on a pathway to budget-doubling within the next 10 years. Secure and consistent funding for biomedical research is integral to the Nation's economic and global competitiveness. NIH is a world-leading institution that must be adequately funded so that its research can reduce healthcare costs, increase productivity, and save and improve the quality of lives.

NAEVR requests that Congress make vision health a top priority by increasing National Eye Institute (NEI) funding by at least 7 percent, to a level of $736 million, in this year that NEI celebrates its 40th anniversary. Over the past 6 funding cycles, NEI lost 18 percent of its purchasing power. Despite funding challenges, NEI has maintained its impressive record of breakthroughs in basic and clinical research that have resulted in treatments and therapies to save and restore vision and prevent eye disease. NEI will be challenged further, as 2010 begins the decade in which more than half of the 78 million baby boomers will turn 65 and be at greatest risk for developing aging eye disease. Adequately funding the NEI is a cost-effective investment in our Nation's health, as it can delay, save, and prevent expenditures, especially to the Medicare and Medicaid programs.

Fiscal year 2010 funding at $736 million enables NEI to expand its impressive record of basic and clinical collaborative research that has resulted in treatments and therapies to save and restore vision.

NEI continues to be a leader in basic research—especially that which elucidates the genetic basis of ocular disease—and in translational research, as those gene discoveries can lead to development of diagnostics and treatments. NEI Director Paul Sieving, M.D., Ph.D., has reported that one-quarter of all genes identified to date through NEI's collaboration with the National Human Genome Research Institute (NHGRI) are associated with eye disease/visual impairment. Recent examples include:

—In 2005, NEI reported that gene variants of Complement Factor H (CFH), the protein product of which is engaged in the control of the body's immune response, are associated with increased risk of developing age-related macular degeneration (AMD), the leading cause of vision loss. NEI-funded researchers are now working on potential therapies, including the manufacture and use of a protective version of the CFH protein in an augmentation strategy similar to that of treating diabetes with insulin. This therapy is under development and expected to enter phase I clinical safety trials in summer 2009.

—In March 2008, NEI-funded researchers announced that damage from both AMD and diabetic retinopathy was prevented and even reversed when the protein Robo4 was activated in mouse models that simulate the two diseases. Robo4 treated and prevented the diseases by inhibiting abnormal blood vessel growth and by stabilizing blood vessels to prevent leakage. Since this research into the "Robo4 Pathway" used animal models associated with these diseases that are already used in drug development, the time required to test this approach in humans could be shortened, expediting approvals for new therapies

—In late April 2008, researchers funded by the NEI and private funding organization Foundation Fighting Blindness reported on their use of gene therapy to restore vision in young adults who were virtually blind from a severe form of the neurodegenerative disease Retinitis Pigmentosa, known as Leber Congenital Amaurosis (LCA). Seven years earlier, the researchers shared on Capitol Hill results of a preclinical study of the same gene therapy, which at the time was successfully giving vision to dogs born blind with LCA. The subsequent human gene therapy trial validated the process of putting genes in the body to restore vision. Although the primary goal of the phase I study was to ensure patient safety, the researchers reported through both objective and subjective testing that the patients were able to read several lines on an eye chart, had better peripheral vision, and better eyesight in dimly lit settings. In further research, the investigators will treat LCA patients as young as 8 years old, since they believe the most dramatic results will be seen in young children.

—In late 2008, NEI initiated its new NEI Glaucoma Human genetics collaBORation, known as NEIGHBOR, through which seven U.S. research teams will lead genetic studies of the disease. Glaucoma is called the "stealth robber of vision" as it often has no symptoms until vision is lost, and anywhere from 50–75 percent of individuals with it are undiagnosed. It is also the leading cause of preventable vision loss in African-American and Hispanic populations, which emphasizes the vital nature of determining the genetic basis of this disease.

FISCAL YEAR 2010 FUNDING AT $736 MILLION ENABLES NEI TO FULLY FUND NEW INITIATIVES THAT MORE FULLY CHARACTERIZE EYE DISEASE

NEI has been a leader in collaborative research, the use of networks to study diagnostics and treatments and their use in clinical settings, and in ocular epidemiology to characterize the nature and frequency of eye disease in diverse populations to better manage pubic health. In fiscal year 2008, NEI reported on/launched the initial phase of three important new programs to characterize eye disease requiring adequate future funding.

—In early 2009, the NEI and the National Aeronautics and Space Administration (NASA) reported on the use of a compact fiber optic probe developed for the space program that has proven valuable as the first noninvasive early detection device for cataracts, the leading cause of vision loss worldwide. Using a laser light technique called dynamic light scattering (DLS), which was developed to analyze the growth of protein crystals in a zero-gravity environment, the probe measures the amount of light scattering by an anti-cataract protein called alpha-crystallin. The probe senses protein damage due to oxidative stress, a key process involved in many medical conditions including age-related cataract and diabetes, as well as Alzheimer's and Parkinson's disease.

—In late 2008, NEI launched a new research network, the Neuro-Ophthalmology Research Disease Investigator Consortium, or NORDIC. It will initially lead multi-site observational and treatment trials, involving nearly 200 community and academic practitioners, to address the risks, diagnosis, and treatment of two "rare" diseases: idiopathic intracranial hypertension (visual dysfunction due to increased intracranial pressure) and thyroid eye disease (also called Graves' disease, in which muscles of the eye enlarge and cause bulging of the eyes, retraction of the lids, double vision, decreased vision, and irritation). The NEI and NORDIC's principal investigator have already begun coordinating with the Department of Defense's (DOD) newly established Vision Center of Excellence (VCE) about the applicability of NORDIC research to combat-related eye injuries, especially those associated with Traumatic Brain Injury (TBI).

—There is currently almost no information on the prevalence, risk factors, and genetic determinants in Asian Americans—one of the fastest growing racial groups in the United States. Studies from East Asia have suggested that Asians have a spectrum of eye diseases different from that of White Americans, African Americans, and Hispanics. In late 2008, NEI launched the Chinese American Eye Study to characterize the extent of eye disease in Chinese Americans, the largest Asian sub-group in the United States. Participants 50 years and older will be evaluated for blindness, visual impairment, and eye disease. These results will add to the expanding body of knowledge about vision health disparities already characterized by NEI in the African-American and Hispanic populations.

VISION IMPAIRMENT/EYE DISEASE IS A MAJOR PUBLIC HEALTH PROBLEM THAT INCREASES HEALTHCARE COSTS, REDUCES PRODUCTIVITY, AND DIMINISHES QUALITY OF LIFE

The NEI estimates that more than 38 million Americans age 40 and older experience blindness, low vision, or an age-related eye disease such as AMD, glaucoma, diabetic retinopathy, or cataracts. This is expected to grow to more than 50 million Americans by year 2020. The economic and societal impact of eye disease is increasing not only due to the aging population, but to its disproportionate incidence in minority populations and as a co-morbid condition of chronic disease, such as diabetes.

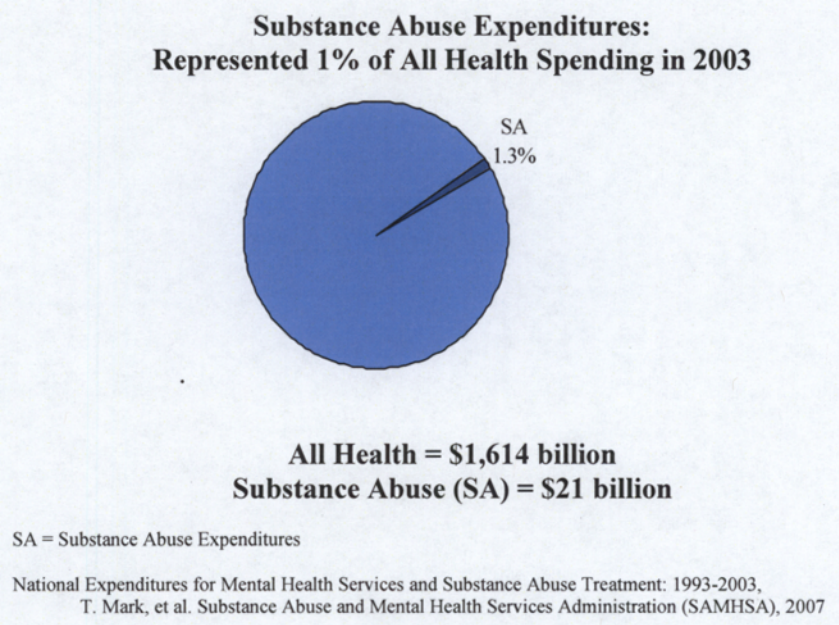
Although the NEI estimates that the current annual cost of vision impairment and eye disease to the United States is $68 billion, this number does not fully quantify the impact of direct healthcare costs, lost productivity, reduced independence, diminished quality of life, increased depression, and accelerated mortality. The continuum of vision loss presents a major public health problem and financial challenge to the public and private sectors.

In public opinion polls over the past 40 years, Americans have consistently identified fear of vision loss as second only to fear of cancer. As recently as March 2008, the NEI's Survey of Public Knowledge, Attitudes, and Practices Related to Eye Health and Disease reported that 71 percent of respondents indicated that a loss of their eyesight would rate as a "10" on a scale of 1 to 10, meaning that it would have the greatest impact on their day-to-day life.

In 2009, the NEI will celebrate its 40th anniversary as the NIH Institute that leads the Nation's commitment to save and restore vision. During the next decade, more than half of the 78 million baby boomers will celebrate their 65th birthday and be at greatest risk for developing aging eye disease. As a result, sustained, adequate Federal funding for the NEI is an especially vital investment in the health, and vision health, of our Nation as the treatments and therapies emerging from research can preserve and restore vision. Adequately funding the NEI can also delay, save, and prevent health expenditures, especially those associated with the Medicare and Medicaid programs, and is, therefore, a cost-effective investment.

NAEVR urges fiscal year 2010 NIH and NEI funding at $32.4 billion and $736 million, respectively, reflecting an at least 7 percent increase more than fiscal year 2009.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS



Chairman Harkin, Ranking Member Cochran, members of the subcommittee, on behalf of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and our component organizations, the National Prevention Network, and the National Treatment Network, thank you for your leadership on issues related to addiction. I am Flo Stein, NASADAD President and member from North Carolina. I am pleased to present testimony regarding fiscal year 2010 funding priorities.

Scope of the Problem.—According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), approximately 23.2 million Americans aged 12 or older needed services for an alcohol or illicit drug problem in 2007. During the same year, approximately 2.4 million received treatment for such a problem at a specialty facility. As a result, approximately 20.8 million people needed but did not receive services in 2007 in a specialty facility.

Substance Abuse Spending Represents a Tiny Fraction of all Health Expenditures.—Substance abuse expenditures represented 1.3 percent of all healthcare expenditures in 2003 ($21 billion for substance abuse compared to $1,614 billion for all health expenditures). Using inflation adjusted terms, the growth rate for all health spending from 1993 to 2003 was 4.6 percent, while the growth rate for substance abuse spending during this same time period was 1.4 percent.

Yet Addiction is Associated With Many Other Diseases.—In a 2004 study appearing in the Journal of the American Medical Association (JAMA), researchers examined "actual causes of death" defined by the Centers for Disease Control and Prevention (CDC) as factors that contribute to leading killers such as heart disease, cancer and stroke. The study identified nine leading "actual causes of death." Tobacco, alcohol and illicit drugs—killing 530,000 Americans in 2000—were 3 of the top 9. The others were diet/weight; microbial agents; toxic agents; motor vehicles; firearms and sexual behaviors.

Unaddressed Substance Abuse Problems are Costly.—As noted in SAMHSA's National Expenditures for Mental Health Services and Substance Abuse Treatment, 1993–2003 (2007), when substance abuse spending was $15.5 billion in 1998, the total economic costs of alcohol abuse were approximately $184.6 billion and the total economic costs for drug abuse were $143.4 billion (Harwood, 2000). These costs were

linked not only to medical consequences of alcohol/drug use, but also crime, lost earnings, motor vehicle crashes, and more.

Financial Investments in Addiction Services Save Taxpayer Dollars.—The National Institute on Drug Abuse (NIDA) notes that for every $1 spent on addiction treatment programs, there is an estimated $4 to $7 reduction in the cost of drug-related crimes. With some outpatient programs, total savings can exceed costs by a ratio of 12:1 (NIDA InfoFacts, 2006).

Maintain SAMHSA as Strong Agency.—NASADAD supports action to ensure that SAMHSA remains a unique, strong and vibrant agency. SAMHSA has demonstrated excellent leadership and collaboration—promoting innovative strategies to improve our service delivery system. NASADAD thanks Dr. Eric Broderick, Acting Administrator of SAMHSA, for his work. SAMHSA is to be commended and should be considered a vital voice in discussions related to health reform.

Top Priority for Fiscal Year 2010—Increase Funding for Substance Abuse Prevention and Treatment (SAPT) Block Grant.—NASADAD recommends $1,928.6 million for the SAPT Block Grant in fiscal year 2010—an increase of $150 million more than fiscal year 2009 and more than the President's request. Since 2007, as the economy and State budgets struggled, unemployment grew by 5.5 million. This is critical news for the SAPT Block Grant given that the NSDUH found unemployed persons need services at almost twice the rate as those with jobs. An increase in SAPT Block Grant funds would help our public treatment system to better serve this increased need on the part of the low-income and uninsured population.

Background.—The SAPT Block Grant, a program distributed by formula to all States and territories, serves our Nation's most vulnerable, low-income populations: those with HIV/AIDS, pregnant and parenting women, youth, and others. This vital program helps States and communities address their own unique needs—whether the problem is alcohol, methamphetamine, and prescription drug abuse or persons using multiples substances. The SAPT Block Grant represents approximately 40 percent of treatment expenditures by State substance abuse agencies across the country.

SAPT Block Grant Funded Services Achieve Results.—The SAPT Block Grant is an effective and efficient program that emphasizes accountability through the reporting of outcomes data. In particular, States have worked diligently with SAMHSA to implement the National Outcome Measures (NOMs) initiative. The SAMHSA/State partnership on NOMs promotes continuous quality improvement through a more systematic approach to data management and reporting. States now measure the impact of services on the use of alcohol and other drug use; employment; having stable housing; involvement with criminal activity; and efforts to live productively in the community. As noted by SAMHSA in 2008, SAPT Block Grant funded programs had positive results, where ". . . at discharge, clients have demonstrated high abstinence rates from both illegal drug (68.3 percent) and alcohol (73.7 percent) use."

In my own State of North Carolina, our Division of Mental Health, Developmental Disabilities and Substance Abuse Services reported 21,102 to treatment admissions in State fiscal year 2006/2007. In State fiscal year 2006/2007, North Carolina showed the following client outcomes at discharge: 82 percent were abstinent from alcohol use; 74 percent were abstinent from drug use; and 77 percent were involved in social support groups.

Important Prevention Funding Within SAPT Block Grant.—Twenty percent of the SAPT Block Grant is dedicated to funding much needed substance abuse prevention programming. In many States set-aside funding represents a large source of prevention funds for the agency. Overall, SAPT Block Grant funding represents 64 percent of State substance abuse agency prevention funding. In 21 States, the set-aside represents 75 percent or more of the agency's prevention budget.

The prevention set-aside has also helped produce demonstrable results. The Monitoring the Future (MTF) Survey found a 25 percent decline in any illicit drug use in the past month by 8th, 10th, and 12th graders combined between 2001 and 2008. As a result, there were 840,000 fewer teens using drugs in 2008 compared to 2001. A strong commitment to the SAPT Block Grant will ensure a strong commitment to much needed prevention services for our youth.

Recent History of SAPT Block Grant Funding.—NASADAD is thankful for the increase of $19.9 million for the SAPT Block Grant in fiscal year 2009. However, the program has suffered over the past few years: from fiscal year 2004 to fiscal year 2008, funding was cut by more than $20 million. In fact, it is estimated that the 2010 SAPT Block Grant appropriation would have to be increased by $403.7 million above the 2009 appropriation to maintain services at 2004 levels using the CPI–U as the proxy (Data courtesy of the New York State Office of Alcoholism and Sub-

stance Abuse Services (OASAS)]). As a result, NASADAD and others view an increase of $150 million as a down payment to make up for lost ground.

Center for Substance Abuse Treatment (CSAT).—NASADAD recommends $489.3 million in fiscal year 2010—an increase of $75 million compared to fiscal year 2009 and an increase of $29.3 million compared to the President's request. NASADAD acknowledges Dr. H. Westley Clark, Director of CSAT, for his excellent leadership.

NASADAD is thankful for the President's proposed $45.7 million increase for CSAT in fiscal year 2010. NASADAD is also thankful for an increase of $14.5 million for CSAT in fiscal year 2009. This increase reversed the previous administration's proposal to cut CSAT by $63 million. The fiscal year 2009 omnibus bill restored all or a portion of a number of NASADAD priority programs that were set to be eliminated.

Center for Substance Abuse Prevention (CSAP).—NASADAD recommends $276.3 million—an increase of $75 million compared to fiscal year 2009 and an increase of $77.7 million compared to the President's fiscal year 2010 request. NASADAD applauds the work of Fran Harding, Director of CSAP, for her work and dedication.

NASADAD appreciates the $6.8 million increase for CSAP in fiscal year 2009. Approving the fiscal year 2009 omnibus package restored funding for CSAP programs which were slated to be eliminated or reduced by the previous administration.

Safe and Drug Free Schools and Communities—State Grants.—NASADAD is extremely concerned with the President's proposal to eliminate or zero out the Safe and Drug Free Schools and Communities (SDFSC)—State Grants portion in fiscal year 2010.

NASADAD believes that the SDFSC State Grants program is an effective initiative that represents a core component of each State's substance abuse prevention system. The efficiency of the program can in part be attributed to principles of effectiveness that each grantee follows. These principles include (1) an assessment of the problem; (2) development of measurable goals and objectives; (3) implementation of effective programs and (4) assessment of program outcomes.

We believe the program also benefits from close collaboration with NASADAD members. In particular, certain Governors choose NASADAD members as the designee to manage these important funds. This designation allows for a more comprehensive and coordinated approach to planning and implementing an effective State-wide system of care.

NASADAD recommends $346.5 million, representing a $51.8 million increase more than fiscal year 2009 and representing a $346.5 million increase more than the President's fiscal year 2010 request for the program.

National Institute on Drug Abuse (NIDA).—NASADAD recommends $1,105.1 million for NIDA, representing a $59.3 million increase compared to the President's fiscal year 2010 request and a $72.3 million increase compared to fiscal year 2009. NASADAD wishes to thank Dr. Nora Volkow, Director of NIDA, for her collaboration with State substance abuse agencies through its "Blending Initiative." This work improves the translation of research into everyday practice.

National Institute on Alcohol Abuse and Alcoholism (NIAAA).—NASADAD recommends $481.7 million for NIAAA, which represents a $26.6 million increase compared to the President's fiscal year 2010 request and a $31.5 million increase compared to fiscal year 2009.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION FOR STATE COMMUNITY SERVICES PROGRAMS

The National Association for State Community Services Programs (NASCSP), the national association representing State administrators of the Department of Health and Human Services' Community Services Block Grant (CSBG) and State directors of the Department of Energy's Low-Income Weatherization Assistance Program, would like to thank Congress for its continued support of the CSBG and requests an appropriation of $800 million for fiscal year 2010. We are requesting $800 million in CSBG funding for fiscal year 2010 to ensure the CSBG Network has adequate resources to sustain its expanded efforts to address the long-term needs of those families affected by the current economic recession and those transitioning from welfare to work. In addition, increased funding would enable the network to continue and strengthen its efforts to assist low-income workers in remaining at work through supportive services such as transportation and child care. The across the board cuts to the CSBG funding in past years have severely decreased the ability of the CSBG Network to provide and enhance essential services to low-income Americans. It is essential that the CSBG funding be increased for fiscal year 2010.

BACKGROUND

The States believe the CSBG is a unique block grant that has successfully transferred decisionmaking to the local level. Federally funded with oversight at the State level, the CSBG has maintained a local network of nearly 1,100 agencies which operate in 99 percent of counties in the Nation. This network serves nearly 16.2 million low-income individuals, members of more than 6.4 million low-income families, CSBG eligible entities, largely local Community Action Agencies (CAAs), provide States with a stable and guaranteed network of designated entities which are mandated to change the conditions that perpetuate poverty for individuals, families, and communities. There is no other program in the United States mandated by Federal statute to respond to poverty. To fulfill that mandate, CAAs provide services based on the characteristics of poverty in their communities. For one community, this might mean providing job placement and retention services; for another, developing affordable housing. In rural areas, it might mean providing access to health services or developing a rural transportation system.

Since its inception, the CSBG has shown how partnerships between States and local agencies benefit citizens in each State. We believe it should be viewed as a model of how the Federal Government can best promote self-sufficiency for low-income persons in a flexible, decentralized, nonbureaucratic, and accountable way.

Long before the creation of the Temporary Assistance for Needy Families (TANF) block grant, the CSBG set the standard for private-public partnerships that work to revitalize local communities and address the needs of low-income residents. Family oriented, while promoting economic development and individual self-sufficiency, the CSBG relies on an existing and experienced community-based service delivery system of CAAs and other nonprofit organizations to produce results for its clients.

WHAT DO LOCAL CSBG AGENCIES DO?

One thing that is common to all CAAs is the goal of self-sufficiency for all of their clients. But, since CAAs operate in rural areas as well as in urban areas, it is difficult to describe a typical CAA. Most CAAs will provide some, if not all, of the services listed below:

—a variety of crisis and emergency safety net services;
—employment and training programs;
—transportation and child care for low-income workers;
—individual development accounts;
—micro business development help for low-income entrepreneurs;
—local community and economic development projects;
—housing, transitional housing, and weatherization services;
—Head Start;
—energy assistance programs;
—nutrition programs;
—family development programs; and
—senior services.

CSBG is the core funding which holds together a local delivery system able to respond effectively and efficiently, without a lot of red tape, to the needs of individual low-income households as well as to broader community needs. In addition, CSBG funds many of these services directly. Without the CSBG, local agencies would not have the capacity to work in their communities developing local funding, private donations and volunteer services and running programs of far greater size and value than the actual CSBG dollars they receive.

CAAs manage a host of other Federal, State, and local programs which makes it possible to provide a one-stop location for persons whose problems are usually multifaceted. More than half (52 percent) of the CAAs manage the Head Start program in their community. Using their unique position in the community, CAAs recruit additional volunteers, bring in local school district personnel, tap into faith-based organizations for additional help, coordinate child care and bring needed healthcare services to Head Start centers. In many States they also manage the Low Income Home Energy Assistance Program (LIHEAP), raising additional funds from utilities for this vital program. CAAs may also administer the Weatherization Assistance Program and are able to mobilize funds for additional work on residences not directly related to energy savings that, for example, may keep a low-income elderly couple in their home. CAAs also coordinate their programs with the Community Development Block Grant program to stretch Federal dollars and provide a greater return for tax dollars invested. They also administer the Women, Infants and Children nutrition program, as well as job training programs, substance abuse programs, transportation programs, domestic violence and homeless shelters, and food pantries.

For every CSBG dollar they receive, CAAs leverage $5.59 in non-Federal resources (State, local, and private) to coordinate efforts that improve the self-sufficiency of low-income persons and lead to the development of thriving communities.

WHO DOES THE CSBG SERVE?

National data compiled by NASCSP show that the CSBG serves a broad spectrum of low-income persons, particularly those who are not being reached by other programs and are not being served by welfare programs. Based on the most recently reported data, from fiscal year 2007 CSBG serves:

—More than 3 million families with incomes at or below the poverty level; of these customer families, 1.4 million are severely poor as they have incomes at or below 50 percent of the poverty guideline.
—More than 1.3 million families headed by single mothers.
—More than 1.7 million "working poor" families relying on wages or unemployment benefits as income.
—More than 384,000 TANF participant families, 23 percent of all TANF families nationwide.
—About 4 million children.
—Almost 2.7 million people without health insurance.
—More than 1.7 million adults who had not completed high school.

MAJOR CHARACTERISTICS OF THE CSBG NETWORK

Due to the unique structure of the CSBG, the CSBG Network has earned a reputation for its:

Emergency Response.—CAAs are utilized by Federal and State emergency personnel as a frontline resource to deal with emergency situations such as floods, hurricanes, and economic downturns. They are also relied on by citizens in their community to deal with individual family hardships, such as house fires or other emergencies. In fact, during and after Hurricanes Katrina and Rita, the State CSBG offices and local CAAs quickly mobilized to provide immediate and long-term assistance to evacuees.

Leveraging Capacity.—In fiscal year 2007, every CSBG dollar leveraged $18.40 from all other sources. Of those leveraged funds, $5.59 came from non-Federal resources (State, local, and private) to coordinate efforts that improve the self-sufficiency of low-income persons and lead to the development of thriving communities.

Volunteer Mobilization.—CAAs mobilize volunteers in large numbers. In fiscal year 2006, the most recent year for which data are available, the CAAs elicited more than 46 million hours of volunteer efforts, the equivalent of almost 21,857 full-time employees. Using just the minimum wage, these volunteer hours are valued at nearly $266 million.

Adaptability.—CAAs provide a flexible local presence that governors have mobilized to deal with emerging poverty issues.

Moreover, the CSBG Network has also earned a reputation for its:

Accountability.—The Federal Office of Community Services, State CSBG offices, and CAAs have worked closely to develop a results-oriented management and accountability (ROMA) system. Through this system, individual agencies determine local priorities within six common national goals for CSBG and report on the outcomes that they achieved in their communities.

Local Direction and Oversight.—Tri-partite boards of directors guide CAAs. These boards consist of one-third elected officials, one-third representatives from the private sector, and not less than one-third of the members are representative of the low-income persons in the neighborhoods served by the CAA. The boards are responsible for establishing policy and approving business plans of the local agencies. Since these boards represent a cross-section of the local community, they guarantee that CAAs will be responsive to the needs of their community.

The statutory goal of the CSBG is to ameliorate the effects of poverty. The primary goal of every CAA is self-sufficiency for its clients. Helping families become self-sufficient is a long-term process that requires multiple resources. This is why the partnership of Federal, State, local, and private enterprise has been so vital to the successes of the CAAs.

EXAMPLES OF CSBG AT WORK

Since 1994, CSBG has implemented a Results-Oriented Management and Accountability (ROMA) system. Through ROMA, the effectiveness of programs is captured through the use of goals and outcomes measures. Below you will find several of the network's nationally aggregated outcomes achieved by individuals, families

and communities as a result of their participation in innovative CSBG programs during fiscal year 2007:

—*Increased Economic Asset Enhancement and Utilization*.—694,000 low-income households achieved an increase in financial assets or financial skills as a result of Community Action assistance.

—*Procured Supports To Reduce or Eliminate Barriers to Employment*.—1.3 million low-income participants obtained supports which reduced or eliminated barriers to initial or continuous employment through assistance from Community Action.

—*Gained Employment*.—193,000 low-income participants in Community Action employment initiatives got a job, obtained an increase in employment income, or achieved "living wage" employment and benefits.

—*Improved Child and Family Development*.—2.9 million Infants, children, youth, parents, and other adults participated in developmental or enrichment programs facilitated by Community Action and achieved program goals.

—*Secured Independent Living for Low-Income Vulnerable Populations*.—2 million low-income vulnerable individuals received services from Community Action and maintained an independent living situation as a result.

At the end of the day, the CSBG Network represents our abiding national commitment to care for the less fortunate and in recognition that we are stronger when we do so. The CSBG and CSBG Network, in addition to other nonprofit faith-based and community-based organizations, are a critical complement to the public sector's efforts towards helping to lift low-income Americans and their communities out of poverty and into self-sufficiency.

In fiscal year 2007, the CSBG Network assisted approximately 20 percent of the persons in poverty that year and almost 15 million low-income individuals who are members of more than 6.4 million low-income families. Renewed funding for the CSBG Network is one of the best ways to ensure that America has an experienced, guaranteed and trusted network to assist its working and vulnerable families in achieving and maintaining self-sufficiency. As such, NASCSP requests $800 million in CSBG funding for fiscal year 2010.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF STATE DIRECTORS OF CAREER TECHNICAL EDUCATION CONSORTIUM

DEPARTMENT OF EDUCATION BUDGET

In his budget submission to Congress, President Obama has requested flat funding for programs funded under the Carl D. Perkins Career Technical Education (CTE) Act. If this level of funding holds, this will be the third year in a row these programs will have received flat funding. These programs are worthy of stronger support because of the valuable contributions they make to serving adults and high school students in their journey for education and training and eventual entry into the workforce. Perkins CTE programs:

—Provide education that is relevant to students;

—Are actively reforming high school curriculum;

—Provide coordination between high schools and community colleges; and

—Prepare workers for jobs that are in demand.

We respectfully request that the subcommittee include $1.4 billion in support of Perkins programs. The last substantial funding increase for Perkins occurred in fiscal year 2002. Since that time funding has decreased by $42 million. When factoring in inflation this is the equivalent of a reduction of $254 million.

Perkins includes a "hold harmless" provision that protects small States from significant losses when there are reductions in Tech Prep (title II of Perkins) funding. However, this provision only applies as long as the total funding for Tech Prep does not fall below 1998 levels. Unfortunately, during the fiscal year 2008 appropriations cycle, Tech Prep funding fell below this level and in turn, the hold harmless provision put in place to protect small States was de-activated. While most States have taken a loss of Tech Prep funds, the small States have felt this cut in funding disproportionately. These States have seen their Tech Prep funds reduced between 7 and 56 percent below their fiscal year 2007 levels, costing some States hundreds of thousands of dollars over the last 2 years. Below is a chart that details the States and the approximate amount of funds they have lost over the last 2 years. The funding figures are approximated because only tentative fiscal year 2009 allocation numbers are available.

State	Amount
Alaska	$221,390

State	Amount
Delaware	426,666
District of Columbia	349,264
Hawaii	224,508
Montana	144,226
Nevada	279,600
New Hampshire	295,212
North Dakota	50,758
Rhode Island	370,442
South Dakota	92,616
Vermont	209,334
Wyoming	86,416

Tech Prep funding for the last 2 years was less than $100,000 below the fiscal year 1998 hold harmless level of $103 million. If funding for Tech Prep is raised ever so slightly to $103 million these States will not be so negatively impacted.

Why Career Technical Education?

Career technical education (CTE) provides students and adults with the academic and technical skills, knowledge and training necessary to succeed in future careers and develop skills they will use throughout their careers. CTE programs have been organized into 16 career clusters, or similar occupational groupings, that identify the knowledge and skills students need as they follow a pathway to their goals. These clusters are: Agriculture, Food, and Natural Resources; Architecture and Construction; Arts, A/V Technology and Communications; Business Management and Administration; Education and Training; Finance; Government and Public Administration; Health Science; Hospitality and Tourism; Human Services; Information Technology; Law, Public Safety, Corrections, and Security; Manufacturing; Marketing; Science, Technology, Engineering and Mathematics; and Transportation, Distribution and Logistics.

CTE prepares students for the world of work by introducing them to workplace competencies, and makes academic content accessible to students by providing it in a hands-on context.

CTE programs can be found in comprehensive high schools with career technical education programs, as well as high schools solely devoted to career technical education. Community colleges, technical institutes, and skill centers also offer career technical education at the postsecondary level. Nationally, about 60 percent of Perkins funds are allocated for secondary school purposes and 40 percent for postsecondary programs.

Programs of Study

The Carl D. Perkins Career and Technical Education Act of 2006 (Public Law 109–270), which funds CTE programs, requires States to develop programs of study to guide students when choosing courses. These programs of study include career and technical areas that:

—Incorporate both secondary and postsecondary education elements;
—Include rigorous content, challenging academic standards, and relevant career and technical content in a coordinated, nonduplicative series of courses that align secondary and postsecondary education;
—May allow high school students to participate in dual or concurrent enrollment programs or otherwise acquire postsecondary credit; and
—Result in an industry-recognized credential or certificate, or associate or baccalaureate degree.

Tech Prep

Tech Prep is a program in the Perkins Act that links a minimum of 2 years of secondary school and 2 years of post-secondary school or an apprenticeship program, resulting in an associate degree or certificate. Tech Prep allows students to begin a sequence of classes in a career pathway while still in high school. Students enroll in both academic and career and technical classes in the career field of their choosing in order to develop the technical skills necessary for future employment.

The Benefits of CTE

Academic

—Students enrolled in CTE programs are held to the same rigorous academic standards as all students;

—CTE provides a strong foundation for those pursuing a traditional 4-year degree; and
—CTE students are more interested and motivated in their coursework because of its connection to the real world, and have lower dropout rates than traditional students.

Economic

—Many sectors of the economy that require skilled workers report a shortage of qualified applicants to fill these positions. CTE programs prepare individuals for skilled professions that are essential to our Nation's economic recovery.
—CTE programs prepare students, adults, and displaced workers for entry into high-skill, high-wage, and high-demand careers in every industry sector.

The Federal role in "vocational" education began as a way to prepare students for the newly industrialized economy. Over the years, the program has evolved to match the needs of the changing economy, focusing on postsecondary as well as secondary education while giving students skills they can use throughout their careers.

In 2006, the language "vocational and technical" was updated to "career and technical" education. This transition was more than just a name change. It represented a fundamental shift in philosophy from CTE being for those who were not going to college to a system that prepares students for both employment and postsecondary education. The integration of academic and technical education programs was strengthened, further emphasizing the goal of ensuring that students who participate in CTE are taught the same rigorous content aligned with challenging academic standards as all other students. With all school programs now adhering to the same academic standards, the separate "track" system that has stigmatized CTE is disappearing. The chart that follows summarizes these changes.

Traditional vocational education	New career and technical education
For specific students	For all students
Limited program areas offered Separate ''track'' with a focus on technical education	16 Career Clusters and 79 pathways offered Integrated with academics in a rigorous and relevant curriculum
High school focused	High school and postsecondary partnerships providing pathways to employment and/or associate, bachelor's, and advanced degrees
Students trained with focus on specific occupational skill set	Progression of foundational, pathway, occupational, and 21st century skills

Career technical education programs have changed with the times and are a fundamental piece of the education and training available to Americans so that they can get the skills they need in today's economy. Today, there are more than 15 million students and displaced workers enrolled in CTE programs all across America. An increase in funding would enable CTE programs to produce more skilled workers to fill the jobs that are crucial to America's economy. Funds for these programs will help high schools that are reeling from State and local budget reductions and help community colleges accommodate their increasing enrollments. We hope that you can provide $1.4 billion for Perkins CTE supported programs in the fiscal year 2010 budget.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS

The National Alliance of State and Territorial AIDS Directors (NASTAD) represents the Nation's chief State health agency staff who have programmatic responsibility for administering HIV/AIDS and viral hepatitis healthcare, prevention, education, and supportive service programs funded by State and Federal Governments.

As you craft the fiscal year 2010 Labor, Health and Human Services, and Education, an Related Agencies appropriations legislation, we urge you to consider the following critical funding needs of HIV/AIDS, viral hepatitis, and sexually transmitted diseases (STD) programs:

—$1.6 billion for the Ryan White Part B Program, including $514 million for the Part B Base and $1.1 billion for the AIDS Drug Assistance Program (ADAP);
—$1.6 billion for the Centers for Disease Control and Prevention's (CDC) HIV/AIDS Prevention Program, including an additional $249 million for State and

local health department prevention cooperative agreements to include an additional $49 million for State and local HIV/AIDS surveillance systems, and the expansion of the domestic HIV/AIDS Testing Initiative to additional populations and jurisdictions;

—$50 million for CDC's Viral Hepatitis Prevention Program, including a doubling of resources for the Adult Viral Hepatitis Prevention Coordinator Program to $10 million.

—$16 million for hepatitis B vaccination for high-risk adults through the Section 317 Vaccine Program;

—$451 million for CDC's STD Prevention Program for prevention, treatment and surveillance cooperative agreements with State and local health departments; and

—$610 million for the Minority AIDS Initiative to enhance capacity in communities of color.

HIV/AIDS Care and Treatment Programs

The Health Resources and Services Administration administers the $2.2 billion Ryan White Program that providing health and support services to more than 500,000 HIV-positive individuals. NASTAD respectfully requests a minimum increase of $362 million in fiscal year 2010 for State Ryan White Part B grants, including an increase of at least $113 million for the Part B Base and at least $269 million for ADAPs. With these funds all States and territories provide care, treatment, and support services to persons living with HIV/AIDS. People living with HIV need access to trained HIV clinicians, life-saving and life-extending therapies, and a full range of support services to live as healthy a life as possible and to ensure adherence to complicated treatment regimens. All States are reporting to NASTAD that they are seeing a significant increase in the number of individuals seeking Part B Base and ADAP services—for some States it's a doubling of new clients per month from the previous year. This is due to a number of factors including, increased testing efforts and unemployment.

Ryan White Part B Base programs include ambulatory medical services, case management, laboratory services, and an array of support services. As of October 10, 2008, four States report that 266 individuals are on either a medical or support service waiting list for services that include housing, mental health counseling, specialty medical care, and transportation. Five States report that funding is insufficient to ensure that all eligible patients attend medical appointments every 3 months, which is the standard of care. Eight part B programs are also considering cost containment measures for their part B services in light of high demand and reduced funding.

State ADAPs provide medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. While only three States currently have a waiting list with 53 individuals, the present fiscal condition of State ADAPs remain fragile. In fiscal year 2008, State ADAPs were relatively stable due to increased State contributions, increased rebates from drug companies, $39.7 million in ADAP Supplemental grants, transfers of Part B Base funding into ADAP, and program savings from the Medicare Part D Prescription Drug Benefit. The continuing increase in clients and the cuts in State contributions to ADAP (one State has cut their ADAP contribution by $70 million) render the fiscal future of ADAPs uncertain. On average, State spending accounts for 21 percent of the total ADAP budget. Additionally, CDC estimates that their on-going Domestic HIV/AIDS Testing Initiative will find 20,000 new infections over the next year.

While we are very supportive of the funding increases in recent years for the community health center (CHC) program, we want to be clear that this hasn't necessarily translated into more care for person living with HIV/AIDS. CHCs focus on primary care with most of the HIV/AIDS care being provided in centers with Ryan White Part C grants.

HIV/AIDS Prevention and Surveillance Programs

At the request of Congress, the CDC developed a Professional Judgment Budget detailing the needed resources to significantly reduce the number of Americans becoming infected with HIV each year. CDC identified the need for a funding increase of $878 million for total funding of $1.6 billion for CDC's HIV prevention program in fiscal year 2010. As Congress strives to reach the $1.6 billion overall investment in HIV prevention, NASTAD respectfully requests an initial increase of $249 million in State and local health department HIV prevention and surveillance cooperative agreements. This would include an additional $49 million for State and local HIV/AIDS surveillance systems and the expansion of the Domestic HIV/AIDS Testing Initiative to additional populations and jurisdictions.

An estimated 56,300 new infections occur every year while State and local HIV prevention cooperative agreements have been cut by $21 million between fiscal year 2003 and fiscal year 2008. CDC's 2007 surveillance reports showed a 15 percent increase in HIV diagnoses in the 34 States included in the national database while CDC's HIV prevention funding was cut in fiscal year 2008 and flat-funded in fiscal year 2009. Additionally, core HIV/AIDS surveillance funding has eroded over the last decade, while the importance of this data has become paramount for targeting prevention efforts and directing Ryan White resources.

The Nation's prevention efforts must match our commitment to the care and treatment of infected individuals. State and local public health departments know what to do to prevent new infections, they just need the resources. First and foremost we must address the devastating impact on racial and ethnic minority communities. We must expand outreach and HIV testing efforts targeting high-risk populations including gay and bisexual men of all races, racial, and ethnic minority communities, substance users, women, and youth. But, testing alone can never end the epidemic. All tools in the prevention arsenal must be supported. Additional resources must be directed to build capacity and provide technical assistance to enable community-based organizations and healthcare providers to implement evidence-based behavior change interventions, ensure fiscal responsibility and refer partners of HIV-positive individuals to counseling and testing services.

The Domestic HIV/AIDS Testing Initiative is an important step to increasing knowledge of serostatus, particularly among African Americans. Currently 25 jurisdictions (20 States and five cities) receive $36 million for the Expanded Testing Initiative (ETI), including rapid testing, in clinical settings such as emergency rooms, community health centers, correctional health facilities, and STD and tuberculosis clinics. Both CDC and NASTAD conducted assessments of year 1 including progress and challenges faced. Following significant scale-up efforts in all jurisdictions, 21 of the funded jurisdictions conducted 446,503 tests in year 1 of the ETI. Nearly 4,000 new HIV infections were identified, 80 percent of which were in clinical settings. During the first year, 86 percent of testing occurred in clinical settings. Of the total number of tests conducted in the first year, 64 percent were administered to African Americans. Seventy percent of the newly identified infections were among African Americans.

We are requesting that CDC receive sufficient resources to expand the number of jurisdictions participating in the initiative—all jurisdictions have a need for increased resources for testing if we are to truly commit to providing access to testing for all individuals who do not yet know their HIV status. Additional funding would also allow the targeting of additional populations such as gay and bisexual men of all races and Latinos. Another key component of the initiative to expand is identification, notification and counseling of partners of persons living with HIV/AIDS. Partner services are time and resource intensive but maximize prevention efforts.

With 21 percent of HIV-infected persons unaware that they have HIV, increased funding for testing and partner services will avert millions in unnecessary healthcare costs.

We urge the subcommittee to not include language banning use of Federal funds for syringe exchange programs in the fiscal year 2010 Labor, Health and Human Services, and Education, an Related Agencies appropriations bill. Abundant research, endorsed by the findings of eight federally commissioned reviews, has conclusively demonstrated that syringe exchange is effective in reducing the transmission of HIV without increasing drug use. In communities that fund and support access to sterile injection equipment using State and local funds, transmission of HIV and hepatitis in persons who inject drugs has declined as a proportion of all cases by mode of transmission. Unfortunately, State and locally funded syringe exchange are only reaching a small portion of persons who inject drugs. It's time for the Federal Government to use every tool at its disposal to arrest the further spread of HIV and hepatitis C.

We also urge you to eliminate funds for the three separate Federal abstinence-only-until-marriage programs. Instead, we request that you create a dedicated Federal funding stream of at least $50 million in your 2010 budget to fund medically accurate, comprehensive sex education programs that teach young people about both abstinence and contraception.

Lastly, we thank you and ask that you continue to limit the funding for the duplicative Early Diagnosis Grant Program in Section 209 of the Ryan White Treatment Modernization Act of 2006. This program is a carve out of limited HIV testing resources when there is already $10 million dedicated to perinatal prevention.

Viral Hepatitis Prevention Programs

NASTAD respectfully requests an increase of $36.4 million for a total of $50 million in fiscal year 2010 for the CDC's Division of Viral Hepatitis (DVH) to enable State and local health departments to provide basic core public health services. DVH currently receives $18.3 million to address chronic viral hepatitis B and C impacting 6.2 million Americans. This is $7 million less than its peak funding of $25 million in fiscal year 2001. Currently CDC addresses viral hepatitis on outbreak at a time, which is neither cost-effective nor real prevention.

Of the DVH funding, $5.2 million is used to fund the Adult Viral Hepatitis Coordinator Program with an average award to States of $90,000. Doubling this program to $10 million would allow States to implement a hepatitis prevention strategy. The coordinator position receives precious little above personnel costs, leaving little to no money for the provision of public health services including public education, hepatitis counseling, testing, and hepatitis A and B vaccine. In addition, there are no funds for surveillance of chronic viral hepatitis, which would allow States to better target their limited resources. Given the recent hepatitis public health crises in Nevada and New York, the Government has a choice—invest in prevention now or wait until public systems are overwhelmed by a lack of infrastructure to address future outbreaks.

The greatest remaining challenge for hepatitis A and B prevention is the vaccination of high-risk adults. High-risk adults account for more than 75 percent of all new cases of hepatitis B infection each year and annually result in an estimated $658 million in medical costs and lost wages. In fiscal year 2007, CDC allowed States to use $20 million of 317 Vaccine funds to vaccinate high-risk adults for hepatitis B and $16 million in fiscal year 2008. By targeting high-risk adults, including those with hepatitis C, for vaccination, the gap between children and adults who have not benefited from routine childhood immunization programs can be bridged. NASTAD requests a continuation of the $16 million in section 317 Vaccine funds in fiscal year 2010 for hepatitis B vaccination for high-risk adults with the request that in the future DVH receives dedicated funding for hepatitis A and B vaccine for high-risk adults and funding to support the infrastructure necessary for vaccine delivery.

STD Prevention Programs

NASTAD supports an increase of $299 million for a total of $451 million in fiscal year 2010 for STD prevention, treatment and surveillance activities undertaken by State and local health departments. STD prevention programs at CDC have been cut by $6 million since fiscal year 2004 while the number of persons infected continues to climb. The United States has the unwanted distinction of having the highest rates of STDs of all industrial nations with 1 in 4 adolescent girls in the United States, or more than 3 million, having an STD. The rates of syphilis infection have increased for the seventh year in a row. In 1 year, our Nation spends more than $8 billion to treat the symptoms and consequences of STDS. Additional Federal resources are needed to reverse these alarming trends and reduce the Nation's health spending.

Minority AIDS Initiative

NASTAD also supports a $200 million increase for a total of $610 million for the Minority AIDS Initiative (MAI) in fiscal year 2010. The MAI provides targeted resources to four agencies and the Office of the Secretary to address the HIV/AIDS epidemic in hard-hit communities of color. The data from CDC on the disproportionate impact on African Americans and Latinos continues to be alarming. Support for the MAI along with the traditional funding streams that serve these populations is essential.

As you craft the fiscal year 2010 Labor, Health and Human Services, and Education, an Related Agencies appropriations bill, we ask that you consider all of these critical funding needs. National Alliance of State and Territorial AIDS Directors thanks the Chairman, Ranking Member and members of the subcommittee, for their thoughtful consideration of our recommendations. Our response to the HIV, viral hepatitis, and STD epidemics in the United States defines us as a society, as public health agencies, and as individuals living in this country. There is no time to waste in our Nation's fight against these infectious and often chronic diseases.

PREPARED STATEMENT OF THE NATIONAL CONGRESS OF AMERICAN INDIANS

On behalf of the tribal nations of the National Congress of American Indians (NCAI), we are pleased to present our recommendations for fiscal year 2010 funding

of Indian programs in the Departments of Labor, Health and Human Services, and Education, and Related Agencies. President Obama released a broad budget plan for fiscal year 2010 and from what NCAI has reviewed of the blueprint so far, the new administration plans to ensure America's promise extends to the entire Nation, including throughout Indian country.

After tribes witnessed years of declining resources for critical Indian programs in the Federal budget, the attention the administration's fiscal year 2010 proposed budget has given to tribal priorities is a welcome change. The chairman of this subcommittee has heard often of the social and economic challenges facing Indian country. This subcommittee has also heard that the recent resurgence of tribal self-determination has resulted in measurable improvements in the poverty, income, and unemployment among Indian people.

Indian tribes are rebuilding our Nations in ways that honor our ancestors and cultures as well as meeting the demands and opportunities of living in the modern world. An analysis of socioeconomic change between 1990 and 2000 showed that Indian country economies grew at a faster pace than the economy as a whole. Although Indian tribes have made great strides in addressing the long-accumulated economic deficits in our communities, much work remains to be done. Tribes also have a critical role to play in the recovery as the Nation pulls out of the current destructive recession. As the President and Congress aim to invest in people to strengthen the middle class and the drivers of economic growth, NCAI looks forward to tribal self-determination playing a part in the solution. To ensure tribes continue to make progress, sustained investment in tribal governments and programs that support self-determination will be critical in fiscal year 2010. With the new administration and the fiscal year 2010 budget request, there is renewed hope in Indian country.

The President's fiscal year 2010 budget priorities appear to align with many of Indian country's priorities: education, healthcare, infrastructure, and clean energy. Below are some budget recommendations for the Labor, Health and Human Services, and Education, and Related Agencies appropriations bill.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tragically, over the last year, nearly 3,000 American Indians and Alaska natives died of cardiovascular disease, more than 16,500 were diagnosed with a sexually transmitted disease, 5,000 were diagnosed with diabetes for the first time, more than 22,000 are now living with cancer (45 percent of which were diagnosed in the late-stages), and 400 took their own life.

These people are our tribal leaders; our daughters and sons; our mothers and fathers; and, our brothers and sisters. For more than 100 years, Native people have experienced inferior health outcomes. Our life expectancy is still 5 years less than that of other Americans. Adequate funding is needed to end this lasting injustice and uphold the Federal trust responsibility of the United States and the Federal Government.

Provide $1 billion overall for Head Start funding. Provide $10 million for Esther Martinez language programs under the Administration for Native Americans. Fifteen million dollars to fund SAMHSA Behavioral Health Services Grants for American Indian and Alaska Natives. Increase Circles of Care, SAMHSA by $5 million

ADMINISTRATION FOR CHILDREN AND FAMILIES

Head Start.—Over the past 40 years, Head Start has played a major role in the education of Indian children and in the well-being of many tribal communities. However, because of inadequate funding, only about 16 percent of the age-eligible Indian child population is enrolled in Indian Head Start. The comprehensive nature of this program integrates education, health, and family services. Since it closely mirrors a traditional Indian educational model, it is one of the most successful Federal programs operating in Indian country. Despite these successes, Head Start funding has declined by 14 percent over the last 6 years, after factoring in inflation. Head Start should be funded at a rate substantially greater than inflation to make up for prior year cuts and also to trigger special Indian expansion funds that Congress provided when the Head Start Act was reauthorized in 2007.

—$1 billion—Head Start funding (overall)

ADMINISTRATION FOR NATIVE AMERICANS

Native Languages.—Throughout Indian country, tribes are combating the loss of traditional languages by advocating for and instituting language programs within their communities. These language programs serve Native communities by preventing the loss of tribal traditions and cultures. The tribal students in these lan-

guage immersion programs perform substantially better academically, including on national tests, than Native students who have been enrolled in such programs.

—$10 million—Esther Martinez language programs under the Administration for Native Americans

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

American Indian and Alaska Native Grant Program.—This grant program within SAMHSA has been authorized to award grants to Indian health programs to provide the following services: prevention or treatment of drug use or alcohol abuse, mental health promotion, or treatment services for mental illness. To date, these funds have never been appropriated.

—$15 million to fund SAMHSA Behavioral Health Services Grants for American Indian and Alaska natives.

Circles of Care.—Increase funding to $10 million a year for the Circles of Care children's mental health grant program under Programs of National and Regional Significance under SAMHSA. This grant program has historically been funded at about $5 million a year, which provides for approximately seven tribal grants during each 3-year grant cycle. The program has been very successful and has spawned several new tribal children's mental health programs in Indian country that as a result have been self-sustaining.

—Increase of $5 million

DEPARTMENT OF EDUCATION

The administration intends to make investments in education so all Americans can have the chance to receive a world-class education from cradle to career. The 2007 National Indian Education Study indicated that in reading and math, American Indian and Alaska native students scored significantly lower than their peers in both fourth and eighth grades. To ensure that Native students—from pre-school to college—meet the same challenging academic standards as other populations and experience the benefits of a quality and supportive education, it is imperative that the Federal Government uphold its responsibility for the education of Indian people.

Provide $195.5 million for title VII funding under the No Child Left Behind Act. Increase Impact Aid funding 10 percent to adjust for inflation and population growth ($1,365 million). Provide $32 million for title III, Higher Education Act (HEA). Provide $62 million (one-time) forward funding for Tribal Colleges and Universities (TCUs). Provide $10 million for tribal education departments.

Title VII Funding.—This funding provides critical support for culturally based education approaches for American Indian and Alaska native students and addresses the unique educational and cultural needs of Native students. It is well-documented that Native students are more likely to thrive in environments that support their cultural identities while introducing different ideas. Title VII has produced many success stories within our communities, but increased funding is critical in this area to bridge the achievement gap for Native students.

—$195.5 million

Impact Aid Funding.—Impact Aid provides resources to public schools whose tax bases are reduced because of Federal activities, including the presence of an Indian Reservation. Impact Aid affects Native children living on or near tribal lands and children of military families living on or near bases. Approximately 95 percent of American Indian and Alaska Native youth are educated in public schools. Impact Aid funding must be adjusted based on population increases and inflation.

—Increase impact aid funding 10 percent to adjust for inflation and population growth ($1,365 million)

TCUs.—Titles III and V of the HEA, known as Aid for Institutional Development programs, support institutions with a large proportion of financially disadvantaged students and low cost-per-student expenditures. TCUs fit this definition. The Nation's 36 TCUs serve some of the most impoverished areas in the Nation, yet they are the country's most poorly funded postsecondary institutions. Congress recognized the TCUs as young and struggling institutions and authorized a separate section of title III (part A, section 316) specifically to address their needs. Additionally, a separate section (section 317) was created to address similar needs of Alaska native and Native Hawaiian institutions. Section 316 is divided into two competitive grants programs: Formula funded basic development grants and competitive single-year facilities construction grants. Under the Tribal College Act, securing the one-time payment to transition institutional operating grants to a forward funded program would finally end the cycle of delayed payments, short-term loans, and layoffs that currently plague TCUs each year; and, further for the first time, it would provide these institutions the resources they need at the start of each academic year.

—$32 million—Title III, HEA
—$62 million (one-time) forward funding for TCUs

Tribal Education Departments.—More than 100 Indian tribes have started Tribal Education Departments (TED). TEDs develop and administer policies, gather and report data and perform critical research to help tribal students from early childhood through higher and adult education. TEDs serve thousands of tribal students nationwide in BIA, tribal, and public schools. They also cultivate leadership skills and train a potential workforce. Funding for TEDs has been authorized by Congress but never appropriated in either the BIA budget or that of the Department of Education. Both of these authorizations are retained in the No Child Left Behind Act of 2001. Tribes must have access to funding in order to close the achievement gaps so that tribal students will be better equipped to perform well in school. We recommend that $5 million of the funding be directed from the Department of the Interior and $5 million of the funding be directed from the Department of Education.
—$10 million—Tribal education departments

CONCLUSION

NCAI realizes Congress must make difficult budget choices this year. As elected officials, tribal leaders certainly understand the competing priorities that you must weigh over the coming months. However, the Federal Government's constitutional and treaty responsibility to address the serious needs facing Indian country are unique. These responsibilities remain unchanged, whatever the economic climate and competing priorities may be. We at NCAI urge you to make a strong, across-the-board commitment to meeting the Federal trust obligation by fully funding those programs that are vital to the creation of vibrant Indian nations. Such a commitment, coupled with continued efforts to strengthen tribal governments and to clarify the Government-to-government relationship, truly will make a difference in helping us to create stable, diversified, and healthy economies in Indian country.

PREPARED STATEMENT OF THE NATIONAL CONSUMER LAW CENTER [1]

The Federal Low Income Home Energy Assistance Program (LIHEAP) [2] is the cornerstone of Government efforts to help needy seniors and families avoid hypothermia in the winter and heat stress (even death) in the summer. LIHEAP is an important safety net program for low-income, unemployed, and underemployed families struggling in this economy. In fiscal year 2009, the program is expected to assist 7.3 million low-income households afford their energy bills. Residential consumers continue to pay much higher heating bills than in the past, and depending on the region of the country and the heating fuel, the increase in expenditures for heating fuel have been substantial over time. In light of the crucial safety net function of this program in protecting the health and well-being of low-income seniors, the disabled and families with very young children, we respectfully request that LIHEAP be fully funded at its authorized level of $5.1 billion for fiscal year 2010 and that advance funding of $5.1 billion be provided for the program in fiscal year 2011.

HOME ENERGY BILLS REMAIN HIGH AT A TIME WHEN UNEMPLOYMENT AND UNDEREMPLOYMENT IS GROWING

Residential heating expenditures remain at high levels. Average residential heating expenditures this winter are expected to be about 38 percent higher for heating oil, 16 percent higher for natural gas, 42 percent higher for propane, and 24 percent higher for electricity when compared to the 5-year average for 2002–2007.[3] The steady, high energy bills are hitting low-income households struggling in this economic downturn. According to the Bureau of Labor Statistics, in March 2009, the number of unemployed workers was 13.2 million, with half the increase in the number of unemployed occurring within the past 4 months.[4] According the Economic Policy Institute, the number of involuntary part-time workers nearly doubled to more than 8 million in the past year, largely due to full-time workers accepting re-

---

[1] Prepared by Olivia Wein, Staff Attorney, National Consumer Law Center (202–452–6252, owein@nclcdc.org).
[2] 42 U.S.C. §§ 8621 et seq.
[3] Derived from data in the Energy Information Agency, Short-Term Energy Outlook (Feb. 2009), Table WF01.
[4] US, DOL, Bureau of Labor Statistics, *The Employment Situation: March 2009* (rel. April 3, 2009).

duced hours.[5] The hardship low-income households face is also apparent in the data below on the number of households falling behind.

STATES' DATA ON ELECTRIC AND NATURAL GAS DISCONNECTIONS AND ARREARAGES SHOW THAT MORE HOUSEHOLDS ARE FALLING BEHIND

The steady and dramatic rise in residential energy costs has resulted in increases in electric and natural gas arrearages and disconnections. For example, in Rhode Island in 2008 there were 8 percent more service disconnections for nonpayment than in any other year on record, and 21 percent of those accounts were not restored.[6] A recent national survey by the National Association of Regulatory Utility Commissioners found that almost 40 million electricity and natural gas residential consumers held nearly $8.7 billion in past-due accounts at the end of the 2007–2008 Winter heating season. The survey also concluded that in calendar year 2007, 8.7 million residential consumers had their electricity or natural gas service terminated for failing to pay their bills, with 3.6 million who remained disconnected as of this past May 2008.[7]

Although there are winter utility shut-off moratoria in place in many States, not every home is protected against energy shut-offs in the middle of winter. As we approach the lifting of winter shut-off moratoria, we expect to see a wave of disconnections as households are unable to afford the cost of the energy bills. Low-income families are falling further behind as we endure year after year of rising home energy prices. We expect the number of disconnections to grow and the gap between disconnections and reconnections to also grow, especially in light of the economic challenges faced by the unemployed and underemployed workers.

Iowa.—Iowa has experienced a steady increase in enrollment for the regular LIHEAP program from fiscal year 2007 to fiscal year 2009 with 86,000 households in 2007; 87,000 in 2008 and projects 95,700 in fiscal year 2009.[8] As a testament to the difference LIHEAP can make for low-income households, in February 2009, the number of Iowa low-income households with past-due energy accounts and the total amount of the low-income arrears were lower than for the past 3 years at this point in time (e.g., February 2006, February 2007, and February 2008). Comparatively, when looking at the arrearage data for February over time for the total residential gas and electric accounts in arrears and the amount of those arrears, those numbers are at historic highs.[9]

Ohio.—Ohio has experienced a steady and dramatic demand for low-income energy assistance. The number of households entering into the State's low-income energy affordability program, the Percentage of Income Payment Program (PIPP), increased 9 percent from January 2008 to January 2009. The increase is an even more dramatic 86 percent between January 2003 and January 2009. The total dollar amount owed (arrearage) by low-income PIPP customers increased 11 percent from January 2008 to January 2009 and 52 percent when comparing PIPP customer arrears from January 2003 to January 2009.[10] Ohio has experienced a steady increase in enrollment for the regular LIHEAP program (HEAP) from fiscal year 2007 to fiscal year 2009 with 360,000 households in 2007; 370,000 in 2008 and projects 400,000 in fiscal year 2009.[11]

Pennsylvania.—Pennsylvania has also experienced a steady increase in enrollment for the regular LIHEAP program from fiscal year 2007 to fiscal year 2009 with 367,000 households in 2007; 398,000 in 2008 and projects 490,000 in fiscal year 2009.[12] Utilities in Pennsylvania that are regulated by the Pennsylvania Public Utility Commission (PA PUC) have established universal service programs that assist utility customers in paying bills and reducing energy usage. Even with these programs, electric and natural gas utility customers find it difficult to keep pace with their energy burdens. The PA PUC estimates that more than 17,745 households entered the current heating season without heat-related utility service—this number includes about 3,373 households who are heating with potentially unsafe heating sources such as kerosene or electric space heaters and kitchen ovens. In

[5] See Ross Eisenbrey and Kathryn Edwards, *Downtime: Workers forced to settle for fewer hours*, Economic Policy Institute (Jan. 14, 2009).

[6] Analysis of John Howat, senior policy analyst at National Consumer Law Center (April 2009).

[7] Sandra Sloane, Mitchell Miller, Beverly Barker, Lisa Colosimo, "2008 Individual State Report by NARUC Consumer Affairs Subcommittee on Collections Data Gathering." (Approved on Nov. 17, 2008 by the NARUC Consumers Affairs Committee).

[8] NEADA press releases from April 25, 2008 and January 12, 2009.

[9] Based on data provided by the Iowa Bureau of Energy Assistance.

[10] Public Utilities Commission of Ohio.

[11] NEADA press releases from April 25, 2008 and January 12, 2009.

[12] NEADA press releases from April 25, 2008 and January 12, 2009.

mid-December 2008, an additional 13,595 residences where electric service was previously terminated were vacant and more than 6,442 residences where natural gas service was terminated were vacant. In 2008, the number of terminations increased 73 percent compared with terminations in 2004. As of December 2008, 18.3 percent of residential electric customers and 16.9 percent of natural gas customers were overdue on their energy bills. These 2008 overdue utility bills have increased 9.57 percent more than 2007. In addition, in recognition of the increases in media reports of deaths of terminated customers the PA PUC implemented a new reporting requirement. Utilities in Pennsylvania are now required to file reports regarding any incidents involving death at locations where residential utility service has been terminated.[13] The economic downturn is putting additional pressures on local human service agencies as well. A report on the effect of economy on Pittsburgh, Pennsylvania shows a 73.3 percent increase in "first time" applicants for a range of basic needs assistance, including energy assistance.[14]

States are Predicting Record LIHEAP Participation.—NEADA reports that for fiscal year 2009, 15 States have projected increases in participation of at least 21 percent, with Texas estimating a 201 percent increase; Florida 200 percent; California 162 percent; Tennessee 60 percent; Arkansas 50 percent; Arizona 35 percent; Alaska 34 percent; New Mexico 26 percent; Oregon 26 percent; Alabama 25 percent; Massachusetts 25 percent; New Hampshire 25 percent; Pennsylvania 23 percent; Connecticut 23 percent; and Delaware 21 percent.[15] In Arkansas, many of the community action agencies are estimating that about 40 percent of the people contacting them for services over the past 8 to 10 months are new applicants; overwhelmingly, these new applicants are seeking utility assistance.[16] Thus there is great need for a fully funded LIHEAP program in the States.

LIHEAP IS A CRITICAL SAFETY NET PROGRAM FOR THE ELDERLY, THE DISABLED AND HOUSEHOLDS WITH YOUNG CHILDREN

LIHEAP is Vital to Poor Seniors.—Poor seniors are cutting back on energy usage because it is not affordable. In general, elder households use less total household energy than nonelderly households, which is attributable primarily to the smaller dwelling units. However, poor elderly households use markedly less energy than nonpoor elderly households. Even worse, poor elderly households, on average, consume 12 percent more energy per square foot of living space (this measurement is also referred to as energy intensity) than non-poor elderly households. This disparity is attributable to the poorly weatherized living spaces and the use of old, inefficient heating equipment and appliances.[17] LIHEAP is critical for helping low-income seniors maintain safe temperatures in their homes.

Dire Choices and Dire Consequences.—Recent national studies have documented the dire choices low-income households face when energy bills are unaffordable. Because adequate heating and cooling are tied to the habitability of the home, low-income families will go to great lengths to pay their energy bills. Low-income households faced with unaffordable energy bills cut back on necessities such as food, medicine and medical care.[18] The U.S. Department of Agriculture has released a study that shows the connection between low-income households, especially those with elderly persons, experiencing very low food security and heating and cooling seasons when energy bills are high.[19] A pediatric study in Boston documented an increase in the number of extremely low-weight children, age 6 to 24 months, in the 3 months following the coldest months, when compared to the rest of the year.[20]

---

[13] Pennsylvania Public Utility Commission Bureau of Consumer Services.

[14] Vivien Luk and Stacy Kehoe, *Understanding the Impact of the Economic Downturn on Pittsburgh Residents and Human Service Agencies*, the Forbes Funds (November 2008).

[15] NEADA press release, *Applications for Low Income Energy Assistance Reach Record Levels: States Call on Congress to Increase Funding for LIHEAP* (January 12, 2009).

[16] Estimates provided by Arkansas Community Action Agencies Association, Inc.

[17] NCLC analysis of U.S. Energy Information Administration, 2001 Residential Energy Consumption Survey data on elderly energy consumption and expenditures.

[18] *See e.g.*, National Energy Assistance Directors' Association, *2008 National Energy Assistance Survey*, Tables in section IV, G and H (April 2009) (To pay their energy bills 32 percent of LIHEAP recipients went without food, 42 percent went without medical or dental care, 38 percent did not fill or took less than the full dose of a prescribed medicine, 15 percent got a payday loan). *Available at* http://www.neada.org/communications/press/2009-04-28.htm.

[19] Mark Nord and Linda S. Kantor, *Seasonal Variation in Food Insecurity Is Associated with Heating and Cooling Costs Among Low-Income Elderly Americans*, The Journal of Nutrition, 136 (Nov. 2006) 2939–2944.

[20] Deborah A. Frank, MD et al., *Heat or Eat: The Low Income Home Energy Assistance Program and Nutritional and Health Risks Among Children Less Than 3 Years of Age*, AAP Pediat-

Continued

Clearly, families are going without food during the winter to pay their heating bills, and their children fail to thrive and grow. The loss of essential utility services can be devastating, especially for poor families that can find themselves facing eviction. A 2007 Colorado study found that the second leading cause of homelessness for families with children is the inability to pay for home energy.[21]

When people are unable to afford paying their home energy bills, dangerous and even fatal results occur. In the winter, families resort to using unsafe heating sources, such as space heaters,[22] ovens and burners, all of which are fire hazards. In 2006, 73 percent of home heating fire deaths, 43 percent of home heating fire injuries and 51 percent of property damage from home heating fires involved stationary or portable space heaters. In the summer, the inability to keep the home cool can be lethal, especially to seniors. According to the CDC, older adults, young children and person with chronic medical conditions are particularly susceptible to heat-related illness and are at a high risk of heat-related death. The CDC reports that 3,442 deaths resulted from exposure to extreme heat during 1999–2003.[23] The CDC also notes that air-conditioning is the number one protective factor against heat-related illness and death.[24] LIHEAP assistance helps these vulnerable seniors, young children and medically vulnerable persons keep their homes at safe temperatures during the winter and summer and also funds low-income weatherization work to make homes more energy efficient.

LIHEAP is an administratively efficient and effective targeted health and safety program that works to bring fuel costs within a manageable range for vulnerable low-income seniors, the disabled and families with young children. LIHEAP must be fully funded at its authorized level of $5.1 billion in fiscal year 2010 in light of the steady increase in home energy costs and the increased need for assistance to protect the health and safety of low-income families by making their energy bills more affordable during this economic downturn. In addition, fiscal year 2011 advance funding would facilitate the efficient administration of the State LIHEAP programs. Advanced funding provided certainty of funding levels to states to set income guidelines and benefit levels before the start of the heating season. States can also plan the components of their program year (e.g., amounts set aside for heating, cooling and emergency assistance, weatherization, self-sufficiency, and leveraging activities).

PREPARED STATEMENT OF THE NATIONAL COALITION OF STD DIRECTORS

The National Coalition of STD Directors (NSCD) is a nonprofit, nonpartisan association of public health sexually transmitted (STD) program directors in the 65 Centers for Disease Control and Prevention (CDC) directly funded project areas, which includes all 50 States, 7 cities, and 8 U.S. territories. As the only national organization with a constituency that provides frontline STD services, NCSD is the leading national voice for strengthening STD prevention, research and treatment. These efforts include advocating for effective policies, strategies, and sufficient resources, as well as increasing awareness of the medical and social impact of STDs.

We appreciate this opportunity to provide the subcommittee with information about the health crisis caused by the persistent and staggeringly high rates of STDs in the United States and about the programs of the CDC that combat these diseases.

The United States has the highest STD rates in the industrialized world, with more than 19 million people contracting an STD annually. In 1 year, our Nation spends more than $8.4 billion to treat the symptoms and consequences of STDs. The indirect costs are higher, including lost wages and productivity, as well as human costs such as anxiety, shame, anger, depression and the challenges of living with infertility or cancer. The health consequences of STDs include: chronic pain, infer-

---

rics v. 118, no. 5 (Nov. 2006) e1293–e1302. See also, Child Health Impact Working Group, *Unhealthy Consequences: Energy Costs and Child Health: A Child Health Impact Assessment Of Energy Costs And The Low Income Home Energy Assistance Program* (Boston: Nov. 2006) and the *Testimony of Dr. Frank Before the Senate Committee on Health, Education, Labor and Pensions Subcommittee on Children and Families* (March 5, 2008).

[21] Colorado Interagency Council on Homelessness, *Colorado Statewide Homeless Count Summer, 2006*, research conducted by University of Colorado at Denver and Health Sciences Center (Feb. 2007).

[22] John R. Hall, Jr., *Home Fires Involving Heating Equipment: Space Heaters* (In 2006 there were an estimated 64,100 home fires involving space heaters resulting in 540 deaths, 1,400 injuries and $943 million in property damage) National Fire Protection Association (Jan. 2009).

[23] CDC, "Heat-Related Deaths—United States, 1999–2003" MMWR Weekly, July 28, 2006.

[24] CDC, "Extreme Heat: A Prevention Guide to Promote Your Personal Health and Safety" *available at* http://emergency.cdc.gov/disasters/extremeheat/heat_guide.asp.

tility, pregnancy complications, pelvic inflammatory disease, cervical cancer, birth defects, and increased vulnerability to HIV, the virus that causes AIDS. Persons with a pre-existing STD have a three- to fivefold increased risk of acquiring HIV through sexual contact. In addition, studies have shown that HIV-infected persons who are also infected with other STDs are more likely to transmit HIV. Comprehensive STD treatment can reduce the likelihood of HIV transmission.

STDs have a disproportionate impact on young people—women, men who have sex with men (MSM), and racial and ethnic minorities. Of the approximately 19 million new STD infections each year, nearly half are among young people ages 15 to 24. Chlamydia, which leads to infertility, is the most frequently reported disease in the United States. Nearly 1 million women will have a severe case of pelvic inflammatory disease due to STDs. The transmission of STDs to babies—prenatally, during birth, or after—can cause serious life-long complications including physical disabilities, developmental disabilities, and death. MSM have historically experienced high rates of all STDs, including HIV/AIDS. In 2007, 65 percent of all primary and secondary syphilis cases were among MSM. The syphilis rate among males is now six times the rate among females, a dramatic disparity that did not exist a decade ago, when rates were nearly equivalent between the sexes. This trend suggests that the increase in cases among men have been primarily among men who have sex with men. Persons of color, particularly African-Americans, American Indians/Alaska natives, and Hispanics are also at higher risk of contracting STDs. In 2007, the rate of chlamydia among African Americans was eight times that of whites, for American Indian/Alaska natives it was five times higher than whites, and for Hispanics it was three times higher than whites. African American women experience syphilis rates 14 times higher than white women. Socioeconomic, cultural and linguistic barriers to quality healthcare and STD prevention and treatment services have likely contributed to a higher prevalence and incidence of STDs among racial and ethnic minorities.

While rates of STDs in this country have continued to skyrocket, Federal funding for CDC's Division of STD Prevention has steadily declined since fiscal year 2003. For every $1 spent on STD prevention, $43 is spent each year on STD-related costs. In addition, for every $1 spent on research, $92 is spent each year on STD-related costs.

NSCD requests an fiscal year 2010 funding level of $451.3 million, an increase of $299 million, for the STD prevention, treatment, and surveillance programs of the CDC. These funds will significantly enhance the CDC's ability to reduce STD rates across the country.

Public Health Infrastructure (+$40 Million)

Federal funding for CDC's Division of STD Prevention has been relatively flat for the past 15 years. The combined effect of this, along with steadily increasing rates of STDs and more recently, drastic State and local budget cuts due to the economic crisis, STD programs are in crisis mode and stretched thinner than ever. STD programs have had to cut staff, dramatically cut clinical services or close clinic doors altogether, and eliminate critical services such as free condom distribution programs. The public health infrastructure must be rebuilt and modernized. Investments in training, information and surveillance systems, public health laboratories, and better diagnostic technologies would increase efficiency, ensure program effectiveness, and protect the health of future generations.

Public Health Workforce (+$24 Million)

A critical piece of rebuilding the public health infrastructure is scaling up the public health workforce. One-quarter of the current public health workforce will be eligible to retire by 2012. We must invest now in training and retraining the next generation of public health professionals. This is particularly critical for STD programs. The underpinning of all STD programs is the Disease Intervention Specialist (DIS), who provide partner services to individuals infected with STDs, their partners, and to other persons who are at increased risk for STD infection. DIS are specially trained public health workers who are responsible for locating, counseling, and coordinating the testing of individuals exposed to an STD. DIS complete an intensive CDC training course, which provides a strong foundation in field investigation techniques, both on the ground and on the Internet. In some States, DIS also assist in the HIV Partner Services program, by assisting newly HIV-infected individuals with informing their partners of their status and encouraging those partners to seek HIV counseling, testing, and related prevention services. DIS also provide surge capacity during an emergency response, such as the current swine flu epidemic. The versatile expertise of DIS make them indispensable during a public health crisis, and also highlights the need for increased resources to support the

training and hiring of new DIS. The current economic crisis has forced many States to freeze the hiring of new DIS and even lay off DIS, in spite of increasing STD cases.

Expand Chlamydia Screening and Infertility Prevention (+$100 Million)

Chlamydia is the most commonly reported disease in the United States, as well as the primary cause of infertility. The Infertility Prevention Project (IPP), a collaborative effort between CDC and Office of Population Affairs within the Department of Health and Human Services, has been working to reduce STD-related infertility for 15 years. IPP provides funding to screen low-income women for chlamydia and gonorrhea in STD and family planning clinics. This project is a major success story in STD prevention, having been highly successful in reducing new cases of chlamydia and gonorrhea in areas where it has been implemented. However, additional resources are needed to bring this project to scale and reach a greater number of at-risk women. Chlamydia screening has also been shown to be extremely cost effective. Among 21 evidence-based clinical services recommended by the U.S. Preventive Service Task Force, chlamydia screening for young women ranked among the top 5 as having the most health benefits and best value for the dollar.

Additional Federal resources would help support increased chlamydia screening in the public sector, expand school-based and correctional-based screening, as well as initiate a series of demonstration projects in the private sector aimed at increasing private sector screening rates.

Gonorrhea Control and Health Disparities Reduction (+$78 Million)

Gonorrhea is the second most commonly reported infectious disease in the United States. African Americans are the most heavily impacted by this disease, with overall rates 19 times greater than that of whites in 2007. African-American men aged 15 to 19 years old experience gonorrhea rates 39 times higher than white men in the same age group. An increasing issue of concern in the treatment of gonorrhea is antimicrobial drug resistance. In 2006, 13.8 percent of all gonorrhea cases demonstrated resistance, while 39 percent of the cases specifically among MSM demonstrated resistance. In 2007, CDC revised its gonorrhea treatment guidelines to include only a single class of antibiotics.

Additional Federal resources would be used to monitor antimicrobial resistant gonorrhea and test alternate or new drug regimens, initiate culturally competent social marketing campaigns, increase screening and partner services in hyperendemic areas, and develop demonstration research projects to determine the effectiveness and cost-effectiveness of gonorrhea prevention and control interventions.

Syphilis Elimination (+$50 Million)

The rates of primary and secondary syphilis, the most infectious stages of the disease, decreased throughout the 1990s, and in 2000 reached an all-time low. However, since 2000 as STD funding has declined, the syphilis rate in the United States has increased by 76 percent. Since 1999, the Syphilis Elimination Effort (SEE), a collaboration between CDC and State, local, and nongovernmental partners, has worked to eliminate syphilis from all areas of the country and reduce long-standing health disparities. These strategies include: expanded surveillance and outbreak response activities, rapid screening and treatment in and out of medical settings, expanded laboratory services, strengthened community involvement and agency partnerships, and enhanced health promotion. These efforts have been shown to be successful, but must be funded adequately. A 2008 study suggested that SEE funding in a given year was associated with subsequent declines (over the following 2 years) in syphilis rates in a given State. The greater a State's per capita syphilis elimination funding in a given year, the greater the decline in syphilis rates in subsequent years. While the activities of SEE have proven themselves to be effective, they must be adequately and consistently funded to ultimately eliminate this disease in the United States.

Additional Federal resources for SEE would be prioritized for increased screening, particularly among HIV positive persons and pregnant women, the development and evaluation of rapid diagnostic tests, implementation of social marketing campaigns targeted towards MSM and minority populations, and expanded screening in correctional facilities.

Build a Response to Viral STDs (Herpes, HPV, Hepatitis B)

More than 45 million Americans, almost 26 percent of the U.S. population, are infected with herpes simplex virus (HSV), a treatable but incurable viral STD. Improved treatment of HSV is fundamental to reducing the rates of transmission. Individuals with herpes are more susceptible to acquiring HIV. An estimated 20 million Americans are infected with human papillomavirus (HPV), the cause of about 90

percent of all cervical cancer cases. CDC would utilize additional funds to monitor the HPV vaccine introduction and behavioral impact of HPV vaccine through demonstration projects and an expansion of an existing, multi-level, multi-year behavioral research project. The most common source of hepatitis B virus (HBV) infection among adults is sexual contact. Funding is needed to expand prevention efforts on HPV and HBV and to deliver education on the availability of preventive vaccines.

PREPARED STATEMENT OF THE NATIONAL DOWN SYNDROME SOCIETY

Mr. Chairman and members of the subcommittee: As Chairperson of the National Down Syndrome Society, I want to take this opportunity to thank you for the leadership role this subcommittee has played over the years in supporting and creating awareness on Down syndrome. I am pleased to offer the following written testimony regarding appropriation requests for Down syndrome in fiscal year 2010.

There are more than 400,000 people living with Down syndrome in the United States, and about 5,000 babies, or 1 in 800, that are born each year. Down syndrome occurs in people of all races and economic levels, and it is the most frequently occurring chromosomal condition. The incidence of births of children with Down syndrome increases with the age of the mother. But due to higher fertility rates in younger women, 80 percent of children with Down syndrome are born to women under 35 years of age.

Advancements in the treatment of health problems have allowed people with Down syndrome to enjoy fuller and more active lives, and become more integrated into the economic and social structures of our communities. Unfortunately, while progress has also been made in public policies that enhance the lives of individuals with Down syndrome, barriers still exist, making it difficult for people to access adequate healthcare, housing, employment, and education.

We have been working with Congress for decades to address these challenges and advance public policies that promote the acceptance and inclusion of individuals with Down syndrome, and help them to achieve their full potential in all aspects of their lives.

Mr. Chairman, we understand the challenges the subcommittee faces in prioritizing requests, we believe that funding the requirements of the Prenatally and Postnatally Diagnosed Conditions Awareness Act of 2007 (Public Law 110–374) is imperative given the significant impact Down syndrome has on families and communities across the country and the great potential for improvements in quality of life. On behalf of the National Down Syndrome Society, we recommend that you appropriate $5 million in the fiscal year 2010 to implement the requirements of the Prenatally and Postnatally Diagnosed Conditions Awareness Act of 2007.

As you know, last year, Congress passed the Prenatally and Postnatally Diagnosed Conditions Awareness Act of 2007. This new law seeks to ensure that pregnant women receiving a positive prenatal diagnosis of Down syndrome and parents receiving a postnatal diagnosis will receive up-to-date, scientific information about life expectancy, clinical course, intellectual and functional development, and prenatal and postnatal treatment options. It offers referrals to support services such as hotlines, Web sites, informational clearinghouses, adoption registries, parent support networks, and Down syndrome and other prenatally diagnosed conditions programs. The goal is to create a sensitive and coherent process for delivering information about the diagnosis across the variety of medical professions and technicians, to avoid any conflicting, inaccurate, or incomplete information. Also, the legislation would promote the rapid establishments of links to community supports and services for parents who choose to take their baby with Down syndrome home or for those who choose to have their child adopted.

It is estimated that more than 1,000 prenatal tests are available or in development. Included among them are tests for conditions that are not life-threatening, could be helped by surgery or medical care, or don't appear until adulthood. The prognoses for people with some prenatally diagnosable disabilities have been improving markedly in recent years, leaving medical professionals scrambling to keep up with changing data. By including $5 million in the fiscal year 2010 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill, the Department of Health and Human Services (HHS) will be able to fund its responsibilities to:

—Collect and distribute information relating to Down syndrome and other prenatally or postnatally diagnosed conditions;
—Coordinate the provision of supportive services for patients receiving a positive diagnosis of a prenatally or postnatally diagnosed condition; and

—Oversee the new requirements for healthcare providers established by the law. The funding is also needed to carry out the requirement that the CDC assist State and local health departments to integrate testing results into surveillance systems.

Mr. Chairman, thank you for your time and attention. Given the considerable impact this condition has on families and communities across the country, the promise of further assistance and improving research outcomes for individuals with Down syndrome is crucial. We are thrilled beyond measure that Congress enacted this legislation and hope that funding this request will help to shift the way the Nation regards individuals with disabilities. Through providing accurate, updated information about diagnosable conditions like Down syndrome to pregnant women, the expectation is that individuals and families will make better, more-informed decisions. But the bigger impact will be better understanding on the part of the American people about the nature of disability and the value of these citizens to their families, their communities and to our country. Should you have any questions or require additional information, please feel free to call on me.

PREPARED STATEMENT OF THE NEPHCURE FOUNDATION

ONE FAMILY'S STORY

Chairman Cochran and members of the subcommittee thank you for the opportunity to provide written testimony today, I am Dee Ryan and my husband is Lieutenant Colonel John Kevin Ryan, an Iraq war veteran. I would like to tell you about my 6-year-old daughter Jenna's nephrotic syndrome (NS), a medical problem caused by rare diseases of the kidney filter. When affected, these filters leak protein from the blood into the urine and often cause kidney failure requiring dialysis or kidney transplantation. We have been told by our physician that Jenna has 1 of 2 filter diseases called Minimal Change Disease or Focal and Segmental Glomerulosclerosis (FSGS). According to a Harvard University report there are presently 73,000 people in the United States who have lost their kidneys as a result of FSGS. Unfortunately, the causes of FSGS and other filter diseases are very poorly understood.

In October 2007 my daughter began to experience general swelling of her body and intermittent abdominal pain, fatigue, and general malaise. Jenna began to develop a cough and her stomach became dramatically distended. We rushed Jenna to the emergency room where her breathing became more and more labored and her pulse raced. She had symptoms of pulmonary edema, tachycardia, hypertension, and pneumonia. Her lab results showed a large amount of protein in the urine and a low concentration of the blood protein albumin, consistent with the diagnosis of FSGS. Jenna's condition did not begin to stabilize for several frightening days.

Following her release from the hospital we had to place Jenna on a strict diet which limited her consumption of sodium to no more than 1,000 mg per day. Additionally, Jenna was placed on a steroid regimen for the next 3 months. We were instructed to monitor her urine protein levels and to watch for swelling and signs of infection, in order to avoid common complications such as overwhelming infection or blood clots. Because of her disease and its treatment, which requires strong suppression of the immune system, Jenna did have a serious bacterial infection several months after she began treatment.

We are frightened by her doctor's warnings that NS and its treatment are associated with growth retardation and other medical complications including heart disease. As a result of NS, Jenna has developed hypercholesterolemia and we worry about the effects the steroids may have on her bones and development. This is a lot for a little girl in kindergarten to endure.

Jenna's prognosis is currently unknown because NS can reoccur. Even more concerning to us is that Jenna may eventually lose her kidneys entirely and need dialysis or a kidney transplant. While kidney transplantation might sound like a cure, in the case of FSGS, the disease commonly reappears after transplantation. And even with a transplant, end stage renal disease caused by FSGS dramatically shortens one's life span.

The NephCure Foundation (NCF) has been very helpful to my family. They have provided us with educational information about NS, Minimal Change Disease, and FSGS and the organization works to provide grant funding to scientists for research into the cause and cure of NS.

Mr. Chairman, because the causes of NS are poorly understood, and because we have a great deal to learn in order to be able to effectively treat NS, I am asking you to please significantly increase funding for the National Institutes of Health. Also, please support the establishment of a collaborative research network that

would allow scientists to create a patient registry and biobank for NS/FSGS, and that would allow coordinated studies of these deadly diseases for the first time. Finally, please urge the National Institute of Diabetes and Digestive and Kidney Disease (NIDDK) to continue to focus on FSGS/NS research in general, consistent with the recent program announcement entitled Grants for Basic Research in Glomerular Disease (R01) (PA–07–367).

Mr. Chairman, on behalf of the thousands of people suffering from NS and FSGS and NCF, thank you for this opportunity to submit this testimony to the subcommittee and for your consideration of my request; Thank you.

MORE RESEARCH IS NEEDED

We are no closer to finding the cause or the cure of FSGS. Scientists tell us that much more research needs to be done on the basic science behind the disease.

NCF, the University of Michigan, and other important university research health centers have come together to support the establishment of the Nephrotic Syndrome Rare Disease Clinical Research Network. This network is a new collaboration between research institutions and NCF supporting research on NS and FSGS. This initiative has tremendous potential to make significant advancements in NS and FSGS research by pooling efforts and resources. The addition of Federal resources to this important initiative is crucial to ensuring the best possible outcomes for the Nephrotic Syndrome Rare Disease Clinical Research Network occur.

NCF is also grateful to the NIDDK for issuing of a program announcement (PA) that serves to initiate grant proposals on glomerular disease The PA, issued in March of 2006, is glomerular-disease specific. The announcement will utilize the R01 mechanism to award researchers funding.

We ask the subcommittee to encourage the ORD to support the Nephrotic Syndrome Rare Disease Clinical Research Network to expand FSGS research. We also ask the NIDDK to continue to issue glomerular disease program announcements.

TOO LITTLE EDUCATION ABOUT A GROWING PROBLEM

When glomerular disease strikes, the resulting NS causes a loss of protein in the urine and edema. The edema often manifests itself as puffy eyelids, a symptom that many parents and physicians mistake as allergies. With experts projecting a substantial increase in nephrotic syndrome in the coming years, there is a clear need to educate pediatricians and family physicians about glomerular disease and its symptoms.

We also applaud the work of the NIDDK in establishing the National Kidney Disease Education Program (NKDEP), and we seek your support in urging the NIDDK to make sure that glomerular disease remains a focus of the NKDEP.

We ask the subcommittee to encourage the NIDDK to have glomerular disease receive high visibility in its education and outreach efforts, and to continue these efforts in conjunction with NCF's work. These efforts should be targeted towards both physicians and patients.

GLOMERULAR DISEASE STRIKES MINORITY POPULATIONS

Nephrologists tell us that glomerular disease strikes a disproportionate number of African Americans. No one knows why this is, but some studies have suggested that a genetic sensitivity to sodium may be partly responsible. DNA studies of African Americans who suffer from FSGS may lead to insights that would benefit the thousands of African Americans who suffer from kidney disease.

I ask that the NIH pay special attention to why this disease affects African Americans to such a large degree. NCF wishes to work with the NIDDK and the National Center for Minority Health and Health Disparities (NCMHD) to encourage the creation of programs to study the high incidence of glomerular disease within the African-American population.

There is also evidence to suggest that the incidence of glomerular disease is higher among Hispanic Americans than in the general population. An article in the February 2006 edition of the NIDDK publication Recent Advances and Emerging Opportunities, discussed the case of Frankie Cervantes, a 6-year-old boy of Mexican and Panamanian descent. Frankie has FSGS received a transplanted kidney from his mother. We applaud the NIDDK for highlighting FSGS in their publication, and for translating the article about Frankie into both English and Spanish. Only through similar efforts at cross-cultural education can the African-American and Hispanic-American communities learn more about glomerular disease.

We ask the subcommittee to join with us in urging the NIDDK and NCMHD to collaborate on research that studies the incidence and cause of this disease among minority populations. We also ask that the NIDDK and the NCMHD undertake cul-

turally appropriate efforts aimed at educating minority populations about glomerular disease.

PATIENT REGISTRY AND BIOBANK

Experts currently believe glomerular disease is increasing in frequency and it is often misdiagnosed or undetected and, as a result, is often unreported. Since many cases of glomerular disease are unreported, it is difficult to ascertain different aspects of the disease and to form more comprehensive data sets on the patient population. While databases and registries have helped defeat other diseases, one does not exist for FSGS.

The development of a biobank would be beneficial in understanding the genetic components of glomerular disease and their corresponding interactions with environmental factors.

We ask the subcommittee to support the funding of the first-ever national database/registry for FSGS within NIDDK. Experts say that the incidence of FSGS is increasing and that the disease is often misdiagnosed, undetected, or unrecorded. We also ask the subcommittee support the development of a biobank as a further means of understanding the causes of FSGS, both genetic and environmental.

PREPARED STATEMENT OF THE NATIONAL FEDERATION OF COMMUNITY BROADCASTERS

Thank you for the opportunity to submit testimony to this subcommittee regarding the appropriation for the Corporation for Public Broadcasting (CPB). As the President and CEO of the National Federation of Community Broadcasters (NFCB), I speak on behalf of 250 community radio stations and related individuals and organizations across the country. Nearly half our members are rural stations and half are controlled by people of color. In addition, our members include many Low Power FM stations that are putting new local voices on the airwaves. NFCB is the sole national organization representing this group of stations which provide independent, local service in the smallest communities of this country as well as the largest metropolitan areas.

In summary, the points we wish to make to this subcommittee are that NFCB:

—Requests $542 million in funding for CPB for fiscal year 2012;
—Supports a $307 million supplemental appropriation in fiscal year 2010 to ensure that public broadcasting is not lost to any parts of the country because of the economic crisis;
—Requests $40 million in fiscal year 2010 for conversion of public radio and television to digital broadcasting;
—Requests $27 million in fiscal year 2010 for replacement of the radio interconnection system;
—Requests that advance funding for CPB is maintained to preserve journalistic integrity and facilitate planning and local fundraising by public broadcasters;
—Supports CPB activities in facilitating programming and services to Native American, African-American, and Latino radio stations;
—Supports CPB's efforts to help public radio stations utilize new distribution technologies and requests that the subcommittee ensure that these technologies are available to all public radio services and not just the ones with the greatest resources.

Community Radio fully supports the appropriation of $542 million in Federal funding for the Corporation for Public Broadcasting in fiscal year 2012. Federal support distributed through CPB is an essential resource for rural stations and for those serving communities of color. These stations provide critical, life-saving information to their listeners and are often in communities with very small populations and limited economic bases, thus the community is unable to financially support the station without Federal funds. For example, these stations offer programming in languages other than English or Spanish, they can offer emergency information targeted for a particular geographic area, and can offer in-depth programming on public health issues.

In larger towns and cities, sustaining grants from CPB enable community radio stations to provide a reliable source of noncommercial programming about the communities themselves. Local programming is an increasingly rare commodity in a Nation that is dominated by national program services and concentrated ownership of the media. Federal funding allows an alternative to exist in these larger markets. And with large newspaper shedding journalists, local community radio may be one of the only outlets able to pick up the slack in coverage of local political matters.

For more than 30 years, CPB appropriations have been enacted 2 years in advance. This insulation has allowed pubic broadcasting to grow into a respected, inde-

pendent, national resource that leverages its Federal support with significant local funds. Knowing what funding will be available in advance has allowed local stations to plan for programming and community service and to explore additional non-governmental support to augment the Federal funds. Most important, the insulation that advance funding provides "go[es] a long way toward eliminating both the risk of and the appearance of undue interference with and control of public broadcasting." (House Report 94–245.)

For the past few years, CPB has increased support to rural stations and committed resources to help public radio take advantage of new technologies such as the Internet, satellite radio, and digital broadcasting. We support these new technologies we can better serve the American people, but want to ensure that smaller stations with more limited resources are not left behind in this technological transition. We ask that the subcommittee include language in the appropriation that will ensure that funds are available to help the entire public radio system, particularly rural and minority stations, utilize new technology.

NFCB commends CPB for the leadership it has shown in supporting and fostering programming services to Latino stations and Native American stations. For example, Satélite Radio Bilingüe provides 24 hours of programming to stations across the United States and Puerto Rico addressing issues of particular interest to the Latino population in Spanish and English. At the same time, Native Voice One (NV1) is distributing politically and culturally relevant programming to Native American stations. There are now more than 33 stations in the United States controlled by and serving Native Americans.

Five years ago, CPB funded the establishment of the Center for Native American Public Radio (CNAPR). After 4 years in operation, CNAPR has assisted with the renewal of licenses and expansion of the interconnection system to all Native stations and has advanced the opportunity for native nations to own their own, locally controlled station. In the process of this work, it was recognized that radio would not be available to all native nations and broadband and other new technologies would be necessary. CNAPR has been repositioned as Native Public Media (NPM) and is working hard to double the number of native stations within the next 3 years. These stations are critical in serving local, isolated communities (all but one are on Indian Reservations) and in preserving cultures that are in danger of being lost. CPB's 2003 assessment recognized that ". . . Native Radio faces enormous challenges and operates in very difficult environments." CPB funding is critical to these rural, minority stations. The funding of the Intertribal Native Radio Summit by CPB in 2001 helped to gather these isolated stations together into a system of stations that can support one another. The CPB assessment goes on to say "Nevertheless, the Native Radio system is relatively new, fragile and still needs help building its capacity at this time in its development." NPM promises to leverage additional new funding to ensure that these stations continue providing essential services to their communities.

CPB also funded a Summit for Latino Public Radio which took place in September 2002 in Rohnert Park, California, home of the first Latino public radio station. This year, CPB has provided funding to the Latino Public Radio Consortium to develop a strategic plan and business model to expand the service of public radio to the Latino population. The Latino population is growing in this country and requires news services geared toward them in order to fully participate in civic life. Hispanics were 12.5 percent of the population in 2000, by 2007 they were 15 percent, and the number is only growing.[1]

CPB plays an extremely important role in the public and Community radio system: They convene discussions on critical issues facing us as a system. They support research so that we have a better understanding of how we are serving listeners. And, they provide funding for programming, new ventures, expansion to new audiences, and projects that improve the efficiency of the system. This is particularly important at a time when there are so many changes in the radio and media environment with media consolidation and new distribution technologies.

Community radio supports a $307 million supplemental appropriation in fiscal year 2010 to ensure that public broadcasting is not lost to any parts of the country because of the economic crisis. Public Broadcasting is requesting a one-time investment of Federal resources to help stations maintain local service and assist their communities cope with the economic crisis and to assure continuity of public broadcasting service to the American people. Financial contributions from corporations, foundations, institutions are down dramatically and listeners contributions, the main source of funding for Community radio are beginning to be impacted by the

[1] Pew Hispanic Center, Statistical Portrait of Hispanics in the United States, 2007.

growing unemployment. Community stations are critical sources of local information and it is essential that they be able to continue to provide their unique local service.

Community radio supports $40 million in fiscal year 2010 for the conversion to digital broadcasting by public radio and television. While public television's digital conversion needs are mandated by the FCC, public radio is converting to digital to provide more public service and to keep up with commercial radio. The Federal Communications Commission has approved a standard for digital radio transmission that will allow multicasting. CPB has provided funding for more than 650 radio transmitters to convert to digital. Of those, 160 are multicasting two or more streams of programming. The development of second and third audio channels will potentially double or triple the service that public radio can provide listeners, particularly in un-served and underserved communities. However, this initial funding still leaves nearly 200 radio transmitters that must ultimately convert to digital or become obsolete.

Community radio strongly supports $27 million in fiscal year 2009 for the public radio interconnection system. Public radio pioneered the use of satellite technology to distribute programming. The Public Radio Satellite System's recently launched ContentDepot continues this tradition of cutting edge technology. Satellite capacity supporting it must be renewed and upgrades are necessary at the station and network operations levels. Interconnection is vital to the delivery of the high-quality programming that public broadcasting provides to the American people. This is the last year of a 3-year request for $80 million to the complete the project.

We are in a period of tremendous change. "Radio is well on its way to becoming something altogether new—a medium called audio."[2] The digital movement is transforming the way we do things; new distribution avenues like digital satellite broadcasting and the Internet are changing how we define our business; and, the concentration of ownership in commercial radio makes public radio in general, and Community radio in particular, more important as a local voice than we have ever been. New Low Power FM stations are providing local voices in their communities an avenue of expression, and many new community stations will be going on the air within the next few years. Community radio is providing essential local emergency information, programming about the local impact of major global events taking place, and culturally relevant information and entertainment in native languages, as well as helping to preserve cultures that are in danger of dying out. During the natural disasters of recent years, radio proved once again that it is the most dependable and available medium for getting emergency information to the public.

During these challenging times, the role of CPB as a convener of the system becomes even more important. The funding that it provides will allow smaller stations to participate alongside larger stations that have more resources as we move into a new era of communications.

PREPARED STATEMENT OF THE NATIONAL FRAGILE X FOUNDATION

Mr. Chairman and members of the subcommittee: As President of the Board of Directors for the National Fragile X Foundation, I want to take this opportunity to thank you for the leadership role this subcommittee has played over the years in the fight for Fragile X-associated Disorders. I am pleased to offer the following written testimony regarding appropriation requests in fiscal year 2010.

Fragile X-associated Disorders are genetic disorders that cause behavioral, developmental, and language disabilities across a person's lifespan. It is linked to a mutation on the X chromosome, and is the most commonly inherited form of intellectual disabilities. Fragile X is also linked to reproductive problems in women including early menopause Fragile X-associated primary ovarian insufficiency (FXPOI) and, a Parkinson's-like condition in older male carriers Fragile X-associated tremor/ataxia syndrome (FXTAS). More than 100,000 Americans have Fragile X Syndrome and more than 1 million Americans carry a Fragile X mutation and either have, or are at risk for developing a Fragile X-associated disorder.

These appropriations requests are significant in order to continue to build the infrastructure needed and assure continued progress toward targeted treatments for Fragile X-associated Disorders. The National Fragile X Foundation has invested significantly in the creation of the Fragile X Clinical & Research Consortium, a network of 20 clinics across the country who collaborate to align data collection efforts, participate in clinical trials of new pharmacological agents, share research findings and develop consistent best practices and standards of care for the treatment of Fragile X-associated Disorders.

---

[2] The State of the News Media, Pew Project for Excellence in Journalism, 2008.

In addition, these appropriations requests would assist in building upon important work already initiated by the Federal Government. We have been successful at building programs at the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and Health Resources and Services Administration (HRSA). The CDC has recognized the value of this important collaboration, and has provided resources to ensure the continued growth and evolution of the Fragile X Clinical & Research Consortium. Previously, the CDC had secured nearly $4.5 million in funding since fiscal year 2005 for the CDC Fragile X National Public Health Initiative. The program is currently funded at just more than $1.8 million annually. Furthermore, the CDC has worked with Congress to define the highest impact public health priorities for the Fragile X community. These efforts led to:

—Development of a newborn screening test for fragile X syndrome;
—Single gene resource network for fragile X syndrome;
—Fragile X syndrome cascade testing and genetic counseling protocols;
—Fragile X Family Needs Assessment; and
—Support for the Fragile X Clinical & Research Consortium.

Moreover, public efforts, including three National Institute of Child Health and Human Development (NICHD)-funded Fragile X Research Centers, has proven critically important in the development of effective treatments. The development of key therapeutics for Fragile X will likely be effective for a much larger population living with related autism spectrum disorders. We recognize that in order to translate basic science findings into viable treatments for Fragile X, additional coordination and resources are required at the NIH.

The Fragile X community has been working to promote the work of NIH to ensure improved coordination among the various Institutes to ensure the most effective use of Federal research dollars devoted to Fragile X-associated Disorders (i.e., Fragile X Syndrome, Fragile X-associated Tremor/Ataxia Syndrome, and Fragile X-associated Primary Ovarian Insufficiency). Congress has advocated for greater resources at NIH leading to an increase in NIH Fragile X-associated Disorders efforts from approximately $12 million annually in 2001 to approximately $27 million in fiscal year 2009. With this increase, NIH recently awarded the largest Fragile X Federal research grant in history, a 5-year, $21.8 million grant to a team of researchers at the UC Davis School of Medicine and M.I.N.D. Institute.

As you know, the fiscal year 2008 Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act included language directing the NIH, under the leadership of the NICHD (Senate Report 110–107) to coordinate, intensify, and expedite research efforts related to Fragile X-associated Disorders. The law specifically directed the NIH to convene a scientific session in 2008 to develop pathways to new opportunities for collaborative, directed research across Institutes, and to produce a blueprint of coordinated research strategies and public-private partnership opportunities for Fragile X. The NICHD was directed to lead this initiative and was urged to collaborate with the three existing federally funded Centers of Excellence as well as the Fragile X Clinical & Research Consortium.

In response to this directive, NICHD leadership convened a 2-day scientific session and created a rigorous working group infrastructure consisting of the world's leading researchers and NIH staff to ensure timely development of the NIH Research Blueprint on Fragile-X associated disorders. The leadership team at NICHD and three working groups prepared a comprehensive blueprint that will provide a clear direction for future research activities for Fragile-X associated disorders. The final draft of this report was completed in late 2008, and will be published by NIH this week.

Mr. Chairman, we respectfully request Congress to continue its support of these ongoing initiatives, and to support increased prioritization of Fragile X-associated Disorders at the CDC and NIH in order to accelerate the critical work being accomplished through the Fragile X Clinical & Research Consortium.

The National Fragile X Foundation recommends that you appropriate the following fiscal year 2010 requests:

—A $2 million increase in funding from fiscal year 2009 levels, for the National Fragile X Public Health Initiative and other CDC initiatives to:
  —Focus efforts on identifying ongoing needs, effective treatments, and positive outcomes for families by increasing epidemiological research, surveillance, screening efforts, and the introduction of early interventions and supports for individuals living with Fragile X-associated Disorders.
  —Focus on the continued growth and development of initiatives that support health promotion activities and foster rapid, high-impact translational research practice for the successful treatment Fragile X-associated Disorders,

including ongoing collaborative activities with the Fragile X Clinical & Research Consortium.

—Report language and increased resources for Fragile X at the NIH to:

—Support continued implementation of the recommendations outlined in the NIH Fragile X-associated Disorders Research Blueprint as well as increased NIH support for the Fragile X Clinical & Research Consortium.

—Enhance its efforts across its Institutes to translate basic science findings into viable treatments for Fragile X, and encourage clinical drug trials for this orphan indication.

—Maximize Fragile X resources by ensuring that appropriate resources and direction is provided to implement the objectives outlined in the Fragile X Research Blueprint.

—Strengthen and broaden research on Fragile X- associated disorders (i.e., FXTAS and FXPOI).

Furthermore, as part of our overall to increase support and prioritization of Fragile X-associated Disorders at the Federal level, the Fragile X community is also working with the Defense Subcommittee on Appropriations to include Fragile X-associated Disorders among the list of eligible healthcare conditions for targeted biomedical research funding through the U.S. Department of Defense. The success from all of these intense public and private research efforts, including the NIH and CDC, has brought discoveries to bear for Fragile X-associated Disorders. However, we feel continued expansion of Federal efforts and resources at each of these agencies will be instrumental to conduct promising research on Fragile X-associated Disorders.

Mr. Chairman, thank you for your time and attention. We, at the National Fragile X Foundation, believe that continued awareness and support for enhancing Fragile X research and translational activities is imperative. Given the significant impact this condition has on families and communities across the country, the promise of a breakthrough for the treatment and cure of this disease is urgent. Should you have any questions or require additional information, please feel free to call on me.

PREPARED STATEMENT OF THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

The National Health Care for the Homeless Council respectfully asks the Senate Committee on Appropriations to strengthen and expand the Nation's health centers by appropriating $2.9 billion for the Consolidated Health Centers Program in fiscal year 2010.

The National Health Care for the Homeless Council is a membership organization engaged in education and advocacy to improve healthcare for homeless persons and all Americans. We represent 111 organizational members, including 100 Health Care for the Homeless (HCH) projects, and more than 700 individuals who provide care to people experiencing homelessness throughout the country.

Homelessness and Health.—Poverty, lack of affordable housing, and the lack of comprehensive health insurance are among the underlying structural causes of homelessness. For those struggling to pay for housing and other basic needs, the onset of a serious illness or disability easily can result in homelessness following the depletion of financial resources. The experience of homelessness causes poor health, and poor health is exacerbated by restricted access to appropriate healthcare—which only prolongs homelessness. Additional barriers to healthcare access include lack of transportation, inflexible clinic hours, complex requirements to qualify for public health insurance, and mandatory unaffordable co-payments for various services.

Mainstream healthcare safety net providers often fail to meet the needs of homeless people. In the absence of universal healthcare, the Federal Government supports a separate healthcare system for low-income and uninsured people. Community Health Centers and publicly funded mental health and addictions programs form the core of this healthcare safety net. Unfortunately, limited resources, lack of experience with this population, and insufficient linkages to a full range of health and supportive services seriously restrict the ability of mainstream providers to meet the unique needs of people experiencing homelessness.

The Federal Health Care for the Homeless Program—administered by the Health Resources and Services Administration (HRSA)—currently supports 205 HCH projects in all 50 States, the District of Columbia, and Puerto Rico. Congress established HCH in 1987 to provide targeted services for people experiencing homelessness, including primary and behavioral healthcare along with social services, as well as intensive outreach and case management to link clients with appropriate resources. Approximately 70 percent of those served by HCH projects lack comprehensive health insurance. The HCH program has been reauthorized three times, most

recently in 2008 with passage of the Health Care Safety Net Act. HCH projects served 742,588 in 2007—a sizable number, but far below the 3.5 million Americans who annually experience homelessness. Authorizing language designates 8.7 percent of the total Health Center appropriation to support the HCH program.

Community Health Centers.—Over the past several years, the expansion of community health centers has received bipartisan support from Members of Congress. Federally-Qualified Health Centers (FQHCs) consistently have proven their effectiveness in delivering comprehensive medical care to underserved populations. Though health centers currently serve more than 16 million people annually, at least 56 million Americans—both insured and uninsured—face inadequate access to primary care due to a shortage of physicians and other providers. Without sufficient access to care, the health problems of the insured and underinsured are exacerbated, resulting in costly treatment, medical complications, and even premature death.

Within the current economic context, a massive unmet need remains for health center resources despite years of incremental expansion through the Health Center Growth Initiative. The deteriorating economy leaves more Americans unemployed, at risk of homelessness, and in need of health services. According to the Department of Labor, unemployment jumped to 8.5 percent in March 2009, the highest in 14 years. With continued increases in unemployment, more Americans are expected to lose health coverage, thus placing additional burden upon community health centers.

Fiscal Year 2010 Appropriations.—In recognition of the growing need for primary healthcare services, the Senate Committee on Appropriations along with other Members of Congress has been supportive of strengthening and expanding community health centers. In the current year, Congress appropriated $2.2 billion—$125 million above the fiscal year 2008 appropriation. This included $56 million in base grant adjustments and provided a total of $191 million (8.7 percent) for the HCH program.

To continue strengthening the Nation's health center infrastructure, we encourage the Senate Committee on Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies to appropriate $2.9 billion for the Community Health Center program (including $252 million for the HCH program) in fiscal year 2010. The National Council's request is consistent with planned increases outlined in the Access for All America Act (S. 486). This important legislation, introduced by Senator Bernie Sanders, would quadruple the amount of funding for community health centers over the next 5 years.

The National Council applauds Congress for its strong support of community health centers. We thank Chairman Harkin and the Senate Committee on Appropriations Subcommittee on Labor, Health and Human Service, and Education, and Related Agencies for your consideration of this testimony.

PREPARED STATEMENT OF THE NATIONAL MARFAN FOUNDATION

Mr. Chairman, thank you for the opportunity to submit testimony regarding the fiscal year 2010 budget for the National Heart, Lung and Blood Institute (NHLBI), the National Institute of Arthritis, Musculoskeletal and Skin Diseases (NIAMS), and the Centers for Disease Control and Prevention (CDC). The National Marfan Foundation is grateful to you and the subcommittee for your strong support of the National Institutes of Health and CDC, particularly as it relates to life-threatening genetic disorders such as Marfan syndrome. Thanks in part to your leadership we are at a time of unprecedented hope for our patients.

It is estimated that 200,000 people in the United States are affected by Marfan syndrome or a related condition. Marfan syndrome is a genetic disorder of the connective tissue that can affect many areas of the body, including the heart, eyes, skeleton, lungs, and blood vessels. It is progressive condition and can cause deterioration in each of these body systems. The most serious and life-threatening aspect of the syndrome is a weakening of the aorta. The aorta is the largest artery carrying oxygenated blood from the heart. Over time, many Marfan syndrome patients experience a dramatic weakening of the aorta which can cause the vessel to dissect and tear.

Early surgical intervention can prevent a dissection and strengthen the aorta and the aortic valves. If preventive surgery is performed before a dissection occurs, the success rate of the procedure is more than 95 percent. If surgery is initiated after a dissection has occurred, the success rate drops below 50 percent. Aortic dissection is a leading killer in the United States, and 20 percent of the people it affects have a genetic predisposition, like Marfan syndrome, to developing the complication.

Fortunately, new research offers hope that a commonly prescribed blood pressure medication might be effective in preventing this frequent and devastating event.

NHLBI

Pediatric Heart Network Clinical Trial

NMF applauds NHLBI for its leadership in advancing a landmark clinical trail on Marfan syndrome. Under the direction of Dr. Lynn Mahoney and Dr. Gail Pearson, the Institute's Pediatric Heart Network has spearheaded a multicenter study focused on the potential benefits of a commonly prescribed blood pressure medication (losartan) on aortic growth in Marfan syndrome patients.

NHLBI Director Dr. Elizabeth Nabel describes this promising research well:

"After the discovery that Marfan syndrome is associated with the mutation in the gene encoding a protein called fibrillin-1, researchers tried for many years, without success, to develop treatment strategies that involved repair of replacement of fibrillin-1. Then a major breakthrough occurred with the discovery that one of the functions of fibrillin-1 is to bind to another protein, TGF-beta, and regulate its effects. After careful analysis revealed aberrant TGF-beta activity in patients with Marfan syndrome, researchers began to concentrate on treating Marfan syndrome by normalizing the activity of TGF-beta. Losartan, which is known to affect TGF-beta activity, was tested in a mouse model of Marfan syndrome and the results showed that drug was remarkably effective in blocking the development of aortic aneurysms, as well as lung defects associated with the syndrome.

Based on this promising finding, the NHLBI Pediatric Heart Network, has undertaken a clinical trial of losartan in patients with Marfan syndrome. About 600 patients aged 6 months to 25 years will be enrolled and followed for 3 years. This development illustrates the outstanding value of basic science discoveries, and identifying new directions for clinical applications. Moreover, the ability to organize and initiate a clinical trial within months of such a discovery is testimony to effectiveness of the NHLBI Network in providing the infrastructure and expertise to capitalize on new findings as they emerge."

Dr. Hal Dietz, the Victor A. McKusick Professor of Genetics in the McKusick-Nathans Institute of Genetic Medicine at the Johns Hopkins University School of Medicine, and the director of the William S. Smilow Center for Marfan Syndrome Research, is the driving force behind this groundbreaking research. Dr. Dietz uncovered the role that fibrillin-1 and TGF-beta play in aortic enlargement, and demonstrated the benefits of losartan in halting aortic growth in mice. He is the reason we have reached this time of such promise and NMF is proud to have supported Dr. Dietz's cutting-edge research for many years.

NMF is also proud to actively support the losartan clinical trial in partnership with the Pediatric Heart Network. Throughout the life of the trial we will provide support for patient travel costs, coverage of select echocardiogram examinations, and funding for ancillary studies. These ancillary studies will explore the impact that losartan has on other manifestations of Marfan syndrome.

NHLBI "Working Group on Research in Marfan Syndrome and Related Conditions"

In April 2007, NHLBI convened a "Working Group on Research in Marfan Syndrome and Related Conditions." Chaired by Dr. Dietz, this panel was comprised of experts in all aspects of basic and clinical science related to the disorder. The panel was charged with identifying key recommendations for advancing the field of research in the coming decade. The recommendations of the Working Group are as follows:

"Scientific opportunities to advance this field are conferred by technological advances in gene discovery, the ability to dissect cellular processes at the molecular level and imaging, and the establishment of multi-disciplinary teams. The barriers to progress are addressed through the following recommendations, which are also consistent with Goals and Challenges in the NHLBI Strategic Plan.

—Existing registries should be expanded or new registries developed to define the presentation, natural history, and clinical history of aneurysm syndromes.
—Biological and aortic tissue sample collection should be incorporated into every clinical research program on Marfan syndrome and related disorders and funds should be provided to ensure that this occurs. Such resources, once established, should be widely shared among investigators.
—An Aortic Aneurysm Clinical Trials Network (ACTnet) should be developed to test both surgical and medical therapies in patients with thoracic aortic aneurysms. Partnership in this effort should be sought with industry, academic organizations, foundations, and other governmental entities.

—The identification of novel therapeutic targets and biomarkers should be facilitated by the development of genetically defined animal models and the expanded use of genomic, proteomic, and functional analyses. There is a specific need to understand cellular pathways that are altered leading to aneurysms and dissections, and to develop robust in vivo reporter assays to monitor TGFb and other cellular signaling cascades.

—The developmental underpinnings of apparently acquired phenotypes should be explored. This effort will be facilitated by the dedicated analysis of both prenatal and early postnatal tissues in genetically defined animal models and through the expanded availability to researchers of surgical specimens from affected children and young adults."

We look forward to working closely with NHLBI to pursue these important research goals and ask the subcommittee to support the recommendations of the Working Group. Mr. Chairman, for fiscal year 2010 NMF joins with other professional and patient organizations in recommending a 7 percent for NHLBI.

NIAMS

NMF is proud of its longstanding partnership with NIAMS. Dr. Steven Katz has been a strong proponent of basic research on Marfan syndrome during his tenure as NIAMS Director and has generously supported several "Conferences on Heritable Disorders of Connective Tissue." Moreover, the Institute has provided invaluable support for Dr. Dietz's mouse model studies. The discoveries of fibrillin-1, TGF-beta, and their role in muscle regeneration and connective tissue function were made possible in part through collaboration with NIAMS.

As the losartan clinical trail moves forward, we hope to expand our partnership with NIAMS to support related studies that fall under the mission and jurisdiction of the Institute. One of the areas of great interest to researchers and patients is the role that losartan may play in strengthening muscle tissue in Marfan patients. We would welcome an opportunity to partner with NIAMS in support of this research moving forward.

For fiscal year 2010, NMF recommends a 7 percent increase for NIAMS.

CDC

Mr. Chairman, we are grateful for the subcommittee's encouragement in recent years of collaboration between CDC and the Marfan syndrome community. One of the most important things we can do to prevent untimely deaths from aortic aneurysms is to increase awareness of Marfan syndrome and related connective tissue disorders.

Despite our ongoing efforts to raise awareness among the general public and healthcare providers, we know of too many families who have lost a loved one because of a missed diagnosis.

We are very appreciative of CDC's support of our 25th annual patient conference taking place in Rochester, Minnesota August 6–9, 2009. We have also discussed other potential collaborations with the National Center on Birth Defects and Development Disabilities focused on education and early diagnosis. We ask the subcommittee to continue to encourage CDC to work with us to initiate these activities in fiscal year 2010.

For fiscal year 2010, NMF joins with the CDC Coalition in recommending an appropriation of $8.6 billion for core CDC programs.

PREPARED STATEMENT OF THE NATIONAL NETWORK TO END DOMESTIC VIOLENCE

Chairman Harkin, Ranking Member Cochran, and members of the subcommittee, thank you for the opportunity to submit written testimony to the Labor, Health and Human Services, and Education, an Related Agencies (LHHS) Appropriations Subcommittee. We are grateful to the subcommittee for your continued leadership and your investment in lifesaving programs that prevent and end domestic violence.

The National Network to End Domestic Violence (NNEDV) is a membership and advocacy organization representing the 56 State and U.S. territory domestic violence coalitions. NNEDV provides a national voice for the coalitions, their more than 2,000 local domestic violence member programs, and the millions of domestic violence survivors who turn to them for services. In their work with victims and their families, our members see the impact that abuse and violence have on the lives of children who are vulnerable both as witnesses to violence and as victims themselves.

Over the last 25 years, millions of victims have found refuge and safety through domestic violence programs funded by the Family Violence Prevention and Services Act (FVPSA). The success of this LHHS-funded program, however, is threatened by budget stagnation and an increasing demand for services. Small budget increases, while appreciated, simply cannot meet the desperate needs of victims. Now, more than ever, we need to increase our country's investment in this vital, cost-effective program. Increases to FVPSA funding will help bridge the unconscionable gap created by an increased demand and inadequate funding. On behalf of the millions of victims and families that our member programs serve each year, we urge you to fully fund the FVPSA/Battered Women's Shelter Services program (FVPSA) at $175 million, the National Domestic Violence Hotline at $3.5 million, and the Community Initiatives to Prevent Abuse (DELTA) program at $6 million in the fiscal year 2010 congressional budget.

DOMESTIC VIOLENCE

Domestic violence is pervasive and life-threatening. According to the 2005 Bureau of Justice Statistics' Family Violence Statistics, of the total victims of violence between 1998 and 2002, 11 percent were victims of family violence.[1] One in four women has been beaten or raped by a husband, boyfriend, or partner in her lifetime.[2] In 2005 alone, 1,181 women were murdered by an intimate partner in the United States[3] and approximately one-third of all female murder victims are killed by an intimate partner.[4]

The cycle of intergenerational violence is perpetuated as children witness violence. It is estimated that a staggering 15.5 million children are exposed to domestic violence every year.[5] Children who are exposed to domestic violence are more likely to exhibit behavioral and physical health problems including depression, anxiety, and violence towards peers.[6] They are also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution, and perpetrate sexual assault.[7] One study found that men exposed to physical abuse, sexual abuse, and adult domestic violence as children were almost four times more likely than other men to have perpetrated domestic violence as adults.[8]

Domestic violence is not just a crime; it is a public health crisis that leads to chronic health conditions, disabilities, lost work time, frequent trips to the emergency room and, all too often, serious injury or death.

In addition to the terrible cost domestic and sexual violence have on the lives of individual victims and their families, these crimes cost taxpayers and communities. In fact, the cost of intimate partner violence exceeds $5.8 billion each year, $4.1 billion of which is for direct medical and mental healthcare services.[9] Research shows that for every 100,000 women between 18 and 64 enrolled, intimate partner violence

---

[1] U.S. Department of Justice, Bureau of Justice Statistics, Family Violence Statistics: Including Statistics on Strangers and Acquaintances, June 2005.

[2] Tjaden, Patricia & Thoennes, Nancy. National Institute of Justice and the Centers of Disease Control and Prevention, "Extent, Nature and Consequences of Intimate Partner Violence: Findings from the National Violence Against Women Survey," 2000. The Centers for Disease Control (CDC) (2008). *Adverse Health Conditions and Health Risk Behaviors Associated with Intimate Partner Violence, United States*, 2005.

[3] Bureau of Justice Statistics, Homicide Trends in the U.S. from 1976–2005. US Department of Justice. (2008).

[4] Bureau of Justice Statistics, Homicide Trends from 1976–1999. U.S. Department of Justice. (2001)

[5] McDonald, R., et al. (2006). "Estimating the Number of American Children Living in Partner-Violence Families." *Journal of Family Psychology, 30(1)*, 137–142.

[6] Jaffe, P. and Sudermann, M., "Child Witness of Women Abuse: Research and Community Responses," in Stith, S. and Straus, M., *Understanding Partner Violence: Prevalence, Causes, Consequences, and Solutions*. Families in Focus Services, Vol. II. Minneapolis, MN: National Council on Family Relations, 1995.

[7] Wolfe, D.A., Wekerle, C., Reitzel, D. and Gough, R., "Strategies to Address Violence in the Lives of High Risk Youth." In Peled, E., Jaffe, P.G. and Edleson, J.L. (eds.), *Ending the Cycle of Violence: Community Responses to Children of Battered Women*. New York: Sage Publications. 1995.

[8] Greendfeld, L. A. (1997). Sex Offences and Offenders: An Analysis of Date on Rape and Sexual Assault. Washington, DC. Bureau of Justice Statistics, U.S. Department of Justice.

[9] National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States*. Atlanta (GA): Centers for Disease Control and Prevention; 2003.

costs a health insurance plan $19.3 million each year.[10] Domestic violence costs U.S. employers an estimated $3 to $13 billion annually.[11]

THE FAMILY VIOLENCE PREVENTION AND SERVICES ACT (FVPSA)

Despite this grim reality, we know that when immediate, essential services are available victims can escape from life-threatening violence and begin to rebuild their shattered lives.

FVPSA has significantly enhanced community-based domestic violence intervention and prevention efforts since it was first authorized by Congress in 1984. Administered by the Department of Health and Human Services Administration on Children and Families through a State formula grant, FVPSA provides funding to States, territories and tribes to support domestic violence services in their communities using a population-based formula. These essential services that are at the core of ending domestic violence: emergency shelters, hotlines, counseling and advocacy, primary and secondary prevention—immediate crisis response and the comprehensive support to help victims put their lives back together. FVPSA also authorizes the Community Initiatives to Prevent Abuse program (frequently referred to as Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) Grants) and the National Domestic Violence Hotline. Working together, these FVPSA programs have made significant progress toward ending domestic violence and keeping families and communities safe. Since its passage in 1984, FVPSA remains the only Federal funding directly for shelter programs.

There are approximately 2,000 FVPSA-funded community-based domestic violence programs for victims and their children, providing emergency shelter to approximately 300,000 victims and offering services such as counseling, crisis lines, safety planning, legal assistance, and preventative education to millions of adults and children annually.[12] In just 1 day in 2008, 60,799 victims were served by 1,553 domestic violence programs. Of the 20,307 victims in emergency shelter that day, nearly 50 percent were children.[13] Programs answered 21,683 hotline calls and trained 30,210 community members.

These effective programs save and help rebuild lives. A recently released multi-State study shows conclusively that the Nation's domestic violence shelters are addressing both urgent and long-term needs of victims of violence, and are helping victims protect themselves and their children.[14] Research shows that shelter programs are among the most effective resources for victims with abusive partners[15] and that staying at a shelter or working with a domestic violence advocate significantly reduced the likelihood that a victim would be abused again and improved the victim's quality of life.[16] The impact of being and feeling safe cannot be underestimated—

---

[10] *Ibid*.

[11] Bureau of National Affairs Special Rep. No. 32, Violence and Stress: The Work/Family Connection 2 (1990); Joan Zorza, *Women Battering: High Costs and the State of the Law*, Clearinghouse Rev., Vol. 28, No. 4,383,385; *Supra note* 10.

[12] National Coalition Against Domestic Violence, *Detailed Shelter Surveys* (2001).

[13] Domestic Violence Counts 08: A 24-hour census of domestic violence shelters and services across the United States. The National Network to End Domestic Violence. (Jan. 2009).

[14] Lyon, E., Lane S. (2009). *Meeting Survivors' Needs: A Multi-State Study of Domestic Violence Shelter Experiences*. National Resource Center on Domestic Violence and UConn School of Social Work. Found at http://www.vawnet.org.

[15] See: Bennett, L., Riger, S., Schewe, P., Howard, A., & Wasco, S. (2004). Effectiveness of hotline, advocacy, counseling and shelter services for victims of domestic violence: A statewide evaluation. Journal of Interpersonal Violence, 19(7), 815–829; Bowker, L. H., & Maurer, L. (1985). The importance of sheltering in the lives of battered women. Response to the Victimization of Women and Children, 8, 2–8; Gordon, J. S. (1996). "Community services for abused women: A review of perceived usefulness and efficacy." Journal of Family Violence 11(4): 315–329; Sedlak, A. J. (1988). Prevention of wife abuse. In V. B. Van Hasselt, R. L. Morrison, A. S. Bellack, & M. Hersen (Eds.), Handbook of Family Violence (pp. 319–358). NY: Plenum Press; Straus, M. A., Gelles, R. J., & Steinmetz, S. K. (1980). Behind closed doors: Violence in the American family. NY: Anchor Press; Tutty, L. M., Weaver, G., & Rothery, M. (1999). Residents' views of the efficacy of shelter services for assaulted women. Violence Against Women, 5(8), 898–925.

[16] See: Berk, R. A., Newton, P. J., & Berk, S. F. (1986). What a difference a day makes: An empirical study of the impact of shelters for battered women. Journal of Marriage and the Family, 48, 481–490; Bybee, D.I., & Sullivan, C.M. (2002). The process through which a strengths-based intervention resulted in positive change for battered women over time. American Journal of Community Psychology, 30(1), 103–132; Constantino, R., Kim, Y., & Crane, P.A. (2005). Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: A pilot study. Issues in Mental Health Nursing, 26, 575–590; Goodkind, J., Sullivan, C.M., & Bybee, D.I. (2004). A contextual analysis of battered women's safety planning. Violence Against Women, 10(5), 514–533; Sullivan, C.M. (2000). A model for effectively advocating for women with abusive partners. In J.P. Vincent & E.N. Jouriles (Eds.), Domestic violence: Guide-

Continued

when asked what he liked best about staying in the shelter, a 10-year-old boy in Maryland replied, "I can sleep at night."

Once FVPSA appropriations reach $130 million, a portion will be set aside solely for children's services. Battered women's shelters and domestic violence programs provide safety and support for children, but struggle to meet the demand for children's services. They see the needs of children who are recovering from the trauma of witnessing or experiencing abuse and they are eager to implement new and expanded children's programming.

The Community Initiatives to Prevent Abuse/DELTA Grants program supports community-based primary prevention that address the underlying causes of domestic violence in order to stop abuse before it starts. DELTA is administered by the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, and it is one of the few funding sources for primary prevention work. DELTA programs use innovative strategies including peer education programs for men about family and relationships, community change initiatives focused on engaging men in prevention efforts, school-based education to prevent youth bullying that often carries into adulthood, and youth-led initiatives to prevent dating violence and promote healthy relationships.

FVPSA also includes the National Domestic Violence Hotline, a 24-hour, confidential, toll-free hotline, located in Texas. Since opening in 1996, the National Domestic Violence Hotline has received more than 2 million calls from individuals in need of support and assistance. Highly trained hotline advocates provide support, information, referrals, safety planning, and crisis intervention to hundreds of thousands of domestic violence victims and perpetrators. More than 60 percent of callers report that their call to the hotline is the first time they open up about the abusive relationship.

THE FUNDING GAP

Due to the overwhelming success of Violence Against Women Act (VAWA) and FVPSA funded programs, more and more victims are coming forward for help each year. This rising demand for services, without a concurrent increase in funding, means that many desperate victims are turned away from life-saving services. In just 1 day last year, nearly 9,000 requests for services went unmet across the country due to a lack of resources, including 3,286 requests for emergency shelter.[17] Additionally, the National Domestic Violence Hotline was unable to answer 42,500 calls (17 percent of the total) because they lacked the resources to answer the calls.

The economic crisis further exacerbates the gap created by the increasing demand for services and the lack of adequate resources. While economic hard times do not cause violence, the economic stresses can increase the frequency and level of violence in a home. With fewer personal, family, and community resources upon which to rely, more victims turn to domestic violence programs for help. A survey of domestic violence shelters across the country revealed that 3 out of 4 domestic violence shelters have seen an increase in women seeking assistance from abuse since September 2008, a major turning point in the U.S. economy. Just as more victims are seeking services, programs are facing cutbacks from State and country funding sources, as well as philanthropic dollars. Many programs have been forced to lay off staff and cuts services—a number of programs have even been forced to close their doors permanently.

Laurie Schipper, Executive Director of the Iowa Coalition Against Domestic Violence explains the stark consequences of this reality, "If women have nowhere to go, especially in rural areas, women and kids are going to die. It's difficult to overstate the gravity of this."[18]

FVPSA REAUTHORIZATION

Due to a busy congressional calendar, FVPSA expired in 2008 and has yet to be reauthorized. The Senate HELP Committee is currently working to reauthorize FVPSA, along with the Child Abuse Prevention and Treatment Act. Advocates remain concerned, however, that while FVPSA remains expired programs will be further jeopardized. We call on the Senate LHHS Appropriations Subcommittee to in-

---

lines for research-informed practice (pp. 126–143). London: Jessica Kingsley Publishers; Sullivan, C.M., & Bybee, D.I. (1999). Reducing violence using community-based advocacy for women with abusive partners. Journal of Consulting and Clinical Psychology, 67(1), 43–53.

[17] Domestic Violence Counts 08: A 24-Hour census of domestic violence shelters and services across the United States. The National Network to End Domestic Violence. (Jan. 2009).

[18] Alex, Tom. Wife flees, alleging decades of abuse. DesMoinesRegister.com, April 18, 2009. Available at: http://www.desmoinesregister.com/apps/pbcs.dll/article?AID=/20090418/NEWS01/904180322.

clude report language in the final appropriations bill that acknowledges the vital work of FVPSA and directs the funding to be spent in a way consistent with its authorization.

NNEDV chairs a national coalition of FVPSA stakeholders who have delineated clear priorities for the FVPSA reauthorization. Collectively, we want to see FVPSA continue its success while expanding to reach the needs of victims who have historically been underserved. These needed improvements will require commitment and investment from the Appropriations Committee.

INVESTING IN SERVICES SAVES LIVES

In the fiscal year 2008 congressional budget, FVPSA funding was cut by $2.1 million, bringing FVPSA funding to $122.6, which is $52.5 million below the authorized level of $175 million. We applaud the subcommittee's commitment to these programs, evidenced in the modest funding increases allocated in fiscal year 2009. FVPSA was funded at $127.7 million (a $5 million increase from fiscal year 2008), the National Domestic Violence Hotline was funded at $3.2 million (a $0.2 million increase from fiscal year 2008), and DELTA was funded at $5.5 million (a $0.5 million increase from fiscal year 2008). While these increases will pay dividends over time by preventing other costly social ills, in order to meet the ever-growing demand for services, it is essential that Congress continue to provide steady increases.

The President's fiscal year 2010 budget proposal requests level funding for all three programs. Yet we know that level funding simply will not bridge the gap in funding. Congress should invest in FVPSA not only to meet the needs of victims in life-threatening situations but also to prevent future social ills.

Fully funding FVPSA at $175 million, the hotline at $3.5 million and DELTA at $5.5 million will allow communities across the country to continue to provide critically needed direct services to victims of domestic violence and their children, which will help to prevent homicides and break the cycle of violence.

Without effective intervention, domestic violence will repeat itself and continue to impact successive generations. FVPSA is a critical component in breaking the cycle of violence affecting our children, families and communities. FVPSA funding, has begun to make our country a safer place for families, victims and communities. Now, however, this phenomenal progress is in jeopardy. We have seen a reduction in homicides and the incidence of these heinous crimes. Yet these tough economic times, combined with funding cuts forcing shelters to close, real victims face life-threatening situations with no support. Every day shelters and service providers must turn away families in danger due to lack of resources. While a tough economy may tempt lawmakers to cut or maintain existing funding levels, we cannot allow this unmet need to continue.

By prioritizing these vital, cost-effective funding streams, Congress will help to break the cycle of domestic violence in our country.

PREPARED STATEMENT OF THE NATIONAL PSORIASIS FOUNDATION

The National Psoriasis Foundation (NPF) appreciates the opportunity to submit written testimony for the record regarding Federal funding for psoriasis and psoriatic arthritis research for fiscal year 2010. NPF serves as the Nation's largest patient-driven, nonprofit, voluntary association committed to finding a cure for psoriasis and psoriatic arthritis, which affects as many as 7.5 million Americans, and eliminating their devastating effects. Psoriasis is among the most prevalent autoimmune diseases.

As part of our mission, we educate health professionals, the public and policymakers to increase public awareness and understanding of the challenges faced by people with psoriasis and psoriatic arthritis. Moreover, NPF maintains a strong commitment to securing public policies and programs that support its focus of education, advocacy, and research toward better treatments and a cure. NPF specifically seeks to advance public and private efforts to improve treatment of these diseases, identify a cure and ensure that all people with psoriasis and psoriatic arthritis have access to the medical care and treatment options they need to live the highest quality of life possible.

NPF stands ready to partner with policymakers at the local, State, and Federal levels to advance policies and programs that will reduce and prevent suffering from psoriasis and psoriatic arthritis. Specifically, NPF advocates that in fiscal year 2010 the National Institutes of Health (NIH) receive an additional $2.1 billion for a total allocation of $32.5 billion to support new investigator-initiated research grants for genetic, clinical, and basic research related to the understanding of the cellular and molecular mechanisms of psoriasis and psoriatic arthritis, as well as studies to ex-

plore the nascent understanding of co-morbidities, such as obesity, depression and heart disease that may be associated with inflammation in the skin and joints. In addition, we urge that Congress provide $1.5 million in fiscal year 2010 to the Centers for Disease Control and Prevention (CDC) to support such data collection to increase understanding of the comorbidities associated with psoriasis, examine the relationship of psoriasis to other public health concerns, such as the high rate of smoking and obesity among those with the disease, and gain insight into the long-term impact and treatment of these two conditions.

THE IMPACT OF PSORIASIS AND PSORIATIC ARTHRITIS

According to the NIH, as many as 7.5 million Americans have psoriasis—an immune-mediated, genetic, chronic, inflammatory, painful, disfiguring, and life-altering disease that requires life-long sophisticated medical intervention and care, and imposes serious adverse effects on the individuals and families affected. On average, 17,000 people with psoriasis live in each Congressional District.

Psoriasis typically first strikes between the ages of 15 and 25, but can occur at any time. It lasts a lifetime. Unfortunately, psoriasis often is overlooked or dismissed, because it typically does not cause death. It is commonly and incorrectly considered by insurers, employers, policymakers, and the public as a mere annoyance—a superficial problem, mistakenly thought to be contagious and/or due to poor hygiene. Yet, together psoriasis and psoriatic arthritis impose significant economic costs on individuals and society. Total direct and indirect healthcare costs of psoriasis are calculated at more than $11,250,000,000 annually with work loss accounting for 40 percent of the cost burden.

There is mounting evidence that people with psoriasis are at elevated risk for myriad other serious, chronic, and life-threatening conditions. Although data are still emerging on the relationship of psoriasis to other diseases and their ensuing costs to the medical system, it is clear that psoriasis goes hand-in-hand with co-morbidities, such as Crohn's disease, diabetes, metabolic syndrome, obesity, hypertension, heart attack, cardiovascular disease, liver disease, and psoriatic arthritis—which occurs in up to 30 percent of people with psoriasis. Other recent studies have found that people with severe psoriasis have a 50 percent higher mortality risk and that these patients die 3 to 6 years younger than those who do not have psoriasis. Of serious concern is that studies have shown that psoriasis causes as much disability as other major chronic diseases, and individuals with psoriasis are twice as likely to have thoughts of suicide, as people without psoriasis or with other chronic conditions.

Despite some recent breakthroughs, many people with psoriasis and psoriatic arthritis remain in need of improved quality of life and effective, safe, and affordable therapies, which could be delivered through an increased Federal commitment to genetic, clinical, and basic research. Research holds the key to improved treatment of these diseases, better diagnosis of psoriatic arthritis and eventually a cure for both conditions.

FEDERAL PSORIASIS AND PSORIATIC ARTHRITIS RESEARCH

Although overall NIH funding levels improved for psoriasis research in fiscal year 2007, 3 out of 5 NIH agencies decreased psoriasis funding that same year. NPF is concerned that at the historical and current rate of psoriasis funding, NIH funding is not keeping pace with research needs, nor is the investment commensurate with the impact of the disease. Within the NIH, the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), the National Center for Research Resources, the National Human Genome Research Institute, and the National Institute of Allergy and Infectious Diseases are the principal Federal Government agencies that currently support psoriasis research. Additionally, research activities that relate to psoriasis or psoriatic arthritis also have been undertaken at the National Cancer Institute. An analysis of longitudinal Federal funding data shows that, on average over the past decade, NIAMS has spent less than $1 per person with psoriasis per year.

Adequate investment in psoriasis and psoriatic arthritis in fiscal year 2010 and beyond is imperative, because a rare opportunity for breakthroughs in both conditions is presenting itself at this time. A convergence of findings reached through various types of studies has stimulated new ideas about the mechanisms involved in psoriasis.

It has taken nearly 30 years to understand that psoriasis is not solely a disease of the skin, but also of the immune system. Finally, scientists are identifying the genes immune cells involved in psoriasis—findings that will help improve understanding of which cells or molecular processes should be targeted in psoriasis drug

development. With these important advances, we are poised and positioned, as never before, to identify and develop a permanent method of control for psoriasis and, eventually, a cure. Greater funding of genetics, immunology and clinical research focused on understanding the mechanisms of psoriasis and psoriatic arthritis is needed. Key areas for additional support and exploration include:

—Studying the genetic susceptibility of psoriasis;
—Developing animal models of psoriasis;
—Identifying the environmental and lifestyle triggers for psoriasis;
—Studying a number of important epidemiologic issues, such as the risk of heart attack, diabetes, increased mortality, and lymphoma in psoriasis patients;
—Identifying and examining immune cells and inflammatory processes involved in psoriasis;
— Examining the relationship between psoriasis and mental illnesses, such as depression and suicidal ideation; and
—Elucidating psoriatic arthritis specific genes and other biomarkers.

THE ROLE OF CDC IN PSORIASIS AND PSORIATIC ARTHRITIS RESEARCH

NPF is concerned that there have been very few efforts to collect epidemiological and other related data on individuals with psoriasis and psoriatic arthritis. Researchers and clinicians continue to be limited in their longitudinal understanding of these conditions and their effects on individual patients. There are many mysteries related to psoriasis and psoriatic arthritis. For example, we know of people who never had any evidence of disease who, after falling ill with the flu or spiking a fear, wake the next day to be covered in psoriasis plaques. Why? A treatment could work well for an individual for years and then suddenly become ineffective. Why?

Researchers agree that collecting data through a patient registry would help increase the understanding of: the other chronic conditions that co-occur with psoriasis; how factors like age or gender impact the course and burden of psoriasis; and how certain environmental exposures might contribute to the occurrence and severity of psoriasis and psoriatic arthritis. In turn, this information would help improve treatments and advance efforts toward a cure. CDC psoriasis and psoriatic arthritis data collection efforts would help answer myriad questions about these autoimmune conditions, contribute to improved disease treatment and management, and further the Nation's efforts to find a cure.

For 3 years, your subcommittee has encouraged CDC to undertake data collection, and we very much appreciate your recognition of this much-needed effort. We have met with CDC staff to offer our assistance and expertise, however, it is clear the agency must receive specific, dedicated funding so it has the resources necessary to develop a registry. To that end, NPF respectfully requests that the subcommittee allocate $1.5 million in fiscal year 2010 for the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) within the CDC to examine and develop options and recommendations for the creation of a National Psoriasis and Psoriatic Arthritis Patient Registry. A national patient registry that collects longitudinal patient data will help researchers to learn about key attributes, such as response to treatment, substantiating the waxing and waning of psoriasis, understanding associated manifestations like nail disease and arthritis, and the relationship of psoriasis to other public health concerns.

FUNDING REQUEST SUMMARY

NPF recognizes that Congress and the Nation face unprecedented fiscal challenges. However, we also believe that greater fiscal year 2010 investment in biomedical and epidemiologic research at NIH and CDC will prove simulative to the economy and bear fruit with regard to the development of new, safe, effective, and long-lasting treatments and—ultimately—a cure for psoriasis and psoriatic arthritis. We thank the subcommittee in advance for providing the following allocations:

—$32.4 billion to NIH and its Institutes and Centers that play an integral role in psoriasis and psoriatic arthritis research and urge them to initiate and/or expand psoriasis and psoriatic arthritis research and;
—$1.5 million to the NCCDPHP within the CDC to collect data on psoriasis and psoriatic arthritis and begin to establish a patient registry to improve the knowledge base of the longitudinal impact of these diseases on the individuals they affect.

CONCLUSION

On behalf of NPF's Board of Trustees and the as many as 7.5 million individual with psoriasis and psoriatic arthritis who we represent, thank you for this oppor-

tunity to submit written testimony regarding the fiscal year 2010 funding levels necessary to ensure that our Nation adequately addresses psoriasis and psoriatic arthritis and to make gains in improving therapies and eventually attaining a cure. We believe that additional research undertaken at the NIH coupled with epidemiologic efforts at the CDC together will help advance the Nation's efforts to improve treatments and identify a cure for psoriasis and psoriatic arthritis. Please feel free to contact us at any time; we are happy to be a resource to subcommittee members and your staff. We very much appreciate the subcommittee's attention to—and consideration of—our requests.

PREPARED STATEMENT OF NATIONAL PUBLIC RADIO

Thank you Chairman Inouye and Senator Cochran for the opportunity to offer testimony on behalf of National Public Radio (NPR), our more than 850 public radio station partners, and for other producers and distributors of public radio programming including American Public Media, Public Radio International, the Public Radio Exchange, and many, many stations, both large and small, that create and distribute content through the Public Radio Satellite System (PRSS).

The state of public radio today is both sobering and heartening. While the economic crisis has undermined the financial stability of the public radio system, the audience is tuning at record levels. But without your help, we will not be able to continue to achieve our public service mission, and your expectations.

AN ADDITIONAL INVESTMENT IN STATIONS

Public broadcasting is requesting $307 million—$96 million for public radio stations and $211 million for public television stations—in additional emergency investment funding for the fiscal year 2010 budget of the Corporation for Public Broadcasting (CPB). This action is necessary to offset the tide of losses at public broadcasting stations. This one-time investment of Federal resources will help protect thousands of station jobs now at risk, and assure continuity in services used daily by tens of millions of Americans. These funds are in addition to the $420 million that Congress approved 2 years ago as part of the advance funding process.

The funds we are requesting only partially close the expected 2-year revenue shortfall of almost $170 million at the public radio station level, plus an additional $55 million in loses at NPR. The remainder will come about as a result of significant cost cutting at the local and national levels. Every week brings another announcement of a service reduction or employment layoff at public broadcasting stations. In fact, a survey last month of locally licensed and operated public radio stations projected more than a 46 percent reduction in financial support from local and State government agencies, a 23 percent decline in foundation and philanthropic contributions and a 23 percent drop in underwriting from local businesses.

Public broadcasting's contribution to America's democracy is more important today than at anytime during our four decades of public service. More than 33 million people each week are tuning into public radio programming and listening to member stations. Our audience has grown 66 percent in the past 10 years, bucking a precipitous decline in other media and stands in sharp contrast with the general overall decline in radio listening. Consider that public radio programming today reaches more people than the circulation of USA Today, the Wall Street Journal, the New York Times, Los Angeles Times, the Washington Post and the next top 45 newspapers combined.

Stations in every State have become living embodiments of journalistic excellence, providing news, information and cultural programming that have become increasingly rare in other media. Public radio programming is rooted in the fundamentals of accuracy, transparency, independence, balance, and fairness and serves as cornerstone of understanding for millions of Americans seeking information, context and insight.

PUBLIC FUNDS FOR PUBLIC MEDIA

CPB is the primary public funding mechanism for public radio, accounting for roughly 12 percent of an average public radio station's annual budget. These funds help public broadcasting stations produce, purchase and distribute programming that sparks imagination and kindles thought about our world. Several stations specifically serve rural and minority communities including numerous African-American, Native American, Latino, and multicultural licensees. In many cases, they are the sole local broadcasting service available. These critical Federal funds allow all

stations to continue serving the needs of public radio's 33 million weekly listeners, irrespective of their communities' location or financial status.

CPB's general appropriation is allocated according to a congressionally set formula that ensures the funds go directly to the people and organizations that create and deliver highly valued programs and services. The public broadcasting community is urging Congress to appropriate $542 million in 2-year advanced funding for fiscal year 2012 for CPB.

THE PUBLIC RADIO SATELLITE SYSTEM

As the public broadcasting community grapples with the financial crisis, we also remain committed to ensuring that the Nation's public radio infrastructure continues to be robust and viable. This commitment requires a periodic investment by Congress in PRSS. This year, CPB is requesting $27 million as the third and final installment of a 3-year request to renew and replenish the PRSS.

This system, originally built in 1979 with funds provided by this Committee, distributes 400,000 hours of programming, or 7½ billion listener hours each year. Every minute of every hour of public radio programming—from NPR's Morning Edition, and All Things Considered, to American Public Media's Marketplace and A Prairie Home Companion, to Public Radio International's This American Life and Capitol News Connection—is distributed by the PRSS. Quite simply, without the PRSS, there would be no public radio in the United States.

An important mission of the PRSS is to facilitate the cost-effective and efficient distribution of news, information, cultural, and educational programming to this country's increasingly diverse population. As part of that mission, the PRSS provides satellite transmission services to distribute programming that targets unserved or underserved audiences from sources who meet certain criteria established by the NPR Board, including demonstrated financial need. PRSS is the indispensable distribution backbone for everything heard on public radio. On behalf of all in public radio, I ask for your support of this critically important funding request.

DIGITAL TRANSITION FUNDING

Change is rapidly occurring in over the air radio broadcasting, the last enclave of the old analogue world. As of today, more than 650 public radio stations had either completed or have nearly completed conversion to a digital signal, which improves the overall listener experience by enhancing audio quality; eliminating reception interference; and utilizing multiple audio programming channels, or multicasting. To continue supporting this necessary change in our basic broadcast technology, CPB is requesting $40 million as part of its fiscal year 2010 budget.

Digital broadcasting technology has enabled public radio stations to increase local services to their communities. More than 160 stations are multicasting—doubling and tripling their programming to broaden and expand the base of listeners. Many stations have created Spanish language channels to provide news, including through BBC Mundo. Stations serving Native American communities are providing tribal programming over the air and online. Local community events such as concerts, town hall meetings, committee hearings, legislative floor sessions, and other government programming are broadcast live using HD radio technology. Listeners with HD radio receivers may view a variety of useful messages that scroll across radio display screens, including artist name and song title, emergency alerts, live weather and real-time traffic updates, local news, school closings, and movie listings.

Digital technology using the Internet and mobile platforms expands public radio programming and community services. Expansion and improvement of public radio Web sites and our digital connections with audiences remain a major priority. Public radio stations and public radio program producers are all expanding to new platforms, and in so doing bring broader, deeper and more varied content to our audiences. The impact is already being felt. News coverage of the U.S. Presidential election resulted in record level traffic to public radio station Web sites and NPR.org in terms of both visitors and page views. Ten million visitors went each month to NPR.org during October and November 2008 to view 115 million pages during the same time period. And just this past week, public radios web sites became an essential platform for updated information on Swine flu.

Other Internet and mobile platform program distribution efforts using iPhone applications, for example, have gained wide acceptance among public radio listeners and brought a new generation of consumers to our coverage. Local public radio station and NPR podcasts have become very popular, with some 14 million downloads occurring each month. Podcasts offered by stations are expanding programming in areas such as science, poetry, music, arts, history, politics, international affairs, and

health. The audience may also now download interactive media such as photo slide shows, video, Web streams and audio of local news, music, and programming on their local station Web site.

Audiences are visiting station Web sites with greater frequency for local news and community events. Online community calendars posted on station Web sites allow local organizations of all sizes and areas to list public events and reach a wide audience. Listeners viewing station Web sites are connecting with local nonprofit organizations to obtain information about special cultural activities, festivals, public health fairs, musical events, educational seminars, lectures, classes, and workshops. Station Web sites also increasingly have online music play lists allowing the audience to find information on music played at their local station. Web-based social-networking features are used to foster online communities to give listeners the opportunity to connect over common interests and passions by engaging in dialogue and sharing viewpoints about their lives.

We are confident in our ability to meet the needs of our audience and our ability to emerge from the current economic crisis more prepared and better structured. But we cannot do either without your help. We ask for your approval of CPB's funding requests, including the additional, emergency, one-time investment to stations of $307 million in fiscal year 2010.

PREPARED STATEMENT OF NATIONAL PRIMATE RESEARCH CENTERS

The Directors of the eight National Primate Research Centers (NPRCs) respectfully submit this written testimony for the record to the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies. The NPRCs appreciate the commitment that the members of this subcommittee have made to biomedical research through your strong support for the National Institutes of Health (NIH), and recommends that you maintain this support for NIH in fiscal year 2010 by providing the agency with at least a 7 percent increase more than fiscal year 2009. The NPRCs also respectfully request that the subcommittee encourage the National Center for Research Resources (NCRR), the sponsoring institute of the NPRCs within NIH, to carry out the NPRCs 5-year Federal advancement initiative, which as explained in this testimony, would help to ensure that the NPRCs continue to serve effectively in their role as a vital national resource.

Through passage of the American Recovery and Reinvestment Act (ARRA) and the Omnibus Appropriations Act for Fiscal Year 2009, the administration and Congress have taken critical steps to jump start the Nation's economy. Simultaneously, Congress is advancing and accelerating the biomedical research agenda in this country by focusing on scientific opportunities to address public health challenges. The success of the U.S. Government's efforts, however, is contingent upon the quality of research resources that enable and enhance scientific research ranging from the most basic and fundamental to the most highly applied.

Biomedical researchers have relied on one such resource—NPRCs—for nearly 50 years for research models and expertise with nonhuman primates. The NPRCs are highly specialized facilities that foster the development of nonhuman primate animal models and provide expertise in all aspects of nonhuman primate biology. NPRC facilities and resources are currently used by more than 2,000 NIH-funded investigators around the country. NCRR provides the NPRCs with an annual base grant (funded through NCRR's P51 program) which supports the operational costs of the NPRCs. In fiscal year 2009, the 8 NPRCs received $79.235 million from NCRR's P51 program.

The NPRCs also serve an essential role in translating basic research toward a clinical outcome. Specifically, the nonhuman primate models that are housed at the NPRCs often provide the critical link between research with small laboratory animals and studies involving humans. As a result, the network of the eight NPRCs is taking a leadership role to encourage collaboration among researchers and healthcare providers across disciplines and institutions, with the goal of advancing biomedical knowledge and improving human health.

The NPRCs face several serious barriers to successfully supporting and advancing nonhuman primate research; specifically, the lack of adequate infrastructure to breed and house animals for research, the limited number of primates available, and the shortage of properly trained staff to handle nonhuman primates and provide sophisticated care. The need to address these problems has become even more critical due to the additional nonhuman-primate-related grants that will be funded as a result of ARRA, the new demands to increase research in nonhuman primate chal-

lenge models for AIDS, and the need for nonhuman primates to enhance our emerging infectious disease and biodefense response capabilities.

NCRR has published on the need for increased primate resources in its 2009–2013 Strategic Plan. The plan specifically States that nonhuman animal models are indispensable for finding ways to treat and prevent cancer, HIV/AIDS, Alzheimer's disease, and Parkinson's disease, as well as to develop effective biodefense strategies. The NPRCs have been leading the development of new IT approaches, including the Biomedical Informatics Research Network (BIRN) for linking brain imaging, behavior, and molecular informatics in nonhuman primate preclinical and translational models research.

In an effort to address many of the concerns within the scientific community, ranging from the lack of infrastructure improvements to the shortage of relevant nonhuman primates to the need for quality, trained personnel, the NPRCs have developed a 5-year Federal advancement initiative which addresses the necessary program capacity expansions and required upgrades. This initiative will help to ensure that the NPRCs will continue to serve effectively in their role as a vital national resource. As part of the 5-year plan development process, the NPRCs calculated the increases in NIH funding dedicated specifically to the National Primate Research Centers Program (NCRR's P51 program) necessary to achieve their goals. Below is an outline of the plan:

—*Primate Infrastructure Investment*.—Request for an additional $90 million over 5 years to improve the quality and capacity of primate housing and breeding facilities and ensure availability of related state-of-the-art diagnostic and clinical support equipment at the NPRCs.

While NIH has been responsive in their actions during the past few years to provide funding to the NPRCs for infrastructure improvements, the difficulty the National Primate Research Centers Program has in meeting even current demands, let alone future increases is inexorably linked to the ability to house these animals in the unique living environments that they require and to provide specialized facilities equipped with state-of-the-art diagnostic and clinical support equipment to conduct research. The NPRCs plan to focus on the following goals in their effort to comprehensively improve primate infrastructure:

—Bring older primate housing facilities and related equipment up to present-day standards.

—Construct additional primate housing facilities and acquire related equipment to accommodate the projected increase in breeding colonies.

—*Primate Model Investment*.—Request for an additional $75 million over 5 years to enhance the availability of primates for research.

NCRR's Expert Panels have repeatedly stated that the NPRCs do not have the capacity to satisfy the needs of outside investigators, and have recommended that the NPRCs program must be responsive to national needs for nonhuman primates. Currently, outside investigators who are already funded for their studies must sometimes wait a year or more to begin their research because of the high demand for the limited number of primates. In addition, there are ongoing difficulties associated with acquiring certain types of primates from their natural places of origin. Accordingly, increasing domestic breeding capabilities and developing bridging programs to effectively use other types of primates are critical to the success of the NPRCs program.

—*Primate Care and Research Personnel Investment*.—Request for an additional $35 million over 5 years to train NPRC personnel in primate care and management.

Numerous scientific reports have highlighted the vital need for experts who are well-trained in laboratory animal medicine and in research methodology. Since nonhuman primates represent the most sophisticated and relevant animal models, there is a heightened responsibility to properly care for and manage these animals. Each NPRC requires a primate management team comprised of behaviorists, veterinarians, and primate research specialists. As the number of primates at the NPRCs grows, the primate management teams must expand proportionally.

Total anticipated cost of the National Primate Research Centers Program 5-year Federal Advancement Initiative—$200 million more than the current funding that is dedicated specifically to the National Primate Research Centers Program during the 5-year period of fiscal years 2010–2015.

Thank you for the opportunity to submit this written testimony and for your attention to the critical need for primate research and enhancement of the NPRCs P51 base grant, as well as our recommendations concerning funding for NIH in the fiscal year 2010 Labor, Health and Human Services, and Education, and Related Agencies Appropriations bill.

PREPARED STATEMENT OF THE NATIONAL SLEEP FOUNDATION

SUMMARY OF FISCAL YEAR 2010 RECOMMENDATIONS

—Provide $5 million in funding for sleep activities within the Community Health Promotion account within the Chronic Disease Program at the Centers for Disease Control and Prevention (CDC). Expanded funding for sleep and sleep disorder-related activities would allow the CDC to create targeted public educational initiatives for schools and workplaces; training materials for current and future health professionals; build and test public health interventions; expand surveillance and epidemiological activities; and create fellowship and research opportunities.

—Encourage the National Institutes of Health (NIH) to conduct multi-center clinical trials to evaluate whether healthcare costs and the incidence of stroke, cardiovascular disease and diabetes can be reduced by treating sleep disorders such as obstructive sleep apnea as part of usual care practices.

Mr. Chairman and members of the subcommittee, thank you for allowing me to submit testimony on behalf of the National Sleep Foundation (NSF). I am Dr. Frankie Roman, Chair of the NSF's Government Affairs Committee and a sleep specialist at Ohio Sleep Disorder Centers, in Akron, Ohio. NSF is an independent, nonprofit organization that is dedicated to improving public health and safety by achieving understanding of sleep and sleep disorders, and by supporting sleep-related education, research and advocacy. We work with sleep medicine and other healthcare professionals, researchers, patients and drowsy driving advocates throughout the country as well as collaborate with many Government, public and professional organizations with the goal of preventing health and safety problems related to sleep deprivation and untreated sleep disorders.

Sleep problems, whether in the form of medical disorders or related to work schedules and a 24/7 lifestyle, are ubiquitous in our society. It is estimated that sleep-related problems affect 50 to 70 million Americans of all ages and socioeconomic classes. Sleep disorders are common in both men and women; however, important disparities in prevalence and severity of certain sleep disorders have been identified in minorities and underserved populations. Despite the high prevalence of sleep disorders, the overwhelming majority of sufferers remain undiagnosed and untreated, creating unnecessary public health and safety problems, as well as increased health care expenses. Annual surveys conducted by NSF show that more than 60 percent of adults have never been asked about the quality of their sleep by a physician, and fewer than 20 percent—have ever initiated such a discussion.

Additionally, Americans are chronically sleep deprived as a result of demanding lifestyles and a lack of education about the impact of sleep loss. Sleepiness affects vigilance, reaction times, learning abilities, alertness, mood, hand-eye coordination, and the accuracy of short-term memory. Sleepiness has been identified as the cause of a growing number of on-the-job accidents, automobile crashes and multi-model transportation tragedies.

According to the National Highway Traffic Safety Administration's 2002 National Survey of Distracted and Drowsy Driving Attitudes and Behaviors, an estimated 1.35 million drivers have been involved in a drowsy driving crash in the previous 5 years. According to NSF's 2009 Sleep in America poll, 54 percent of people report that they have driven drowsy at least once in the past year, with 28 percent reporting that they do so at least once a month or more. A large number of academic studies and Government reports have linked lost productivity, poor school performance, and major public health problems to chronic sleep loss and sleep disorders.

The 2006 Institute of Medicine (IOM) report, Sleep Disorders and Sleep Deprivation: An Unmet Public Health Problem, found the cumulative effects of sleep loss and sleep disorders represent an under-recognized public health problem and have been associated with a wide range of negative health consequences, including hypertension, diabetes, depression, heart attack, stroke, and at-risk behaviors such as alcohol and drug abuse—all of which represent long-term targets of the Department of Health and Human Services (HHS) and other public health agencies. Moreover, the personal and national economic impact is staggering. The IOM estimates that the direct and indirect costs associated with sleep disorders and sleep deprivation total hundreds of billions of dollars annually.

Sleep science and Federal reports have clearly detailed the importance of sleep to health, safety, productivity and well-being, yet studies continue to show that millions of Americans remain at risk for serious health and safety consequences of untreated sleep disorders and inadequate sleep, due to a lack of awareness, community interventions, and inadequate screening. Unfortunately, despite recommendations in numerous Federal reports, there is a lack of epidemiological data, large clinical

trials and no on-going national educational programs regarding sleep issues aimed at the general public, healthcare professionals, underserved communities or major at-risk groups.

NSF believes that every American needs to understand that good health includes healthy sleep, just as it includes regular exercise and balanced nutrition. Sleep must be elevated to the top of the national health agenda in order to adequately address other national public health problems mentioned above. We need your help to make this happen.

First, one of the most devastating sleep disorders is obstructive sleep apnea (OSA), a sleep-related breathing disorder which affects at least 5 percent of adult Americans and is closely related to some of America's most pressing health problems, such as obesity, hypertension, heart failure, and diabetes. NSF and its partners, including the National Center on Sleep Disorders Research at the National Institutes of Health, have been working diligently to create better patient and primary care physician awareness of sleep apnea. However, despite considerable progress, sleep apnea remains woefully underdiagnosed and undertreated primarily due to a lack of understanding in the primary care community, good epidemiological data, and randomized evidence regarding long-term treatment. Therefore, we recommend that the NIH be encouraged to conduct multi-center clinical trials to evaluate whether treatment of OSA can reduce healthcare costs and the incidence of stroke, cardiovascular disease and diabetes.

Second, our biggest challenge is bridging the gap between the established sleep science best practices and the level of knowledge about sleep held by healthcare practitioners, educators, employers, and the general public. Because resources are limited and the challenges great, we think creative and new partnerships are needed to fully develop sleep awareness, education and clinical training initiatives. Consequently, the NSF has spearheaded important initiatives to raise awareness of the importance of sleep to the health, safety, and well-being of the Nation. One of our most important partnerships in these efforts is with the Centers for Disease Control and Prevention (CDC).

For the last 5 years, Congress has recommended that the CDC support activities related to sleep and sleep disorders. As a result, CDC's National Center for Chronic Disease Prevention and Health Promotion has been collaborating with NSF and more than 20 voluntary organizations and Federal agencies to form the National Sleep Awareness Roundtable (NSART), which was officially launched in March of 2007. Congress also provided specific funding for these efforts for the past 2 years.

In fiscal year 2008, Congress provided $818,000 for activities related to sleep and sleep disorders, including CDC's participation in NSART and incorporating sleep-related questions into established CDC surveillance systems. With this funding, CDC included one core sleep question in its national data collection efforts in 2008 and has provided grants to eight States to include an optional sleep module in their data collection efforts through the Behavioral Risk Factor Surveillance System (BRFSS), which will occur in the summer of 2009. CDC also included one question in the Youth Risk Behavior Surveillance System (YRBSS). Of note, the YRBSS has already revealed that only one-third of high school students get 8 or more hours of sleep on an average school night, far below the recommended 9.25 hours. This new data will provide important information on the prevalence of sleep disorders and enable researchers to better address the complex interrelationship between sleep loss and comorbid conditions such as obesity, diabetes, depression, hypertension, and drug and alcohol abuse.

Additionally, CDC and NSART participated in NSF's national public awareness initiatives including National Sleep Awareness Week and Drowsy Driving Prevention Week. CDC also launched its own Sleep and Sleep Disorders Web site, created a fellowship position to analyze sleep and chronic disease data, held a Sleep and Public Health Workshop at the CDC campus, and released a number of multi-media health marketing materials to promote better sleep.

In fiscal year 2009, Congress provided $900,000 to the CDC for sleep activities. CDC plans to expand the number of States it is able to fund for BRFSS data collection and provide support for national public and professional awareness initiatives as well as activities of the National Sleep Awareness Roundtable.

NSF and NSART have actively been involved in conducting outreach to public health officials and are currently working to develop a national action plan. This document will address ways to organize and implement effective public and professional awareness and education initiatives primarily aimed at the diagnosis and treatment of obstructive sleep apnea and the promotion of sleep as a healthy behavior. NSART is seeking to expand its membership by reaching out to new organizations and State and Federal agencies that are interested in raising awareness of sleep issues and implementing NSART initiatives.

Although the CDC has taken initial steps to begin to consider how sleep affects public health issues, the agency needs additional resources to take appropriate actions, as recommended by the IOM and other governmental reports.

Expanded funding for sleep and sleep disorder-related activities would allow the CDC to create much needed educational programs for schools and occupational settings and training materials for current and future health professionals; build and test public health interventions; expand surveillance and epidemiological activities; and create further fellowships and research opportunities. The following are detailed scenarios for various funding levels.

—$2 million:

—*Expand Surveillance on BRFSS*.—CDC could double the number of grants it provides to States to use the optional sleep module and include more core questions in the nationwide data collection through the Behavioral Risk Factor Surveillance System. CDC would also expand its participation in and funding of national public and professional initiatives as well as the goals and activities of the National Sleep Awareness Roundtable.

—$5 million—All activities detailed in the $2 million scenario, plus:

—*Public Education*.—CDC could support the development of a national sleep health communications campaign that use targeted approaches for delivering sleep-related messages, especially in public schools and workplaces. Currently, no such programs exist.

—*Training Materials*.—Tools and programs could be developed for current and future health professionals, including school nurses, to promote sleep as a healthy behavior and increase the diagnosis and treatment of sleep disorders. Today, most health care professionals receive no such training, which increases the Nation's health burden.

NSF and members of the National Sleep Awareness Roundtable believe that an ongoing partnership with CDC is critical to address the enormous public health impact of sleep and sleep disorders. We hope that the Committee will provide funding of $5,000,000 to the CDC to execute programs as outlined here.

Thank you again for the opportunity to present you with this testimony.

PREPARED STATEMENT OF THE NATIONAL TECHNICAL INSTITUTE FOR THE DEAF

Mr. Chairman and members of the subcommittee: I am pleased to present the fiscal year 2010 budget request for NTID, 1 of 8 colleges of Rochester Institute of Technology (RIT), in Rochester, New York. Created by Congress, we provide university technical education, serving a total of 1,450 students, including 1,284 deaf and hard-of-hearing students from across the Nation and 166 hearing students. NTID students live, study, and socialize with more than 15,000 hearing students on the RIT campus.

NTID has fulfilled our mission with distinction for 41 years.

BUDGET REQUEST

This request details the importance of obtaining our full fiscal year 2010 request of $71,352,000. We ask for $65,952,000 for continuing operations and $5,400,000 for construction to replace aging mechanical systems as detailed below. The NTID and President's requests are:

[In millions of dollars]

	Operations	Construction	Total
NTID request	65,952	5,400	71,352
President's request [1]	63,037	5,400	68,437
Difference	2,915	.....	2,915

[1] These numbers are our understanding of what the President will submit to Congress.

We respectfully request your support of our full appropriation request. We do not request new operations funding for additional academic programs or headcount; instead, we commit to fund increases, if any, through reallocating resources. This commitment continues our history of funding changes through internal reallocation. From fiscal year 2003 through fiscal year 2007 we documented $6,200,000 in budget reductions, including the elimination of 49 headcounts, and increasing our revenues. These difficult savings allowed us to improve our programs and services while limiting our request for Federal support. As one example, we dramatically increased

the number of captionists employed to deliver in-classroom speech-to-text real-time access services to students, without additional funding.

We are proud of those cost savings and reallocations accomplishments.

Our fiscal year 2010 operations request represents costs driven by personnel and health benefits, as well as payment for services provided by RIT that are subject to the same inflationary pressures. The significant enrollment increases detailed below add proportionally to anticipated costs. We do not ask for funds to address program modifications; we will reallocate to meet those needs.

ENROLLMENT

As we prepare to enter fiscal year 2010, we do so having attracted, in fiscal year 2009, the largest enrollment in our 41-year history. Truly a national program, NTID enrolls students from all 50 States. Current enrollment of 1,450; in the last 2 years our enrollment has increased by 200 students, an increase of 16 percent. For fiscal year 2010, NTID anticipates maintaining or slightly increasing enrollment. Our 5-year enrollment history follows.

NTID ENROLLMENTS: FIVE-YEAR HISTORY

Fiscal year	Deaf/Hard-of-Hearing students			Subtotal	Hearing students			Grand total
	Undergrad	Grad RIT	MSSE		Interpreting program	MSSE	Subtotal	
2005	1,055	42	49	1,146	100	35	135	1,281
2006	1,013	53	38	1,104	116	36	152	1,256
2007	1,017	47	31	1,095	130	25	155	1,250
2008	1,103	51	31	1,185	130	28	158	1,353
2009	1,212	48	24	1,284	135	31	166	1,450

STUDENT ACCOMPLISHMENTS

For our graduates, 95 percent have been placed in jobs commensurate with the level of their education (using the Bureau of Labor Statistics methodology). Of our fiscal year 2007 graduates (the most recent class for which numbers are available), 63 percent were employed in business and industry, 29 percent in education/nonprofits, and 8 percent in Government.

Graduation from NTID has a significant, positive effect on earnings over a lifetime, and results in a noteworthy reduction in dependence on welfare programs. In fiscal year 2007, NTID, the Social Security Administration, and Cornell University examined approximately 13,000 deaf and hard-of-hearing individuals who applied and attended NTID over our entire history. We learned NTID graduation has significant economic benefits. By age 50, deaf and hard-of-hearing baccalaureate graduates earned on average $6,021 more per year than those with associate degrees, who in turn earned $3,996 more per year on average than those who withdraw. Students who withdraw earned $4,329 more than those who were not admitted. Students who withdrew experienced twice the rate of unemployment as graduates.

The same studies showed 78 percent of these individuals were receiving Supplemental Security Income (SSI) benefits at age 19, but when they were 50 years old, only 1 percent of graduates drew these benefits, while on average 19 percent of individuals who withdrew or were rejected for admission continued to participate in the SSI program. Graduates also accessed Social Security Disability Insurance (SSDI), an unemployment benefit, at far lesser rates than students who withdrew; by age 50, 34 percent of nongraduates were receiving SSDI, while only 22 percent of baccalaureate graduates were receiving them and only 27 percent of associate graduates were receiving them. Considering the reduced dependency on these Federal income support programs, the Federal investment in NTID returns significant societal dividends.

NTID clearly makes a significant, positive difference in earnings, and in lives.

NEW "MILITARY VETERANS WITH HEARING LOSS" PROGRAM

In fiscal year 2010, NTID will establish the "Military Veterans with Hearing Loss" program to enroll veterans who have suffered significant hearing loss as a result of their military service. Recently returned veterans with hearing loss can earn bachelor or graduate-level degrees at RIT with access services—such as real-time captioning and notetaking in the classroom—from NTID. Our faculty and staff are experienced in helping those with sudden hearing loss, and we provide comprehensive services for those with hearing aids or cochlear implants.

The access services provided at NTID are unparalleled. More than 50 classroom captionists provide real-time captioning to students. More than 120 sign language interpreters support students who benefit from interpreting.

As many as 10 veterans could be admitted each year, growing to 50 veterans over time. (RIT also recently announced it will become a "Yellow Ribbon" institution.)

CONSTRUCTION

For the past 3 years, NTID has informed Congress of on-going planning to replace the deteriorating 25 boilers and 23 chillers in individual buildings throughout the RIT campus. Existing heating, ventilation and air conditioning systems remain from the original campus construction more than 40 years ago. Although prudent in providing on-going maintenance, RIT/NTID reached a point where normal maintenance was no longer feasible and the decision was reached to replace the existing system with five new boilers and seven new chillers.

All of the buildings and spaces devoted to NTID programs across the RIT campus are connected to this system. An analysis determined the square footage used by NTID in each building serviced by the new system, and the resulting proportion of the total expenses was allocated to NTID. That analysis showed that NTID buildings and other spaces utilized 15 percent of the total square footage. With a total project cost of $36,000,000, NTID is responsible for $5,400,000 (15 percent) of the total cost, which we request for fiscal year 2010.

In addition to discussions with Congress, this request has been discussed repeatedly over several years with the U.S. Department of Education (ED); presentations and facilities tours were provided during oversight visits to NTID. We understand that the President supports this request, and we ask that Congress also support this construction cost.

NTID BACKGROUND

Academic Programs

NTID offers high-quality, career-focused, associate degree programs preparing students for specific well-paying technical careers. A cooperative education component ties closely to high-demand employment opportunities. Expanding transfer associate degree programs better serve the higher achieving segment of our student population who seek bachelors and masters degrees in an increasingly demanding marketplace. These transfer programs provide seamless transition to baccalaureate studies in other colleges of NTID where we support students in baccalaureate programs with access services and tutoring. One of NTID's greatest strengths is our outstanding track record of assisting high-potential students gain admission to and graduate from the other colleges of RIT at rates that are better than their hearing peers.

Research

Our research program is guided and organized according to these general research areas: language and literacy, teaching and learning, sociocultural influences, career development, technology integration, and institutional research. All benefit the deaf and hard-of-hearing population.

Outreach

Extended outreach activities to junior/senior high school students, expand their horizons regarding a college education. We also serve other universities and postcollege adults.

Student Life

Our activities foster student leadership and community service, and provide opportunities to explore other educational interests.

SUMMARY

It is extremely important that our funding be provided at the full level requested as we continue our mission to prepare deaf and hard-of-hearing people to enter the workplace and society.

Our alumni have demonstrated that they can achieve independence, contribute to society, earn a living, and live a satisfying life as a result of NTID. Research shows that NTID graduates over their lifetimes are employed at a much higher rates, earn substantially more (therefore paying significantly more in taxes), and participate at a much lower rate in Federal welfare programs than those who withdraw or who apply but do not attend NTID.

We are hopeful that the members of the subcommittee will agree that NTID, with its long history of successful stewardship of Federal funds and outstanding educational record of service with deaf and hard-of-hearing people, remains deserving of your support and confidence.

LETTER FROM THE NATIONAL UNION OF LABOR INVESTIGATORS

DEAR SIR OR MADAM: Before the budget for the Department of Labor, Office of Labor-Management Standards (OLMS) is approved, please consider the 43 employees who were recently deemed "unaffordable" because of budget shortfalls, and please consider the OLMS's re-organization in 2008, a reorganization that now seems morally reprehensible. "Fiscal Year 2010 Budget Shortfalls and Solutions" was presented to OLMS employees on May 8, 2009, and during that presentation Deputy Assistant Secretary Andrew Auerbach said that OLMS hired just about as many investigators as it could afford because OLMS had been criticized for leaving itself understaffed.

The presentation went on to point out that approximately $4.5 million cut from the OLMS budget would return OLMS to its 2003 staffing level, and that OLMS's mission would not be compromised because workload and productivity have remained (relatively) constant since 2003. The presentation reported 260 full-time employees in fiscal year 2003, and 303 full-time employees in fiscal year 2009. The result, we were told, is that 43 OLMS employees are no longer affordable.

The tone taken during the presentation was that the result was unavoidable. However, OLMS's reorganization in 2008 moved all managers to a higher pay grade, and given the current budget shortfalls, and the speed with which the reorganization took place, it seems less like a move intended to improve OLMS's effectiveness, and more like a case of traders with inside information dumping stocks just before the company that issued them goes bankrupt. Managers at every level, and in every

office, warned their investigators of potential budget cuts and of the affect they might have on OLMS, and yet management went forward with a reorganization that exacerbated OLMS's budget crisis.

It seems that if an unaltered work load and unaffected productivity has been used to defend OLMS's $4.5 million budget cut, the same logic should be applied to the reorganization. If their job responsibilities have not changed since 2003, why were OLMS managers given a raise in pay and grade, and why haven't managers been returned to their 2003 GS levels in order to address the budget shortfall? If all OLMS management positions were returned to their 2003 pay grade, would (all) 43 employees have become unaffordable?

I appreciate your consideration of this matter.

Sincerely,

BENNETT ALLEN.

LETTER FROM THE NATIONAL UNION OF LABOR INVESTIGATORS

May 11, 2009.

Hon. TOM HARKIN,
Chairman, Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies,
Washington, DC.

DEAR SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES MEMBERS: The new budget is out and our agency, Office of Labor Management Standards (OLMS), within the Department of Labor suffered a severe reduction in our budget. On May 8, 2009, all employees of OLMS were notified that 43 positions were deemed unaffordable by the Employment Standards Administration (ESA), which OLMS falls under. As of the same date, 20 employees were involuntarily transferred to other agencies. They have 5 days to agree to this or lose their job. Though it was repeated this was not a Reduction in Force (RIF), this is essentially what has occurred.

Additionally, the remaining 23 employees/positions have not been identified. OLMS is represented by an independent union, created in 1971, the National Union of Labor Investigators (NULI). Despite an official union request seeking documents regarding the reorganization, nothing has been provided to NULI that represents all bargaining unit employees. Anxiety runs high as OLMS employees cannot know whether they are one of the designated 23 employees, and whether they should immediately look for work.

NULI cannot possibly negotiate the impact of a plan that they do not have and cannot obtain. OLMS has essentially ignored the collective bargaining agreement negotiated by OLMS and NULI; and the right of NULI as the sole and exclusive bargaining representative for all unit employees. Regardless of the political powers, reasonable notice is still warranted. Rights of working people should be respected.

In 1959, the Labor Management Reporting and Disclosure Act was enacted to correct the abuses which had crept into labor and management which was revealed during the investigations of the McClellan Committee. The Secretary of Labor administers and enforces the act.

Shortly after the election of President Obama, the AFL–CIO wrote a proposal entitled AFL–CIO 2008 Transition Project Recommendations for the Obama Administration: Regulations of Union Finances and Elections Under the Labor Management and Disclosure Act that was provided to the Obama-Biden Transition team. Their recommendations asked for immediate revocation of revisions made to union financial disclosures. This was essentially enacted. They recommended a scaling back of OLMS' enforcement efforts. This, too, was enacted.

Additionally, the transition team evaluating the OLMS was headed by Deborah Greenfield, former AFL–CIO Associate General Counsel. Her first stop in that position was to OLMS. Ms. Greenfield was one of the attorney's suing OLMS on behalf of the AFL–CIO. According to a recent Washington Times article, Ms. Greenfield currently is in charge of the Department's Executive Secretariat's office, which handles much of the correspondence for Secretary Solis. This appears to be in violation of President Obama's pledge to the American public when he said:

"No political appointees in an Obama-Biden administration will be permitted to work on regulations or contracts directly and substantially related to their prior employer for two years."

OLMS is not a partisan issue; it is about protecting the money and the democratic rights of American workers who engage in legitimate union activity. We are the only

agency, created by Congress, to oversee and protect the rights of union workers. Allowing the budget to pass as is, allows for the rights of American workers to be trampled on.

The rationale and the statistics provided to justify the decrease in funding and reduction in staff are gravely misconstrued and misleading. The Secretary of Labor has now directed OLMS to reduce the number of staff back to the levels when union officers and employees rest assured that the Government could not closely monitor or oversee their actions. As a society we are aware that when the Government cannot monitor, oversee, or enforce Federal law, those affected by those laws are left susceptible to violations of the law. What does this mean? It simply means that hard-working Americans who are union members may be subjected to an increase of theft: theft of their hard-working union dues and theft of their right to democracy in their union.

I understand that our economy is currently struggling and we all need to make sacrifices. Every other agency within the Department of Labor has seen an increase in funding, except ours. While I greatly applaud the Secretary's efforts to bring back enforcement in areas that have been sorely underfunded in recent years, it seems somewhat antithetical that the one area that protects a large portion of the America's workers are scaled back. Let's not hurt the American workers more by allowing their hard earned money to be misused or having their democratic rights within the union reduced.

I write to you not only as an employee but as a union member as well. I urge the Subcommittee on Labor, Health and Human Services, and Education, and Related Agencies to ask for a full inquiry and accounting into the reasoning behind the reductions of the OLMS budget and who will truly benefit from the lack of enforcement. I also ask that prior to approving the budget to please educate yourself on the true role and purpose of OLMS.

Union rights are human rights. Whether you are for or against labor unions, they are an essential component for any true democracy. Cutting funding will only make unions weaker by reducing the rank and file's faith in their union leadership.

Thank you for you time and consideration.

Sincerely,

ELIZABETH MESSENGER.

PREPARED STATEMENT OF THE NATIONAL WILDLIFE FEDERATION

Mr. Chairman, members of the subcommittee, on behalf of the National Wildlife Federation (NWF), our Nation's largest conservation advocacy and education organization, and our more than 4 million members and supporters, I thank you for the opportunity to provide funding recommendations for the Department of Education, Department of Labor (DOL), and the Corporation for National and Community Service (CNCS).

We believe that the overall Federal investment in environmental education and sustainability education programs nationwide—pennies per capita—is woefully inadequate. While NWF supports numerous programs under the jurisdiction of this subcommittee, the purpose of this testimony is to recommend levels of funding for specific sustainability education, green jobs education and training, and national service programs that we believe are vital to NWF's mission to inspire Americans to protect wildlife for our children's future. NWF also supports climate change education and environmental education programs across the Federal agencies at the U.S. Forest Service, Environmental Protection Agency, National Science Foundation, National Space and Atmospheric Administration, National Oceanic and Atmospheric Administration, and U.S. Department of the Interior.

SUMMARY OF RECOMMENDATIONS

Agency	Program	Fiscal year 2010 recommendation	Fiscal year 2009 level
Education	University Sustainability Program.	$50 million	Not authorized in fiscal year 2009
Education	Healthy High Performance Schools.	$25 million	None
Labor	Green Jobs Act	$125 million	Funded at $500 million total in ARRA
Labor	Community Based Jobs Training Grants.	$250 million—green priority.	$125 million

SUMMARY OF RECOMMENDATIONS—Continued

Agency	Program	Fiscal year 2010 recommendation	Fiscal year 2009 level
CNCS	Clean Energy Service Corps	$100 million	Not authorized in fiscal year 2009

THE NEED FOR ENVIRONMENTAL EDUCATION AND SUSTAINABILITY EDUCATION

As our Nation moves towards a clean energy economy and creates new "green jobs," we must ensure that our education and training infrastructure keeps pace. Congress and President Obama have stated their desire to cap global warming pollution this year, a priority that NWF strongly supports. To be successful as a Nation under a new cap and trade system, we must have an environmentally literate citizenry that has the knowledge and skills to find new and innovative solutions to protect our planet. While public awareness and concern about global warming continues to rise, the vast majority of the public does not understand how climate change works, how it impacts their lives and careers, and how their decisions and actions contribute to it. Consider the following examples:

—Survey research shows that most Americans do not know what the carbon cycle is or understand what actually causes global warming. They do not know how most electricity is generated or the importance of healthy forests and oceans in generating oxygen and absorbing carbon dioxide.

—Less than half of the population recognizes that the cars and appliances they use contribute to global warming, and 8 out of 10 parents admit that they know "little" to "nothing" about the specific causes of climate change.

—The average high school student fails a quiz on the causes and consequences of climate change (nearly 82 percent of participants affirmed, incorrectly, that "scientists believe radiation from nuclear power plants cause global temperatures to rise").

Educating Americans about climate change is a huge opportunity for our Nation to prepare today's leaders, and the leaders of tomorrow, to implement the solutions created by a cap and trade system. Addressing global warming will generate millions of good new jobs and put the United States at the exciting forefront of a new clean energy economy. The successful transition to this new green economy hinges on education and training. This testimony focuses on key programs that educate and train Americans at institutions of higher education, through conservation corps programs that educate and train at-risk youth for careers in clean energy, and through green workforce education and training programs through the Department of Labor.

DEPARTMENT OF EDUCATION

University Sustainability Program (USP)

The National Wildlife Federation supports funding the newly authorized USP at $50 million in fiscal year 2010. Interest in sustainability is exploding on college campuses across the Nation, and institutions are making remarkable changes to try to reduce campus carbon footprints and energy use. However, despite increasing interest and demand from students, sustainability education programs on college campuses are on the decline according to a comprehensive study released in August 2008 by NWF and Princeton Survey Research Associates International, called the "Campus Environment 2008: A National Report Card on Sustainability in Higher Education." Environmental curriculum requirements are slipping and today's students may be less environmentally literate when they graduate than their predecessors.

Congress authorized a new USP at the Department of Education as part U of the recently enacted Higher Education Opportunity Act of 2008 (H.R. 4137). This program has the potential for high-impact, high-visibility, broad support within higher education, and is responsive to an important national trend in higher education. Sustainability on college campuses is critical, from education in the classroom to facility operations. Higher education produces almost all of the Nation's leaders in all sectors and endeavors, and many college campuses are virtually small cities in their size, environmental impact, and financial influence. Campuses use vast amounts of energy to heat, cool, and light their facilities. In all, the Nation's 4,100 campuses educate or employ around 20 million individuals and generate more than 3 percent of the Nation's GDP. The economic clout of these schools is further multiplied by the hundreds of thousands of business suppliers, property owners, and other commercial and nonprofit entities involved with higher education. Funding for the

newly authorized USP is critical to help provide difficult-to-get seed funding to launch sustainability education programs and to help support mainstream higher education associations in including sustainability in their work with their member institutions.

HEALTHY HIGH PERFORMANCE SCHOOLS PROGRAM

The National Wildlife Federation supports funding the Healthy High Performance Schools Program at $25 million in fiscal year 2010. The Healthy High Performance Schools Program seeks to facilitate the design, construction and operation of high performance schools: environments that are not only energy and resource efficient, but also healthy, comfortable, well lit, and containing the amenities for a quality education. This grant program is critical at a time when energy costs for America's elementary and secondary schools are skyrocketing. The No Child Left Behind Act (Public Law 107–110, title 5, part D, subtitle 18) authorized grants to State education agencies to advance the development of "healthy, high performance" school buildings. States may use the funds to provide information, technical assistance, monitor, evaluate, and provide funding to local education agencies for healthy, high-performance school buildings. In turn, local agencies may use the funding to obtain technical assistance, develop plans that address reducing energy and meet health and safety codes, and conduct energy audits. Funds may not be used for construction, maintenance, repair or renovation of buildings. Research clearly shows that improving specific factors such as school indoor environmental quality improves attendance, academic performance, and productivity. This program has yet to be funded by Congress.

NWF also supports a priority for funding green Career and Technical Education programs and initiatives at the Department of Education.

While not yet authorized, NWF strongly supports authorization of and full funding at $100 million per year for the No Child Left Inside (NCLI) Act of 2009, which has the support of more than 1,300 national, State, and local organizations representing more than 45 million Americans. The central new policy in this legislation is the incentive for States to create or update a State Environmental Literacy Plan. Environmental Literacy Plans can be developed to meet the needs of each State and systemically advance environmental education through the K–12 education system. These State plans support teacher training and professional development and support capacity building for environmental education. The House passed a modified version of the bill in the 110th Congress by a bipartisan vote of 293–109.

DEPARTMENT OF LABOR

NWF supports a priority for green jobs education and training at the Department of Labor though the Workforce Investment Act Adult and Youth funding streams, the Energy Efficiency and Renewable Energy Worker Training Program, and the Community-Based Job Training program.

Energy Efficiency and Renewable Energy Worker Training Program

NWF supports funding the Energy Efficiency and Renewable Energy Worker Training Program at $125 million in fiscal year 2010. NWF greatly appreciates this subcommittee's first-time investment in Green Jobs Education and Training in the recent American Recovery and Reinvestment Act (ARRA). This unprecedented investment will help jumpstart the education and training needed to prepare Americans for the clean energy economy. We hope that the subcommittee will fund The Green Jobs Act (GJA), title X of the Energy Independence and Security Act, which authorizes $125 million per year in grants for an Energy Efficiency and Renewable Energy Worker Training Program. NWF is seeking $125 million in this fiscal year 2010 bill, recognizing that the subcommittee will assess how the investment through ARRA is spent before making new funding available. NWF believes it is important to make annual investments in this program through the regular appropriations process, in addition to necessary infusions of funding through stimulus and supplemental bills. This program identifies needed skills, develops training programs, and trains workers for jobs in a range of green industries, but has a special focus on creating "green pathways out of poverty." The program is administered by the Department of Labor in consultation with the Department of Energy. ARRA responds to already existing skill shortages. The National Renewable Energy Lab has identified a shortage of skills and training as a leading barrier to renewable energy and energy efficiency growth. This labor shortage is only likely to get more severe as baby-boomers skilled in current energy technologies retire; in the power sector, for example, nearly one-quarter of the current workforce will be eligible for retirement in the next 5 to 7 years.

Community-Based Job Training Grants Program

NWF supports funding the Community-Based Job Training Grants Program at $250 million in fiscal year 2010. NWF believes that community colleges are critical partners in training and educating the next generation of Americans for green jobs. NWF supports a priority within this program for green jobs education and training grants. The Community-Based Job Training Grants program supports partnerships of community colleges, business, and workforce investment boards seeking to train workers for high-demand occupations. These competitive grants help ensure that efforts funded through the program are well coordinated with other local and regional workforce development efforts. Community-Based Job Training Grants support workforce training for high-growth industries through the Nation's community and technical colleges. Their primary purpose is to build community colleges' capacity to equip workers with the skills required to succeed in local industries.

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

Clean Energy Service Corps

NWF supports funding the Clean Energy Service Corps at $100 million in fiscal year 2010. The Clean Energy Service Corps, building on the legacy of the depression-era Civilian Conservation Corps and modeled after today's Service and Conservation Corps, will address the Nation's energy and environmental needs while providing work and service opportunities, especially for disadvantaged youth ages 16–25. In a manner similar to the Civilian Conservation Corps of the 1930s, disconnected young people may be mobilized through this program to retrofit, weatherize, and otherwise improve the energy efficiency of residential and public facilities that account for more than 40 percent of carbon emissions. Specific projects that are authorized include weatherizing and retrofitting housing units for low-income households, cleaning and improving rivers, and working with schools and youth programs to educate students and youth about ways to reduce home energy use and improve the environment.

CONCLUSION

Providing Federal support for environmental education, sustainability education, green jobs education and training, and green national service programs is critical for securing our new clean energy future and preparing the next generation for the challenges and opportunities ahead.

PREPARED STATEMENT OF THE OVARIAN CANCER NATIONAL ALLIANCE

On behalf of the Ovarian Cancer National Alliance (the Alliance), thank you for this opportunity to submit comments for the record regarding the Alliance's fiscal year 2010 funding recommendations. We believe these recommendations are critical to ensure advances to help reduce and prevent suffering from ovarian cancer. For 12 years, the Alliance has worked to increase awareness of ovarian cancer and advocated for additional Federal resources to support research that would lead to more effective diagnostics and treatments.

As an umbrella organization with 45 State and local organizations, the Alliance unites the efforts of survivors, grassroots activists, women's health advocates, and healthcare professionals to bring national attention to ovarian cancer. Our sole mission is to conquer ovarian cancer.

According to the American Cancer Society, in 2008, more than 22,000 American women were diagnosed with ovarian cancer and approximately 15,000 lost their lives to this terrible disease. Ovarian cancer is the fifth leading cause of cancer death in women. Currently, more than half of the women diagnosed with ovarian cancer will die within 5 years. While ovarian cancer has early symptoms, there is no early detection test. Most women are diagnosed in stage III or stage IV, when survival rates are low. If diagnosed early, more than 90 percent of women will survive for 5 years, but when diagnosed later, less than 30 percent will.

In addition, only a few treatments have been approved by the Food and Drug Administration for ovarian cancer treatment. These are platinum-based therapies and women needing further rounds of treatment are frequently resistant to them. More than 70 percent of ovarian cancer patients will have a recurrence at some point, underlying the need for treatments to which patients do not grow resistant.

For all of these problems, we urgently call on Congress to appropriate funds to find solutions.

As part of this effort, the Alliance advocates for continued Federal investment in the Centers for Disease Control and Prevention's (CDC) Ovarian Cancer Control Ini-

tiative. The Alliance respectfully requests that Congress provide $10 million for the program in fiscal year 2010.

The Alliance also fully supports Congress in taking action on ovarian cancer through its recent passage of Johanna's Law: The Gynecologic Cancer Education and Awareness Act (Public Law 109–475). The Alliance respectfully requests that Congress provide $10 million to implement Johanna's Law in fiscal year 2010.

Further, the Alliance urges Congress to continue funding the Specialized Programs of Research Excellence (SPOREs), including the four ovarian cancer sites. These programs are administered through the National Cancer Institute (NCI) of the National Institutes of Health (NIH). The Alliance respectfully requests that Congress provide $6 billion to NCI for fiscal year 2010.

CDC

The Ovarian Cancer Control Initiative

As the statistics indicate, late detection and, therefore, poor survival are among the most urgent challenges we face in the ovarian cancer field. The CDC's cancer program, with its strong capacity in epidemiology and excellent track record in public and professional education, is well-positioned to address these problems. As the Nation's leading prevention agency, the CDC plays an important role in translating and delivering at the community level what is learned from research, especially ensuring that those populations disproportionately affected by cancer receive the benefits of our Nation's investment in medical research.

Prompted by efforts from leaders of the Alliance and championed by Representative Rosa DeLauro—with bipartisan, bicameral support—Congress established the Ovarian Cancer Control Initiative at the CDC in November 1999. Congress' directive to the agency was to develop an appropriate public health response to ovarian cancer and conduct several public health activities targeted toward reducing ovarian cancer morbidity and mortality.

Through the OCCI, the National Comprehensive Cancer Control Program is helping States address issues related to ovarian cancer. The program currently funds efforts in California, Florida, Michigan, New York, Pennsylvania, Texas, and West Virginia. These projects are working to develop ovarian cancer health messages for the general public and for healthcare providers.

JOHANNA'S LAW: THE GYNECOLOGIC CANCER EDUCATION AND AWARENESS ACT

It is critical for women and their healthcare providers to be aware of the signs, symptoms and risk factors of ovarian and other gynecologic cancers. Often, women and providers mistakenly confuse ovarian cancer signs and symptoms with those of gastrointestinal disorders or early menopause. While symptoms may seem vague—bloating, pelvic or abdominal pain, increased abdominal size and bloating and difficulty, eating or feeling full quickly, or urinary symptoms (urgency or frequency)—they can be deadly without proper medical intervention.

In recognition of the need for awareness and education, Congress unanimously passed Johanna's Law in 2006, enacted in early 2007. This law provides for an education and awareness campaign that will increase providers' and women's awareness of all gynecologic cancers including ovarian. Together, Johanna's Law and the Ovarian Cancer Control Initiative will help increase awareness and understanding of ovarian cancer and work to reduce ovarian cancer morbidity and mortality.

Already, with only a small amount of seed money, the CDC has launched the Inside Knowledge: Get the Facts About Gynecologic Cancer campaign to raise awareness of the five main types of gynecologic cancer: ovarian, cervical, uterine, vaginal, and vulvar. Many fact sheets, including the ovarian cancer fact sheet, are already available on the CDC's Web site for download. The CDC plans to develop broadcast advertisements, posters—such as dioramas for bus stops—and other print materials, a comprehensive brochure on gynecologic cancers, and materials aimed at healthcare providers.

NCI

SPOREs at NIH

The Specialized Programs of Research Excellence were created by the NCI in 1992 to support translational, organ site-focused cancer research. The ovarian cancer SPOREs began in 1999. There are four currently funded Ovarian Cancer SPOREs located at the MD Anderson Cancer Center, the Fred Hutchinson Cancer Research Center, the Fox Chase Cancer Center and the Dana Farber/Harvard Cancer Center.

These SPORE programs have made outstanding strides in understanding ovarian cancer, as illustrated by their more than 300 publications as well as other notable

achievements, including the development of an infrastructure between Ovarian SPORE institutions to facilitate collaborative studies on understanding, early detection, and treatment of ovarian cancer.

Clinical Trials

NCI supports clinical research—the only way to test the safety and efficacy of potential new treatments for ovarian cancer. Two recent studies from NCI clinical trials show the impact of intraperitoneal chemotherapy in treating ovarian cancer (when chemotherapy is introduced directly into the woman's abdominal cavity, rather than her bloodstream) and the importance of ultrasound expertise in properly diagnosing the disease.

NCI supports the Gynecology Oncology Group (GOG), a more than 50-member collaborative focusing on cancers of the female reproductive system. In 2007 alone, GOG published 23 articles about ovarian cancer.

SUMMARY

The Alliance maintains a long-standing commitment to work with Congress, the administration, and other policy makers and stakeholders to improve the survival rate for women with ovarian cancer through education, public policy, research, and communication. Please know we appreciate and understand that our Nation faces many challenges and Congress has limited resources to allocate; however, we are concerned that without increased funding to bolster and expand ovarian cancer education, awareness and research efforts, the Nation will continue to see growing numbers of women losing their battle with this terrible disease.

On behalf of the entire ovarian cancer community—patients, family members, clinicians, and researchers—we thank you for your leadership and support of Federal programs that seek to reduce and prevent suffering from ovarian cancer. Thank you in advance for your support of $10 million in fiscal year 2010 funding for the CDC's Ovarian Cancer Control Initiative and $10 million in fiscal year 2010 funding for Johanna's Law as well as your continued support of the SPORES program, an appropriation of $6 billion to NCI.

PREPARED STATEMENT OF THE ONCOLOGY NURSING SOCIETY

OVERVIEW

The Oncology Nursing Society (ONS) appreciates the opportunity to submit written comments for the record regarding fiscal year 2010 funding for cancer and nursing-related programs. ONS, the largest professional oncology group in the United States, composed of more than 37,000 nurses and other health professionals, exists to promote excellence in oncology nursing and the provision of quality care to those individuals affected by cancer. As part of its mission, ONS honors and maintains nursing's historical and essential commitment to advocacy for the public good.

In 2009, an estimated 1.44 million Americans will be diagnosed with cancer, and more than 565,650 will lose their battle with this terrible disease; at the same time the national nursing shortage is expected to worsen. Overall, age is the number one risk factor for developing cancer. Approximately 77 percent of all cancers are diagnosed at age 55 and older.[1] Despite these grim statistics, significant gains in the war against cancer have been made through our Nation's investment in cancer research and its application. Research holds the key to improved cancer prevention, early detection, diagnosis, and treatment, but such breakthroughs are meaningless, unless we can deliver them to all Americans in need. Moreover, a recent survey of ONS members found that the nursing shortage is having an adverse impact in oncology physician offices and hospital outpatient departments. Some respondents indicated that when a nurse leaves their practice, they are unable to hire a replacement due to the shortage—leaving them short-staffed and posing scheduling challenges for the practice and the patients. These vacancies in all care settings create significant barriers to ensuring access to quality care.

To ensure that all people with cancer have access to the comprehensive, quality care they need and deserve, ONS advocates ongoing and significant Federal funding for cancer research and application, as well as funding for programs that help ensure an adequate oncology nursing workforce to care for people with cancer. ONS stands ready to work with policymakers at the local, State, and Federal levels to advance policies and programs that will reduce and prevent suffering from cancer

---

[1] American Cancer Society. *Cancer Facts and Figures 2008*. http://www.cancer.org/downloads/STT/2008CAFFfinalsecured.pdf.

and sustain and strengthen the Nation's nursing workforce. We thank the subcommittee for its consideration of our fiscal year 2010 funding request detailed below.

SECURING AND MAINTAINING AN ADEQUATE ONCOLOGY NURSING WORKFORCE

Oncology nurses are on the front lines in the provision of quality cancer care for individuals with cancer—administering chemotherapy, managing patient therapies and side effects, working with insurance companies to ensure that patients receive the appropriate treatment, providing treatment education and counseling to patients and family members, and engaging in myriad other activities on behalf of people with cancer and their families. Cancer is a complex, multifaceted chronic disease, and people with cancer require specialty-nursing interventions at every step of the cancer experience. People with cancer are best served by nurses specialized in oncology care, who are certified in that specialty.

As the overall number of nurses is expected to drop precipitously in the coming years, we likely will experience a commensurate decrease in the number of nurses trained in the specialty of oncology. With an increasing number of people with cancer needing high-quality healthcare, coupled with an inadequate nursing workforce, our Nation could quickly face a cancer care crisis of serious proportion, with limited access to quality cancer care, particularly in traditionally underserved areas. A study in the New England Journal of Medicine found that nursing shortages in hospitals are associated with a higher risk of complications—such as urinary tract infections and pneumonia, longer hospital stays, and even patient death.[2] Without an adequate supply of nurses, there will not be enough qualified oncology nurses to provide the quality cancer care to a growing population of people in need, and patient health and well-being could suffer.

Of additional concern is that our Nation also will face a shortage of nurses available and able to conduct cancer research and clinical trials. With a shortage of cancer research nurses, progress against cancer will take longer because of scarce human resources coupled with the reality that some practices and cancer centers' resources could be funneled away from cancer research to pay for the hiring and retention of oncology nurses to provide direct patient care. Without a sufficient supply of trained, educated, and experienced oncology nurses, we are concerned that our Nation may falter in its delivery and application of the benefits from our Federal investment in research.

ONS has joins with President Obama and others in the nursing community in advocating $263 million as the fiscal year 2010 funding level necessary to support implementation of the Nurse Reinvestment Act and the range of nursing workforce development programs housed at the U.S. Health Resources and Services Administration (HRSA). Enacted in 2002, the Nurse Reinvestment Act (Public Law 107–205) included new and expanded initiatives, including loan forgiveness, scholarships, career ladder opportunities, and public service announcements to advance nursing as a career. Despite the enactment of this critical measure, HRSA fails to have the resources necessary to meet the current and growing demands for our Nation's nursing workforce. For example, in fiscal year 2008 HRSA received 6,078 applications for the Nurse Education Loan Repayment Program, but only had the funds to award 435 of those applications.[3] Also, in fiscal year 2008 HRSA received 4,894 applications for the Nursing Scholarship Program, but only had funding to support 172 awards.[4]

A number of years ago, one of the biggest factors associated with the shortage was a lack of interested and qualified applicants. Due to the efforts of ONS, our nursing community partners, and other interested stakeholders, the number of applicants is growing. As such, now one of the greatest factors contributing to the shortage is that nursing programs are turning away qualified applicants to entry-level baccalaureate programs, due to a shortage of nursing faculty. According to the American Association of Colleges of Nursing (AACN), U.S. nursing schools turned away 50,000 qualified applicants from baccalaureate and graduate nursing programs in 2008,

[2] Needleman J., Buerhaus P., Mattke S., Stewart M., Zelevinsky K. "Nurse-Staffing Levels and the Quality of Care in Hospitals." *New England Journal of Medicine* 346:, (May 30, 2002): 1715–1722.

[3] U.S. Health Resources and Services Administration: Nurse Education Loan Repayment Program: http://bhpr.hrsa.gov/nursing/loanrepay.htm. Accessed April 22, 2009.

[4] U.S. Health Resources and Services Administration: Nursing Scholarship Program Statistics: http://bhpr.hrsa.gov/nursing/scholarship/. Accessed April 22, 2009.

due to insufficient number of faculty and inadequate resources.[5] Of those potential students, nearly 7,000 were students pursuing a master's or doctoral degree in nursing, which is the education level required to teach. Within the next decade, it is expected that half of all nurse faculty will reach retirement age.[6] Given the expected wave of retirement among faculty, the nurse faculty shortage is only expected to worsen as there are insufficient numbers of candidates in the pipeline to take their places. The number of full-time nursing faculty required to "fill the nursing gap" is approximately 40,000, and, currently, there are less than 20,000 full-time nursing faculty in the system.

With additional funding in fiscal year 2010, the HRSA Workforce Development Programs will have much-needed resources to address the multiple factors contributing to the nationwide nursing shortage, including the shortage of faculty. Advanced nursing education programs play an integral role in supporting registered nurses interested in advancing in their practice and becoming faculty. As such, these programs must be adequately funded in the coming year.

ONS strongly urges Congress to provide HRSA with a minimum of $263 million in fiscal year 2010 to ensure that the agency has the resources necessary to fund a higher rate of nursing scholarships and loan repayment applications and support other essential endeavors to sustain and boost our Nation's nursing workforce. Nurses—along with patients, family members, hospitals, and others—have joined together in calling upon Congress to provide this essential level of funding. ONS and its allies have serious concerns that without full funding, the Nurse Reinvestment Act will prove an empty promise, and the current and expected nursing shortage will worsen, and people will not have access to the quality care they need and deserve.

SUSTAIN AND SEIZE CANCER RESEARCH OPPORTUNITIES

Our Nation has benefited immensely from past Federal investment in biomedical research at the National Institutes of Health (NIH). ONS has joined with the broader health community in advocating a 10 percent increase ($33.349 billion) for NIH in fiscal year 2010. This level of investment will allow NIH to sustain and build on its research progress, while avoiding the severe disruption to advancement that could result from a minimal increase. Cancer research is producing amazing breakthroughs—leading to new therapies that translate into longer survival and improved quality of life for cancer patients. In recent years, we have seen extraordinary advances in cancer research, resulting from our national investment, which have produced effective prevention, early detection, and treatment methods for many cancers. To that end, ONS calls upon Congress to allocate $5.957 billion to the National Cancer Institute, as well as $227 million to the National Center for Minority Health and Health Disparities in fiscal year 2010 to support the battle against cancer.

The National Institute of Nursing Research (NINR) supports basic and clinical research to establish a scientific basis for the care of individuals across the life span—from management of patients during illness and recovery, to the reduction of risks for disease and disability and the promotion of healthy lifestyles. These efforts are crucial in translating scientific advances into cost-effective healthcare that does not compromise quality of care for patients. Additionally, NINR fosters collaborations with many other disciplines in areas of mutual interest, such as long-term care for older people, the special needs of women across the life span, bioethical issues associated with genetic testing and counseling, and the impact of environmental influences on risk factors for chronic illnesses, such as cancer. ONS joins with others in the nursing community and NCCR in advocating a fiscal year 2010 allocation of $178 million for NINR.

BOOST OUR NATION'S INVESTMENT IN CANCER PREVENTION, EARLY DETECTION, AND AWARENESS

Approximately two-thirds of cancer cases are preventable through lifestyle and behavioral factors and improved practice of cancer screening. Although the potential for reducing the human, economic, and social costs of cancer by focusing on prevention and early detection efforts remains great, our Nation does not invest sufficiently in these strategies. The Nation must make significant and unprecedented

[5] American Association of Colleges of Nursing ,"2006–2007 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing." http://www.aacn.nche.edu/IDS/datarep.htm, March 2007.

[6] Preliminary Results: "National Survey of Nurse Educators: Compensation, Workload, and Teaching Practices." *National League of Nursing/Carnegie Foundation*. (February 7, 2007) http://www.nln.org/newsreleases/pres__budget2007.htm.

Federal investments today to address the burden of cancer and other chronic diseases, and to reduce the demand on the healthcare system and diminish suffering in our Nation, both for today and tomorrow.

As the Nation's leading prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in translating and delivering, at the community level, what is learned from research. Therefore, ONS joins with our partners in the cancer community in calling on Congress to provide additional resources for the CDC to support and expand much-needed and proven effective cancer prevention, early detection, and risk reduction efforts. Specifically, ONS advocates the following fiscal year 2010 funding levels for the following CDC programs:

—$250 million for the National Breast and Cervical Cancer Early Detection Program;
—$65 million for the National Cancer Registries Program;
—$25 million for the Colorectal Cancer Prevention and Control Initiative;
—$50 million for the Comprehensive Cancer Control Initiative;
—$25 million for the Prostate Cancer Control Initiative;
—$5 million for the National Skin Cancer Prevention Education Program;
—$10 million for the Ovarian Cancer Control Initiative; and
—$6 million for the Geraldine Ferraro Blood Cancer Program.

CONCLUSION

ONS maintains a strong commitment to working with Members of Congress, other nursing and oncology societies, patient organizations, and other stakeholders to ensure that the oncology nurses of today continue to practice tomorrow, and that we recruit and retain new oncology nurses to meet the unfortunate growing demand that we will face in the coming years. By providing the fiscal year 2010 funding levels detailed above, we believe the subcommittee will be taking the steps necessary to ensure that our Nation has a sufficient nursing workforce to care for the patients of today and tomorrow and that our Nation continues to make gains in our fight against cancer.

PREPARED STATEMENT OF THE POPULATION ASSOCIATION OF AMERICA/ASSOCIATION OF POPULATION CENTERS

Introduction

Thank you, Mr. Chairman Harkin, Mr. Ranking Member Cochran, and other distinguished members of the subcommittee, for this opportunity to express support for the National Institutes of Health (NIH), the National Center for Health Statistics (NCHS), and Bureau of Labor Statistics (BLS).

Background on the Population Association of America (PAA)/Association of Population Centers (APC) and Demographic Research

The Population Association of America (PAA) is a scientific organization comprised of more than 3,000 population research professionals, including demographers, sociologists, statisticians, and economists. The Association of Population Centers (APC) is a similar organization comprised of 40 universities and research groups that foster collaborative demographic research and data sharing, translate basic population research for policy makers, and provide educational and training opportunities in population studies. Population research centers are located at public and private research institutions, including, for example, the University of Wisconsin—Madison, RAND Corporation, State University New York Albany, Brown University, Ohio State University, University of North Carolina—Chapel Hill, and Pennsylvania State University.

Demography is the study of populations and how or why they change. Demographers, as well as other population researchers, collect and analyze data on trends in births, deaths, and disabilities as well as racial, ethnic, and socioeconomic changes in populations. Major policy issues population researchers are studying include the demographic causes and consequences of population aging, trends in fertility, marriage, and divorce and their effects on the health and well being of children, and immigration and migration and how changes in these patterns affect the ethnic and cultural diversity of our population and the Nation's health and environment.

The NIH mission is to support research that will improve the health of our population. The health of our population is fundamentally intertwined with the demography of our population. Recognizing the connection between health and demography, the NIH supports extramural population research programs primarily

through the National Institute on Aging (NIA) and the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD).

NIA

According to the Census Bureau, by 2029, all of the baby boomers (those born between 1946 and 1964) will be age 65 years and older. As a result, the population age 65–74 years will increase from 6 percent to 10 percent of the total population between 2005 and 2030. This substantial growth in the older population is driving policymakers to consider dramatic changes in Federal entitlement programs, such as Medicare and Social Security, and other budgetary changes that could affect programs serving the elderly. To inform this debate, policymakers need objective, reliable data about the antecedents and impact of changing social, demographic, economic, and health characteristics of the older population. The NIA Division of Behavioral and Social Research (BSR) is the primary source of Federal support for research on these topics.

In addition to supporting an impressive research portfolio, that includes the prestigious Centers of Demography of Aging and Roybal Centers for Applied Gerontology Programs, the NIA BSR program also supports several large, accessible data surveys. One of these surveys, the Health and Retirement Study (HRS), has become one of the seminal sources of information to assess the health and socioeconomic status of older people in the United States. Since 1992, the HRS has tracked 27,000 people, providing data on a number of issues, including the role families play in the provision of resources to needy elderly and the economic and health consequences of a spouse's death. HRS is particularly valuable because its longitudinal design allows researchers: (1) the ability to immediately study the impact of important policy changes such as Medicare Part D; and (2) the opportunity to gain insight into future health-related policy issues that may be on the horizon, such as HRS data indicating an increase in pre-retirees self-reported rates of disability. In 2009 and 2010, HRS is seeking to increase its minority sample size and collect unique, enhanced data on the effects of the current economic downturn on older people.

With additional support in fiscal year 2010, the NIA BSR program could fully fund its existing centers programs and support its ongoing surveys without resorting to cost cutting measures, such as cutting sample size. Currently, the Demography of Aging and Roybal Centers programs are recompeting their 5-year awards. Additional funding may give the Institute resources it needs to award more center grants. NIA could also use additional resources to improve its funding payline and sustain training and research opportunities for new investigators.

NICHD

Since its establishment in 1968, the NICHD Center for Population Research has supported research on population processes and change. Today, this research is housed in the Center's Demographic and Behavioral Sciences Branch (DBSB). The Branch encompasses research in four broad areas: family and fertility, mortality and health, migration and population distribution, and population composition. In addition to funding research projects in these areas, DBSB also supports a highly regarded population research infrastructure program and a number of large database studies, including the Fragile Families and Child Well Being Study, New Immigrant Study, and National Longitudinal Study of Adolescent Health.

NIH-funded demographic research has consistently provided critical scientific knowledge on issues of greatest consequence for American families: work-family conflicts, marriage and childbearing, childcare, and family and household behavior. However, in the realm of public health, demographic research is having an even larger impact, particularly on issues regarding adolescent and minority health. Understanding the role of marriage and stable families in the health and development of children is another major focus of the NICHD DBSB. Consistently, research has shown children raised in stable family environments have positive health and development outcomes. Policymakers and community programs can use these findings to support unstable families and improve the health and well-being of children.

One of the most important programs the NICHD DBSB supports is the Population Research Infrastructure Program (PRIP). Through PRIP, research is conducted at private and public research institutions nationwide. The primary goal of PRIP is "to facilitate interdisciplinary collaboration and innovation in population research, while providing essential and cost-effective resources in support of the development, conduct, and translation of population research." Population research centers supported by PRIP are focal points for the demographic research field where innovative research and training activities occur and resources, including large-scale databases, are developed and maintained for widespread use.

With additional support in fiscal year 2010, NICHD could restore full funding to its large-scale surveys, which serve as a resource for researchers nationwide. Furthermore, the Institute could apply additional resources toward improving its funding payline, which has been as low as the 10th percentile prior to the recent infusion of ARRA funds. Additional support could be used to support and stabilize essential training and career development programs necessary to prepare the next generation of researchers and to support and expand proven programs, such as PRIP.

NCHS

Located within the Centers for Disease Control (CDC), NCHS is the Nation's principal health statistics agency, providing data on the health of the U.S. population and backing essential data collection activities. Most notably, NCHS funds and manages the National Vital Statistics System, which contracts with the States to collect birth and death certificate information. NCHS also funds a number of complex large surveys to help policy makers, public health officials, and researchers understand the population's health, influences on health, and health outcomes. These surveys include the National Health and Nutrition Examination Survey (NHANES), National Health Interview Survey (HIS), and National Survey of Family Growth. Together, NCHS programs provide credible data necessary to answer basic questions about the state of our Nation's health.

Despite a funding increase last year, NCHS continues to feel the effects of long-term funding shortfalls, compelling the agency to undermine, eliminate, or further postpone the collection of vital health data. For example, in 2009, sample sizes in HIS and NHANES have been cut, while other surveys, most notably the National Hospital Discharge Survey, are not being fielded. In addition, in 2009, NCHS has proposed purchasing only "core items" of vital birth and death statistics from the States (starting in 2010), effectively eliminating three-fourths of data routinely used to monitor maternal and infant health and contributing causes of death.

The administration recommends NCHS receive $138 million in fiscal year 2010. PAA and APC, as members of The Friends of NCHS, support the administration's request, but also hope Congress will give the agency an additional $15 million in fiscal year 2010. The additional $15 million should be designated specifically for supporting the States so they can modernize their vital statistics systems and make all collections electronic according to the 2003 birth and death certificates. If NCHS receives this funding, they can abandon their proposal to collect core vs. enhanced vital statistics data as well and focus on improving the current system. The underlying fiscal year 2010 budget request should be targeted at precluding further cuts in key surveys and collecting the full panel of vital statistics data.

If Congress fails to, at a minimum, provide the administration's fiscal year 2010 request, NCHS will be forced to eliminate over-sampling of minority populations in NHANES, which will compromise our understanding of health disparities at a time when our society is becoming increasingly diverse. Further, we will lose insurance coverage information on who's covered and who's not (particularly within minority populations), how people are covered and why they're not—at a time when Congress and the administration are debating healthcare reform. Finally, we will lose vital statistics, adversely affecting the amount of data researchers and health practitioners alike need to be effective in identifying trends and developing interventions.

BLS

During these turbulent economic times, data produced by BLS are particularly relevant and valued. PAA and APC members have relied historically on objective, accurate data from the BLS. In recent years, our organizations have become increasingly concerned about the state of the agency's funding.

We are pleased the administration has requested BLS receive a total of $611,623,000 in fiscal year 2010, an increase of $14,441,000 more than the 2009 enacted level. According to the agency, this funding level would enable BLS to meet its highest-priority goals and objectives in 2010. Ideally, the agency will receive enough funding not only in 2010, but also in future years to invest in research and assure continuous improvement of its measures, including the Consumer Price Index. We also hope BLS receives sufficient funds to maintain, or increase, the sample sizes of key surveys, such as the Current Population Survey. It is imperative sample sizes be increased to ensure surveys are accurate and providing adequate detail. We also hope fiscal year 2010 marks the beginning of a steady, predicable growth trend in the BLS budget.

Summary of Fiscal Year 2010 Recommendations

Despite the generous, short-term funding the NIH received from the American Recovery and Reinvestment Act (ARRA), the agency faces "falling off the cliff" in 2011

when ARRA funds expire. Thus, PAA and APC, as members of the Ad Hoc Group for Medical Research Funding, are asking Congress to provide NIH with and appropriation of $32.4 billion in fiscal year 2010, an increase of 7 percent more than the fiscal year 2009 appropriation. This funding level would put NIH on a stable course, ensuring the agency receives an inflationary increase plus enough money to support the best research projects, including new and innovative projects, and stabilize research training programs in fiscal year 2010.

As part of the NIH request, we also urge the subcommittee to appropriate $194.4 million for the National Children's Study (NCS) in fiscal year 2010 through the NIH Office of the Director, as proposed by the President's budget. This funding will allow for the completion of the pilot phase of the NCS.

PAA and APC, as members of the Friends of NCHS, ask that NCHS receive $138 million in fiscal year 2010, with an additional $15 million set aside for vital statistics infrastructure development. This funding is needed to maintain and improve the Nation's vital statistics system and to sustain and update the agency's major health survey operations.

Finally, we ask you to support the administration's request, $611.6 million, for the BLS, in fiscal year 2010.

Thank you for considering our requests and for supporting Federal programs that benefit the field of demographic research.

PREPARED STATEMENT OF THE PROGRAM FOR APPROPRIATE TECHNOLOGY IN HEALTH

OVERVIEW

Program for Appropriate Technology in Health (PATH) appreciates the opportunity to submit written testimony to the Senate Labor, Health and Human Services, Education, and Related Agencies Appropriations Subcommittee. PATH is a U.S.-based, international nonprofit organization that creates sustainable, culturally relevant solutions that enable communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public- and private-sector partners, we help provide appropriate health technologies and vital strategies that change the way people think and act. Our work improves global health and well-being.

The broad, ongoing, and successful struggle to improve global health relies on the availability of health interventions and technologies designed to prevent, diagnose, and treat disease. Although some effective interventions already exist, many more will be necessary if existing gains against infectious disease and other global health burdens are to be maintained and expanded. The drugs currently available for use against diseases that disproportionately impact the developing world are often too expensive for use in the developing world, and are also subject to disease resistance. Vaccines for many of these infectious diseases do not yet exist and diagnostic equipment, vaccine delivery devices, microbicides, contraceptives, and other health technologies appropriate for the developing world are in many cases not available or affordable. Achieving sustainable progress in the struggle to improve global health will require developing new health technologies, and creating or strengthening infrastructures that facilitate their availability to those who need them most.

Several programs funded in the Labor, Health and Human Services, and Education appropriations bill make a particularly critical contribution to point-of-care diagnostics, a research area that is key to improving health in the developing world. In low-resource settings, where many diagnostic tests are difficult to perform and laboratories are often inaccessible, there is a great opportunity to make significant improvements to global health through the development and use of appropriate point-of-care diagnostics. In poor countries, healthcare facilities can be far away, serving widely dispersed populations. Specialized equipment, personnel, and safe waste disposal systems are often not available. Without diagnostic testing, healthcare professionals have to rely on just evaluating symptoms to diagnose and treat illness—an imperfect method given the similarity of symptoms between many diseases. This lack of clarity puts individuals, communities, and the world in danger. Incorrect diagnoses can harm people and even cost lives. And from a global perspective, ineffectively treated disease can become a starting point for epidemic or pandemic outbreaks.

Fortunately, there is an array of promising new tests in the pipeline—inexpensive, portable, easy-to-use diagnostics that are practical at even small, local health centers, and which can deliver results the same day. Some are new takes on established technologies like the home pregnancy test. Others are exciting scientific advances. Effective diagnosis at, or near, the point of care enables better application of available treatment, avoids overuse of antibiotics that can promote resistant

strains of pathogens, and allows healthcare workers to track outbreaks and mobilize resources quickly.

The National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) continue to make significant contributions to the development of new health technologies. Generally speaking, NIH carries out the critical basic and preclinical research that provides the foundation for new product discovery and development, supports and conducts clinical trials of promising products, and develops the in-country research capacity of developing world partners. CDC monitors and tracks infectious diseases worldwide, provides those involved in the control and prevention of these diseases with the critical intelligence they need to implement their programs effectively, supports researchers in their work by helping to direct their efforts towards the areas with the greatest potential for benefit, and warns researchers when new trends or disease strains emerge.

Point-of-care diagnostics are one of the most critical global health technologies whose development of testing is supported by NIH and CDC. One example of this support is the ongoing and successful partnership between the NIH's National Institute of Biomedical Imaging and Bioengineering (NIBIB) and PATH. Working together with an investment from NIH/NIBIB, PATH formed the Center for Point-of-Care Diagnostics for Global Health (GHDx Center), a diagnostics research, development, testing, needs assessment and training program that works to improve the availability, accessibility, and affordability of essential point-of-care diagnostic tests for use in low-resource settings around the world. The GHDx Center, managed by PATH in collaboration with its partners at the University of Washington, is on the cutting edge of developing new diagnostic tools that can be used in developing countries to quickly and accurately diagnose diseases that disproportionately impact the developing world, but which until now have been difficult to accurately diagnose without laboratory facilities or extensively trained medical workers.

The GHDx Center focuses its work on four main areas that encompass the breadth of the health technology product development cycle. The GHDx Center performs and supports clinical needs assessments that help diagnostics developers target the most pressing global health challenges and increase the likelihood of product success. It supports exploratory technology projects that could have a significant positive impact on public health outcomes. It conducts laboratory and field-based clinical testing of prototype point-of-care diagnostics. Finally, the GHDx Center—in a program led by the University of Washington Department of Global Health and Department of Medicine (Division of Infectious Diseases)—trains individuals with varied experience and backgrounds from the fields of assay and device development, clinical laboratories, and disease specialties, with the objective of creating a networked group of researchers trained in state-of-the-art technology that address the challenges for global health in low-resource settings.

This extraordinarily promising new program would not have been possible without NIH support, and PATH thanks the subcommittee for its wise investments in NIH. Without robust funding for NIH and CDC, much of the cutting-edge research and development being performed on point-of-care diagnostics for the developing world would not be taking place. While many commercial and nonprofit groups are working on diagnostic technologies, they are not necessarily doing so with an eye toward the developing world. For example, their efforts often target diseases that mainly concern wealthier countries, or they assume that sophisticated laboratories and trained personnel will be available to complement and operate their diagnostics. In contrast, diagnostic technologies for malaria, enteric diseases, hepatitis b, and other conditions whose heaviest burden falls on the developing world, or which can be used in resource—poor conditions where laboratory equipment are scarce, do not have a significant commercial market that incentivizes research and development. Without investment by the U.S. Government, efforts to develop these diagnostic technologies—and by doing so improve care and reduce the development of drug resistance—would be hindered significantly. Expanding funds for these agencies would provide a powerful boost to point-of-care diagnostic development and availability.

Another area where agencies funded by this subcommittee are making a significant contribution to global health is in the ongoing effort to develop and test malaria vaccines. Malaria is a devastating parasitic disease transmitted through the bite of infected Anopheles mosquitoes. More than one-third of the world's population is at risk of malaria, with approximately 250 million cases and 1 million deaths per year, the vast majority of which occur among African children under the age of 5. A malaria vaccine is desperately needed to confront this deadly disease and its impact in the developing world. While consistent use of effective insecticides, insecticide-treated nets, and malaria medicines saves lives, eradicating or even significantly reducing the impact of malaria will require additional interventions, includ-

ing vaccines. Immunization is one of the most effective health interventions available. Just as it was necessary to use vaccines to control polio and measles in the United States, vaccines are needed as part of an effective control strategy for malaria.

Several Federal agencies are involved in the research and development of malaria interventions such as vaccines, as is the PATH Malaria Vaccine Initiative (MVI). Indeed, many promising vaccine concepts would never have emerged from the laboratory without the research performed by Government scientists. Government-sponsored research is also critical to eliminating from consideration less promising approaches. Unfortunately, funding for this critical research at NIH and CDC has been relatively flat for several years. By increasing investments in NIH and CDC, Congress can help advance the day when a highly effective malaria vaccine is available, thereby saving many lives.

Continued progress in our Nation's effort to improve global health requires the development of new tools and technologies. Point-of-care diagnostics and, eventually, malaria vaccines, are important components of the portfolio of needed tools and technologies, and the development of those tools and technologies is heavily reliant on Federal support. For this reason, we respectfully request that the subcommittee expand funding for research and development at NIH and CDC. We very much appreciate the subcommittee's consideration of our views, and we stand ready to work with subcommittee members and staff on these and other important tropical disease matters.

PREPARED STATEMENT OF PREVENT BLINDNESS AMERICA

FUNDING REQUEST OVERVIEW

Prevent Blindness America (PBA) appreciates the opportunity to submit written testimony for the record regarding fiscal year 2010 funding for vision-related programs. As the Nation's leading nonprofit, voluntary organization dedicated to preventing blindness and preserving sight, PBA maintains a long-standing commitment to working with policymakers at all levels of government, organizations, and individuals in the eye care and vision loss community, and other interested stakeholders to develop, advance, and implement policies and programs that prevent blindness and preserve sight. PBA respectfully requests that the subcommittee provide the following allocations in fiscal year 2010 to help promote eye health and prevent eye disease and vision loss:

—$4.5 million for the Vision Health Initiative at the Centers for Disease Control and Prevention (CDC);
—$32.4 billion for the National Institutes of Health (NIH) to support biomedical research; and
—$736 million for the National Eye Institute (NEI).

INTRODUCTION AND OVERVIEW

Vision-related conditions affect people across the lifespan from childhood through elder years. Good vision is an integral component to health and well-being, affects virtually all activities of daily living, and impacts individuals physically, emotionally, socially, and financially. Loss of vision can have a devastating impact on individuals and their families. An estimated 80 million Americans have a potentially blinding eye disease, 3 million have low vision, more than 1 million are legally blind, and 200,000 are more severely visually blind. Vision impairment in children is a common condition that affects 5 to 10 percent of preschool age children. Vision disorders (including amblyopia ("lazy eye"), strabismus ("cross eye"), and refractive error are the leading cause of impaired health in childhood.

Of serious concern is that the NEI reports "the number of Americans with age-related eye disease and the vision impairment that results is expected to double within the next three decades." [1] Among Americans age 40 and older, the four most common eye diseases causing vision impairment and blindness are age-related macular degeneration (AMD), cataract, diabetic retinopathy, and glaucoma.[2] Refractive errors are the most frequent vision problem in the United States—an estimated 150 million Americans use corrective eyewear to compensate for their refractive

[1] "Vision Problems in the U.S.: Prevalence of Adult Vision Impairment and Age-Related Eye Disease in America," Prevent Blindness America and the National Eye Institute, 2008.
[2] *Ibid.*

error.[3] Uncorrected or undercorrected refractive error can result in significant vision impairment.[4]

While half of all blindness can be prevented through education, early detection, and treatment, it is estimated that the number of blind and visually impaired people will double by 2030, if nothing is done to curb vision problems. To curtail the increasing incidence of vision loss in America, PBA advocates sustained and significant Federal funding for vision research and application, as well as resources for programs that help promote eye health and prevent eye disease, vision loss, and blindness. We thank the subcommittee for its consideration of our specific fiscal year 2010 funding requests, which are detailed below.

CDC'S VISION HEALTH INITIATIVE: HELPING TO SAVE SIGHT AND SAVE MONEY

The financial costs of vision impairment to our country's fiscal health are staggering. PBA estimates that the annual costs of adult vision problems in the United States are approximately $51.4 billion.[5] The annual cost of untreated amblyopia—reduced vision in an eye that has not received adequate use during early childhood—is approximately $7.4 billion in lost productivity.[6] NEI estimates that in 2003 the total direct and indirect costs of visual disorders and disabilities in the United States were approximately $68 billion, and with each passing year these costs continue to escalate.[7] Vision care services consistently have been found to help prevent blindness, reduce vision loss, improve quality of life and well-being, increase productivity, and reduce costs and burdens on the Nation's healthcare system. Therefore, the Nation must increase access to—and awareness of the importance of—vision screenings and linkage to appropriate care for at-risk and underserved populations, as is provided by the CDC's Vision Health Initiative.

The CDC reports that "vision disability is one of the top 10 disabilities among adults 18 years and older and the single most prevalent disabling condition among children."[8] Effective public health initiatives can dramatically decrease the number of Americans who have vision loss or low vision. Initially funded by Congress in fiscal year 2003, the CDC's Vision Health Initiative program has worked in a cost-effective way to identify, screen, and link to appropriate care individuals at risk for vision loss. This public-private partnership combines the resources of the CDC, chronic disease directors, State and local Agencies on Aging, and nonprofit organizations such as PBA. Highlights of the significant work of the CDC's Vision Health Initiative include:

—Support for the eye evaluation component of the National Health and Nutrition Examination Survey (NHANES) that provides current, nationally representative data and help assess progress for vision objectives contained within Healthy People 2010 and the future efforts for Healthy People 2020.

—Development of the first optional Behavioral Risk Factor Surveillance System (BRFSS) vision module and introducing it into State use in 2005 to gather information about access to eye care and prevalence of eye disease and eye injury. Five States implemented the module in 2005, and 11 States began using the module in 2006.

—Utilization of applied public health research to address the economic costs of vision disorders and develop cost-effectiveness models for eye diseases among various populations. Estimating the true economic burden is essential for informing policymakers and for obtaining necessary resources to develop and implement effective interventions.

—Providing data analyses and a systematic review of interventions to promote screening for diabetic retinopathy and reviewing access to and utilization of vision care in the United States.

—Developing best practices for the integration of vision care services with community health centers, as well as methods for linking clients to appropriate and needed care.

—Aiding in the translation of science into programs, services, and policies and in coordinating service activities with partners in the public, private, and voluntary sectors.

---

[3] *Ibid.*

[4] *Ibid.*

[5] "The Economic Impact of Vision Problems," Prevent Blindness America, 2007.

[6] "Our Vision for Children's Vision: A National Call to Action for the Advancement of Children's Vision and Eye Health, Prevent Blindness America,"Prevent Blindness America, 2008.

[7] Ellwein Leon. Updating the Hu 1981 Estimates of the Economic Costs of Visual Disorders and Disabilities.

[8] "Improving the Nation's Vision Health: A Coordinated Public Health Approach," Centers for Disease Control, 2006.

In fiscal year 2009, PBA requested $4.5 million to sustain and expand the Vision Health Initiative. In the final fiscal year 2009 Omnibus Appropriations Act, Congress allocated $3.222 million. PBA understands the budgetary challenges facing Congress and the Nation and, as such, appreciates this much-needed funding. However, with the demographics of eye disease, we strongly feel that a greater investment in the Vision Health Initiative must be made, so we can mount an adequate effort to address the growing public health threat of preventable vision loss among older Americans, low-income, and underserved populations.

To that end, PBA again respectfully requests the subcommittee provide a $4.5 million allocation for the Vision Health Initiative. Increased fiscal year 2010 funding for this important program will support additional vision screenings, increased public awareness efforts regarding risk of vision loss, develop best practices for linkage to care, and the expansion of eye disease surveillance and evaluation systems, which will help ensure our Nation has much-needed epidemiological data regarding overall burden and high-risk populations, so we can best formulate and assess strategies to prevent and reduce the economic and social costs associated with vision loss and eye diseases.

ADVANCE AND EXPAND VISION RESEARCH OPPORTUNITIES

Our Nation has benefited from past Federal investment in biomedical research at the NIH. Unfortunately, due to flat funding over the past six appropriations cycles, NIH has lost 14 percent of its purchasing power. While we commend Congress for the $10.4 billion in funding provided in the American Recovery and Reinvestment Act, PBA joins the broader vision community in advocating a 7 percent increase ($32.4 billion) for NIH in fiscal year 2010. This level of investment will allow NIH to sustain and expand its research progress and avoid the potential disruption of vital research that could result from a minimal increase.

PBA also calls upon the subcommittee to provide a specific allocation of $736 million for the NEI to bolster its efforts to identify the underlying causes of eye disease and vision loss, improve early detection and diagnosis of eye disease and vision loss, and advance prevention and treatment efforts. Celebrating 40 years of service this year, NEI is a leading Institute in translating basic research into clinical practice. Just as NIH has seen a decline in purchasing power, so too has the NEI, an overall decrease of 18 percent in the last 6 appropriations cycles. In fiscal year 2009, NEI's funding level of $688 million reflected just 1 percent of the estimated $68 billion annual costs of eye disease and vision impairment. Despite significant funding challenges, NEI has maintained its impressive record of breakthroughs in basic and clinical research that have resulted in treatments and therapies to save and restore vision and prevent eye disease. However, NEI will be challenged further, as 2010 begins the decade in which more than half of the 78 million Baby Boomers will turn 65 and be at greatest risk for developing aging eye disease. Adequate funding to NEI is a cost-effective investment in our Nation's health, as it can delay, save, and prevent eye disease-related expenditures, especially to the Medicare and Medicaid programs.

INVESTING IN THE VISION OF OUR NATION'S MOST VALUABLE RESOURCE—CHILDREN

While the risk of eye disease increases after the age of 40, eye and vision problems in children are of equal concern, due to the fact that, if left untreated, they can lead to permanent and irreversible visual loss and/or cause problems socially, academically, and developmentally. Although more than 12.1 million school-age children have some form of a vision problem, only one-third of all children receive eye care services before the age of 6.[9] Approximately 80 percent of what a child learns is done so visually.[10] As such, good vision is essential for educational progress, proper physical development and athletic performance, and healthy self-esteem in growing children. Yet, according to a CDC report, only 1 in 3 children in America has received eye care services before the age of 6.

Vision screening is an appropriate and essential element of a strong public health approach to children's vision care; the sooner vision problems are identified, the faster they can be addressed. As you know, the Maternal and Child Health Bureau (MCHB) oversees the Maternal and Child Health Services State title V (Title V) Block Grant program. As a condition of funding under title V, States are required to report on certain measures to the MCHB. PBA urges the subcommittee to sup-

[9] "Our Vision for Children's Vision: A National Call to Action for the Advancement of Children's Vision and Eye Health, Prevent Blindness America," Prevent Blindness America, 2008.

[10] Ottar WL, Scott WK, Holgado SI. Photoscreening for amblyogenic factors. *J Pediatr Ophthalmol Strabismus*. 1995; 32:289–295.

port the development and implementation of a nationwide title V core performance measure related to vision screening. A core performance measure regarding vision screening will help ensure that more children receive comprehensive eye examinations at a young age and provide specific information to MCHB and other public health officials regarding the progress of the programs and identify areas where improvement can be made to provide better vision care to children served by the title V program. Specifically, we hope the subcommittee will include language in the report accompanying the fiscal year 2010 Labor, Health and Human Services, and Education, an Related Agencies appropriations measure that expresses support for MCHB's work in this area.

We are pleased that the Head Start program currently requires children to be screened for vision problems. Unfortunately, there are no procedures for training, tracking, or even conducting the screening. As such, without a national uniform standard, many Head Start enrollees are falling through the cracks and vision problems are not being identified in this already often underserved and at-risk population. PBA stands ready to work with Head Start, the Congress, and other stakeholders to ensure that all Head Start enrollees receive vision screening services and other related resources available to them in their community. PBA respectfully requests that the subcommittee include language in the report accompanying the fiscal year 2010 Labor, Health and Human Services, and Education, an Related Agencies appropriations measure that encourages collaborations and initiatives within the Head Start program to ensure that such screenings are delivered and provided in a manner that promotes consistency and quality in protocol and administration.

CONCLUSION

On behalf of PBA, our board of directors, and the millions of people at risk for vision loss and eye disease, we thank you for the opportunity to submit written testimony regarding fiscal year 2010 funding for the CDC's Vision Health Initiative, NIH, and NEI. Please know that PBA stands ready to work with the subcommittee and other Members of Congress to advance policies that will prevent blindness and preserve sight.

PREPARED STATEMENT OF THE PANCREATIC CANCER ACTION NETWORK

Mr. Chairman and members of the subcommittee: You may recall that last year you received testimony from Dr. Randy Pausch, a computer science professor at Carnegie Mellon University, author of the widely acclaimed "Last Lecture", which was released on YouTube and later as a book, and at that time, a pancreatic cancer survivor.

Last year, Randy in his frank and humorous manner, told you that it was unlikely that he would survive until Father's Day and that his widow, Jai, and three beautiful children, Dillon, Logan, and Chloe would have to mark that holiday without him.

Approximately 76 percent of pancreatic cancer patients die within the first year of diagnosis. Randy used to call himself a "Pancreatic Cancer Rock Star" given that he had already survived 18 months when he provided his testimony to you. While I am very happy to report that Randy did indeed survive long enough to spend Father's Day with his family, he unfortunately passed soon after on July 25, 2008. With his passing, we lost a dear friend to the pancreatic cancer community, and as I'm sure you would all attest to, a phenomenal pancreatic cancer advocate.

Much has changed in the last year, including some of the statistics. According to the American Cancer Society's recently released Cancer Facts & Figures 2009, the projected incidence for pancreatic cancer rose 12 percent in the last year. Pancreatic cancer is now the 10th most commonly diagnosed cancer in both men and women.

Unfortunately, the survival rate has not changed. Pancreatic cancer is still one of the most deadly cancers and is still the fourth-leading cause of cancer-related death. It is still true that 95 percent of all pancreatic cancer patients die within 5 years of diagnosis, a fact that has changed little in the last 30 years. The new statistics show that 75 percent of these patients die within the first year of diagnosis. There are still no early detection or treatment tools for this disease. And while pancreatic cancer funding did increase last year, it is also still true that pancreatic cancer research is not funded at a level that will likely change this picture any time soon.

The news gets worse as we look to the future. According to an article recently released in the Journal of Clinical Oncology,[1] a 55 percent increase in pancreatic cancer incidence is expected by 2030. This would be among the top five most significant increases across all forms of cancer. According to the authors, "Alarmingly, certain cancer sites with particularly high mortality rates, such as liver, stomach, pancreas, and lung, will be among those with the greatest relative increase in incidence. Therefore, unless substantial improvements in cancer therapy and/or prevention strategies emerge, the number of cancer deaths may also grow dramatically over the next 20 years." We simply cannot afford to keep the status quo in terms of funding levels or scientific approaches for pancreatic cancer in the face of these statistics. We must make finding early detection tools and effective treatments for pancreatic cancer and the other highest mortality cancers an immediate priority.

Admittedly, part of the problem has been the recent flat or declining biomedical research budgets. Adjusting for inflation, the National Cancer Institute's (NCI) budget has decreased by nearly $639 million (13.9 percent) since fiscal year 2003. However, it is also clear that NCI is not making pancreatic cancer a research priority. In fact, the NCI currently allocates just $87 million for pancreatic cancer research, a mere 2 percent of its total budget. A percentage that is also unchanged from last year.

We, like many in the cancer and biomedical research communities, worked hard to secure funding increases for the National Institute of Health (NIH) in the fiscal year 2009 Omnibus Appropriations bill and in the American Recovery and Reinvestment Act and we are grateful to you for granting the community's requests and providing increases through these bills. The Pancreatic Cancer Action Network took part in these efforts because we believed that increasing funding through these bills would lead to increased funding for pancreatic cancer research. Unfortunately, it does not appear that this hope is turning into a reality.

As the National Institute of Health (NIH) was preparing the Challenge Grants, we were excited about the potential that these grants might bring to the most deadly diseases such as pancreatic cancer. Unfortunately, once we had an opportunity to review the Requests for Applications (RFAs), we realized that few if any of the grants were actually applicable to pancreatic cancer.

We have also been looking forward to learning more about how NCI plans to use their remaining portion of the stimulus funds. Our hope is that Dr. Niederhuber will dedicate some portion of the funds for the cancers with the highest mortality, defined as those cancers with 5-year survival rates of 50 percent or less. Currently, just 8 cancers (ovarian, brain, myeloma, stomach, esophageal, lung, liver, and pancreatic) account for 50 percent of all cancer deaths. For some of these, such as pancreatic and lung cancer, there has been little movement in survival rates in the last 30 years.

As you may know, NIH Director, Dr. Raynard Kington recently asked Dr. Niederhuber and Dr. Steve Katz, Director of National Institute of Arthritis and Musculoskeletal and Skin Diseases to co-chair a task force to develop an NIH-wide cancer research plan in response to the President's call to double cancer research funding in 8 years. Ideally, this plan would include some defined focus on steps that should be taken to reduce mortality for the deadliest cancers. Unfortunately, while we have not yet seen the actual plan, based on the NCI's statement about it on April 20, 2009[2] and based on conversations we have had with Dr. Niederhuber earlier this week, we are concerned that again, our hopes may not turn into a reality.

The mission of the Pancreatic Cancer Action Network is based on hope and on action, so it is in the spirit of both that I am today submitting testimony. I am not only asking that you significantly increase funding for the NCI, but that you also take steps to ensure that NCI places special emphasis on the most deadly cancers, including pancreatic cancer.

While I realize that Congress is reluctant to direct how NCI allocates research dollars, I would argue that something is wrong when one of the deadliest types of cancer receives so little attention. In fact, pancreatic cancer research receives the least amount of NCI funding of any of the top cancer killers.

One of our most significant issues in addition to the overall funding level, is that there are relatively few researchers studying pancreatic cancer—including both young investigators and more experienced investigators. While the NCI's commitment to young investigators has increased from 2007 when it awarded zero Career

---

[1] Benjamin D. Smith, Grace L. Smith, Arti Hurria, Gabriel N. Hortobagyi, and Thomas A. Buchholz, "Future of Cancer Incidence in the United States: Burdens Upon an Aging, Changing Nation," *Journal of Clinical Oncology* 27 (April 2009), 4.

[2] National Cancer Institute, *National Cancer Institute's Plan to Accelerate Cancer Research Announced*, http://www.cancer.gov/newscenter/pressreleases/AccelerateResearch (April 22, 2009).

Development Awards (K awards) or Research Training Awards (F and T awards), it still has a long way to go. For example, last year, NCI made nearly 180 awards to young breast cancer researchers and more than 70 K, T, or F awards to young researchers in fields of each of the other top 5 cancer killers (lung, colon, and prostate); only 32 were awarded to young pancreatic cancer researchers. We can and must do better.

The story is much the same for experienced investigators. In 2008, only 32 pancreatic cancer projects were funded at $500,000 or above, and only 11 projects received at least $1 million. In contrast, the number of projects funded at $500,000 or above was 109 for lung, 114 for colon, 237 for breast, and 105 for prostate.

Further, though the pool of researchers that the NCI has funded to conduct pancreatic cancer has expanded, it is still a very small pool, especially when compared to the numbers of researchers funded in the other leading cancer fields. In fact, by way of comparison, in 2008 the NCI funded close to 1,600 different investigators in breast cancer research, of whom 231 received multiple awards. As many as 91 of these researchers received an aggregate of $1 million in funding for their research. By comparison, NCI funded 327 different investigators in pancreatic cancer research last year, of whom 41 received multiple awards and just 13 received an aggregate of $1 million for their research.

Given that the current 5-year survival rate for breast cancer is nearly 90 percent, it is clear that a similar pipeline of committed and federally funded scientists is needed in pancreatic cancer to help speed advances and medical breakthroughs if we are to hope to finally increase survival beyond 5 percent.

The fact is that the number of new pancreatic cancer cases and deaths are increasing—not decreasing. The projected number of new pancreatic cancer cases is expected to reach 70,000 by 2040. As stated above, while overall cancer death rates have significantly declined, the 5-year survival rates for pancreatic cancer have remained largely unchanged in the last 30 years. If we do not take steps to address this issue now, 95 percent of these patients will continue to hear their diagnosis expressed as a death sentence.

Sadly, it is also a fact that for too long, the broader scientific research community has faced the challenge of doing more with less. While they have achieved some important successes, the funding crisis has fostered an environment of focusing on "safe bets." Compared to most other cancers, we know relatively little about pancreatic cancer. More research is needed in the basic biology of the disease to understand how it starts and why it spreads so rapidly. Therefore, pancreatic cancer research does not fall into a "safe bet" category. It falls into the category of high risk/high reward.

The time has come to not only fund new progress and give our researchers the opportunity to do more with more, but to also find new ways to encourage the research community to tackle the hardest and most complex problems. As Randy mentioned in his testimony last year, it is by solving the hardest problems that we will likely see the greatest rewards for the entire field. On behalf of the tens of thousands of pancreatic cancer patients who die without a chance, including Dr. Randy Pausch, I am asking that you not only inject significant new funding into the cancer research community, but that you also issue a challenge to the NCI to focus on the hardest problems by placing special emphasis on finding answers for the most deadly cancers, including pancreatic. Doing so will not only fuel progress, but will also generate jobs and stem the current trend of losing American-trained researchers to other countries more willing to invest in scientific research.

We therefore join with our partners in the One Voice Against Cancer coalition to ask that you provide $5.96 billion in funding for the NCI in fiscal year 2010—an increase of $993 million (20 percent) more than fiscal year 2009. We recognize that this is a significant request. However, the reality is that this is the minimum amount needed to make true progress on all forms of cancer, including pancreatic and the other cancers for which we have yet to see significant improvement in survival.

We also respectfully request that you work with us to ensure that NCI creates a strategic plan for the highest mortality cancers, defined as those with 5 survival rates below 50 percent, and that the NIH-wide cancer research plan that is currently under development also includes these cancers as a specific area of focus.

PREPARED STATEMENT OF THE PULMONARY HYPERTENSION ASSOCIATION

Mr. Chairman, thank you for the opportunity to submit testimony on behalf of the Pulmonary Hypertension Association (PHA).

I would like to extend my sincere thanks to the subcommittee for your past support of pulmonary hypertension (PH) programs at the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA). These initiatives have opened many new avenues of promising research, helped educate hundreds of physicians in how to properly diagnose PH, and raised awareness about the importance of organ donation and transplantation within the PH community.

In addition, I want to commend the subcommittee for actively addressing the current backlog in Social Security Disability applications at the Social Security Administration. Many PH patients end up applying for disability coverage, and streamlining the benefits process would go a long way toward improving the quality of life for our most in-need families.

I am honored today to represent the hundreds of thousands of Americans who are fighting a courageous battle against a devastating disease. PH is a serious and often fatal condition where the blood pressure in the lungs rises to dangerously high levels. In PH patients, the walls of the arteries that take blood from the right side of the heart to the lungs thicken and constrict. As a result, the right side of the heart has to pump harder to move blood into the lungs, causing it to enlarge and ultimately fail.

PH can occur without a known cause or be secondary to other conditions such as: collagen vascular diseases (i.e., scleroderma and lupus), blood clots, HIV, sickle cell, or liver disease. PH does not discriminate based on race, gender, or age. Patients develop symptoms that include shortness of breath, fatigue, chest pain, dizziness, and fainting. Unfortunately, these symptoms are frequently misdiagnosed, leaving patients with the false impression that they have a minor pulmonary or cardiovascular condition. By the time many patients receive an accurate diagnosis, the disease has progressed to a late stage, making it impossible to receive a necessary heart or lung transplant.

PH is chronic and incurable with a poor survival rate. Fortunately, new treatments are providing a significantly improved quality of life for patients with some managing the disorder for 20 years or longer.

Nineteen years ago, when three PH patients found each other, with the help of the National Organization for Rare Diseases, and founded the PHA, there were less than 200 diagnosed cases of this disease. It was virtually unknown among the general population and not well known in the medical community. They soon realized that this was unacceptable, and formally established PHA, which is headquartered in Silver Spring, Maryland.

I am pleased to report that we are making good progress in our fight against this deadly disease. Six new therapies for the treatment of PH have been approved by the FDA in the past 10 years.

Today, PHA includes:

—More than 10,000 patients, family members, and medical professionals as members and an additional 34,000 supporters and friends.

—A network of more than 200 patient support groups.

—An active and growing patient-to-patient telephone helpline.

—Three research programs that, through partnerships with the National Heart, Lung and Blood Institute (NHLBI) and the American Thoracic Society, have committed more than $7.5 million toward PH research as of December 2008.

—Numerous electronic and print publications, including the first medical journal devoted to PH—published quarterly and distributed to all cardiologists, pulmonologists, and rheumatologists in the United States.

A Web site dedicated to providing educational and support resources to patients, medical professionals, and the public. Thanks to support from CDC, PHA's online resources now include the PHA Online University which provides PH-specific continuing education opportunities to medical professionals.

THE PH COMMUNITY

Mr. Chairman, I am privileged to serve as the president of the PHA and to interact daily with the patients and family members who are seeking to live their lives to the fullest in the face of this deadly, incurable disease.

Carl Hicks is a former Army Ranger and a retired Colonel who lead the first battalion into Iraq during the first Iraq war. Every member of his family was touched by pulmonary hypertension after the diagnosis of his daughter Meghan in 1994. I share their story here, in Carl's own words:

"We're sorry Colonel Hicks, your daughter Meaghan has contracted primary pulmonary hypertension. She likely has less than a year to live and there is nothing we can do for her. Those words were spoken in the spring of 1994 at Walter Reed

Army Medical Center. They marked the start down the trail of tears for a young military family that, only hours before, had been in Germany. My family's journey down this trail hasn't ended yet, even though Meaghan's fight came to an end with her death on January 30th, 2009. She was 27.

Pulmonary hypertension struck our family, as it so often does, without warning. One day, we had a beautiful, healthy, energetic 12-year old gymnast, the next, a child with a death sentence being robbed of every breath by this heinous disease. The toll of this fight was far-reaching. Over the years, every decision of any consequence in the family was considered first with regards to its impact on Meaghan and her struggle for breath.

The investment made by our country in my career was lost, as I left the service to stay nearer my family. The costs for Meaghan's medical care, spread over the nearly 14 years of our fight, ran well into the 7 figures. Meghan even underwent a heart and dual-lung transplant These challenges, though, were nothing compared to the psychological toll of losing Meaghan who had fought so hard for something we all take for granted, a breath of air."

Over the past decade, treatment options, and the survival rate, for PH patients have improved significantly. As Meaghan's story illustrates, however, courageous patients of every age lose their battle with PH each day. There is still a long way to go on the road to a cure and biomedical research holds the promise of a better tomorrow.

Thanks to congressional action, and to advances in medical research largely supported by the NHLBI and other Government agencies, PH patients have an increased chance of living with their PH for many years. However, additional support is needed for research and related activities to continue to develop treatments that will extend the life expectancy of PH patients beyond the NIH estimate of 2.8 years after diagnosis.

FISCAL YEAR 2010 APPROPRIATIONS RECOMMENDATIONS

NHLBI

Recently, the World Health Organization's Fourth World Symposium on Pulmonary Hypertension brought together PH experts from around the world. According to these leading researchers, we are on the verge of significant breakthroughs in our understanding of PH and the development of new and advanced treatments. Fifteen years ago, a diagnosis of PH was essentially a death sentence, with only one approved treatment for the disease. Thanks to advancements made through the public and private sector, patients today are living longer and better lives with a choice of six FDA approved therapies. Recognizing that we have made tremendous progress, we are also mindful that we are a long way from where we want to be in (1) the management of PH as a treatable chronic disease, and (2) a cure.

One crucial step in continuing the progress we have made in the treatment of PH is the creation of a pulmonary hypertension research network. Such a network would link leading researchers around the United States, providing them with access to a wider pool of shared patient data. In addition, the network would provide researchers with the opportunities to collaborate on studies and to strengthen the interconnections between basic and clinical science in the field of pulmonary hypertension research. Such a network is in the tradition of the NHLBI, which, to its credit and to the benefit of the American public, has supported numerous similar networks including the Acute Respiratory Distress Syndrome Network and the Idiopathic Pulmonary Fibrosis Clinical Research Network.

In order to maintain the important momentum in pulmonary hypertension research that has developed over the past few years, and to create a much needed pulmonary hypertension research network, the Pulmonary Hypertension Association encourages the subcommittee to provide the NIH, particularly the NHLBI, with a 7 percent increase in funding in fiscal year 2010.

CDC

PHA applauds the subcommittee for its leadership over the years in encouraging CDC to initiate a Pulmonary Hypertension Education and Awareness Program. We know for a fact that Americans are dying due to a lack of awareness of PH, and a lack of understanding about the many new treatment options. This unfortunate reality is particularly true among minority and underserved populations.

Mr. Chairman, we are grateful to the Congress for providing $238,000 in support of a pulmonary hypertension awareness program in fiscal year 2009. By educating physicians and patients about pulmonary hypertension, this funding will save lives. We encourage the subcommittee to continue its support for PH awareness activities through the CDC in fiscal year 2010.

"Gift of Life" Donation Initiative at HRSA

Mr. Chairman, PHA applauds the success of HRSA's "Gift of Life" Donation Initiative. This important program is working to increase organ donation rates across the country. Unfortunately, the only "treatment" option available to many late-stage PH patients is a lung, or heart and lung, transplantation. This grim reality is why PHA established "Bonnie's Gift Project."

"Bonnie's Gift" was started in memory of Bonnie Dukart, one of PHA's most active and respected leaders. Bonnie battled with PH for almost 20 years until her death in 2001 following a double lung transplant. Prior to her death, Bonnie expressed an interest in the development of a program within PHA related to transplant information and awareness. PHA will use "Bonnie's Gift" as a way to disseminate information about PH, transplantation, and the importance of organ donation, as well as organ donation cards, to our community.

PHA has had a very successful partnership with HRSA's "Gift of Life" Donation Program in recent years. Collectively, we have worked to increase organ donation rates and raise awareness about the need for PH patients to "early list" on transplantation waiting lists. For fiscal year 2010, PHA recommends an appropriation of $30 million for this important program.

PREPARED STATEMENT OF THE RELIGIOUS COALITION FOR REPRODUCTIVE CHOICE

Mr. Chairman and members of the subcommittee: The Religious Coalition for Reproductive Choice (RCRC) appreciates this opportunity to submit testimony. We strongly support President Obama's proposal to eliminate the dedicated funding streams for abstinence-only programs and to support proven teen pregnancy prevention programs.

RCRC is an interfaith alliance of national mainstream religious organizations dedicated to ensuring access to reproductive healthcare and achieving reproductive justice. For more than 35 years, RCRC has brought together 40 national religious and religiously affiliated organizations from 15 denominations and traditions. Our membership includes the Episcopal Church, the Presbyterian Church (USA), the United Church of Christ, the United Methodist Church (General Board of Church and Society and Women's Division, General Board of Global Ministries), the Unitarian Universalist Association of Congregations; and Reform, Reconstructionist and Conservative Judaism.

As faith communities, we are committed to sex education in our public schools that empowers and protects young people, honors diverse values, and promotes the highest ethical standards. Religious Americans overwhelmingly favor responsible sex education that is complete, age appropriate and includes accurate information about abstinence and contraception.

Abstinence-only-until-marriage programs cannot offer this and moreover they are ineffective. These programs often are dishonest and scientifically inaccurate. There is no justification for endangering the health and well-being of the young people of our Nation for the sake of a very parochial moral vision.

In fact, while there certainly is great value in adolescents postponing sex until they are mature, Federal policies that withhold important life saving information about STDs or HIV/AIDS or other aspects of reproductive health raise serious moral and ethical questions. Young people have a basic human right to complete and accurate HIV/AIDS and sexual health information. Without it they will be unable to realize the highest attainable standard of health and for some, their futures will be compromised with disease or unintended pregnancy.

SUPPORT OF RELIGIOUS COMMUNITIES FOR COMPREHENSIVE SEXUALITY EDUCATION

Major faith traditions representing millions of Americans support comprehensive sex education. In keeping with our Nation's constitutional guarantee of freedom of religion, they oppose civil laws that would impose specific religious views about sexuality education on all Americans.

These faith communities take seriously their duty to instill a set of religious and moral values that will help guide young people to responsible life choices. They believe that it is the role of Government to ensure that the Nation's youth receive the facts—unblemished by ideology—that will protect them from disease and unintended pregnancy.

RCRC has compiled excerpts of official statements of religious denominations and traditions on the importance of sexuality education. We have attached a copy of the complete document, Religious Communities and Sexuality Education: In the Home, In the Congregation, In the Schools, for your review. But to give you a brief taste of these statements, please consider the following:

United Methodist Church
—"Children, youth and adults need opportunities to discuss sexuality and learn from quality sex education materials in families, churches and schools."
United Synagogue of Conservative Judaism
—". . . supports comprehensive sex education . . . calls upon the U.S. Congress to cease funding of abstinence only education."
Presbyterian Church (U.S.A.)
—". . . supports . . . comprehensive school health education that includes age and developmentally appropriate sexuality education in all grades . . ."
Muslim Women's League
—"Sex education can be taught in a way that informs young people about sexuality in scientific and moral terms."
Episcopal Church
—". . . we encourage the members of this Church to give strong support to responsible local public and private school programs of education in human sexuality."

NEED FOR ATTENTION TO DISEASE PREVENTION

Although the President's budget does not link the issues of teen pregnancy prevention and disease prevention, we know that the most effective programs are comprehensive and do connect the two. According to the American Social Health Association, each year 9 million new cases of STDs occur among young people aged 15–24. Sexually active youth have the highest STD rates of any age group in the country. Young people are at greatest risk for STDs because, as a group, they are more likely to have unprotected sex.

The health consequences of STDs include chronic pain, infertility, cervical cancer and increased vulnerability to HIV, the virus that causes AIDS. The transmission of STDs to babies—prenatally, during birth or after—can cause serious life-long complications and even death.

We urge the Appropriations Committee to include language that expands the requirement for funded programs to include disease prevention.

How did you learn about sex?

This past year, RCRC put out a request to "tell us your story: how did you learn about sex?" We received well more than 400 responses from individuals around the country age 17 through 94. These replies offer thoughtful reflections and often intimate, sometimes painful, glimpses into personal lives.

Among other things, we found that what you learn—or don't learn—as a young person can have life-long repercussions. And abstinence-only programs, by their design, leave out important health information.

"If I had known what sex was, I would have understood what was happening to me when I was molested by a male relative beginning at age 8."——Deborah, 45

"I wish I'd learned what intercourse was and how easy it is to get pregnant."——Anonymous, 79

"I wish I'd learned about STDs and the way in which they can be transmitted. I was under the impression that oral sex was safe, since you couldn't get pregnant from it."——Miranda, 26

"The good girl/bad girl images prevalent when I was young only served to instill a great deal of fear in me, which negatively impacted on my marriage for years."——Anonymous, 57

COMMUNITIES OF COLOR

According to former Surgeon General Joycelyn Elders, the black community's "problem with sexuality has contributed more to the poverty in the black community than anything else in our society. A pregnant teenager who does not finish high school or marry has an 80 percent likelihood of being poor." She challenged Congress to "stop legislating morals and start teaching responsibility." Abstinence-only education has been proved through studies and in harsh reality to be a horrible failure. A low-income woman is four times as likely to have an unintended pregnancy, five times as likely to have an unintended birth and more than four times as likely to have an abortion as her higher-income counterpart. It is the poor and communities of color who suffer from illogical and ineffective public policy. The denominations and people of faith that comprise RCRC agree with Dr. Elders that "If I could make any changes at all to the current health care system, you know I would start with education, education, education. You can't educate people that are not healthy. But you certainly can't keep them healthy if they're not educated."

RCRC addresses these issues through our National Black Church Initiative, a program begun in 1997 to "break the silence" about sex and sexuality in the African

American community. The initiative assists Black clergy and laity in addressing teenage pregnancy, sexuality education and reproductive health within the context of African American religion and culture. We have worked in more than 700 churches providing our "Keeping It Real!" faith based sexuality education curriculum to more than 7,000 young men and women. We have a similar faith based initiative, La Iniciativa Latina (LIL), which provides model programs on sexuality and reproductive health for Latino youth, adults and clergy in the context of Latino values, religion and culture.

But the answer to the Nation's high rate of unintended pregnancy and pandemic of sexually transmitted diseases does not rest with churches and nonprofit organizations alone. Public schools must be part of the solution. We are morally compelled to empower our young people with the knowledge to make responsible decisions. As Dr. Elders so succinctly stated, "Vows of abstinence break more easily than latex condoms." According to the CDC's National Center for Health Statistics, in 2002, the pregnancy rates for black and Hispanic teenagers were each more than two and one-half times the rate for white teenagers. This is the reality.

One of the most compelling arguments for comprehensive sexuality education was made by a member of our youth program, a proud Pentecostal Christian from rural Mississippi. In a meeting with her Member of Congress, she explained that there was no sex education in her high school and a lot of girls in her class got "knocked up." They did not graduate from high school. They did not marry. Their futures were compromised. But the impact of these unintended pregnancies goes well beyond the lives of these young women and their children. They contribute to the economic depression of their communities.

CONCLUSION

Let's be real and make a real difference. We know that 95 percent of Americans will have sex before they marry; therefore programs need to teach about abstinence and also about contraception, relationships and disease prevention. We must empower youth with the knowledge to make responsible decisions.

We believe that being of faith means being engaged in the world. And like it or not, the facts are clear: more than 80 percent of the 750,000 teen pregnancies each year are unintended and 25 percent of American teens contract an STD. We want our young people to be safe. For that to happen, they must be informed by comprehensive sex education. Offering them anything less is irresponsible and dangerous.

PREPARED STATEMENT OF THE RAILROAD RETIREMENT BOARD

Mr. Chairman and members of the committee: We are pleased to present the following information to support the Railroad Retirement Board's (RRB) fiscal year 2010 budget request.

The RRB administers comprehensive retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement and Railroad Unemployment Insurance Acts. The RRB also has administrative responsibilities under the Social Security Act for certain benefit payments and Medicare coverage for railroad workers. During fiscal year 2008, the RRB paid $10.1 billion in retirement/survivor benefits and vested dual benefits to about 598,000 beneficiaries. We also paid $80 million in net unemployment/sickness insurance benefits to about 30,000 claimants.

PROPOSED FUNDING FOR AGENCY ADMINISTRATION

The President's proposed budget would provide $109,073,000 for agency operations, which would enable us to maintain a staffing level of 920 full-time equivalent staff years in 2010. The proposed budget would also provide about $1,651,000 for information technology (IT) investments. This includes $615,000 for costs related to information security and privacy, and for continuity of operations in the event of an emergency. The remaining IT funds will be used for E-Government initiatives, systems modernization, infrastructure needs and system support.

AGENCY STAFFING

The RRB's dedicated, experienced employees have been the foundation for our tradition of excellence in customer service and satisfaction. And, we have an ongoing need and responsibility to effectively manage our human capital resources. This is particularly important given the number of RRB employees who are eligible for retirement and those who soon will be. We are developing a long-range approach to

workforce planning that will position the agency for continued success in administering our programs. This includes a detailed analysis of the demographic features of the RRB workforce and the skills needed to fulfill our mission. It will also establish a procedural framework for recruiting, training, and developing talented employees.

Like many agencies, the RRB has an aging workforce. About 30 percent of our workforce is currently eligible to retire, and more than 50 percent will be eligible by fiscal year 2012. In response to this trend, we have placed added emphasis on filling entry-level positions, focusing on front-line service employees and claims examiners to the extent possible. In anticipation of an increase in the agency attrition rate as more employees become eligible to retire, these new employees will be key to effectively administering the RRB's programs and continuing to provide excellent service over the long term.

SERVICE IMPROVEMENTS

In fiscal year 2009, we have implemented nationwide, toll-free telephone service, which enables us to dynamically route phone calls among our offices based on logical business rules and customer needs. In addition to providing our customers with faster response times, the toll-free service allows agency management to more effectively balance and share workloads among offices. We plan to continue expanding the functionality and services offered through the toll-free number (1–877–772–5772 or 1–877–RRB–5RRB). Enhancements will focus on new self-service options available through the toll-free system.

The RRB's long-term information technology strategy also calls for expanded use of the Internet to provide services to our customers. We plan to use contractor services to augment agency staff to expand the electronic services available to the railroad public via the RRB's website. As part of this strategy, we are continuing to work on the Employer Reporting System to increase the amount of information related to railroad compensation, employment and service that employers can transmit to the RRB through the Internet. In fiscal year 2010, we plan to expand services to provide additional notifications to rail employers and enable employers to correct data through the system.

SYSTEMS MODERNIZATION

Over the last few years, we have undertaken a series of strategic measures to improve computer processes and better position the RRB for the future. First, the agency moved to a relational database environment, and then optimized the data that reside in the legacy databases. Our next steps involve modernizing the agency's computer processes.

Many of the RRB's existing systems are old, complex, and require a large investment in maintenance. As projected staff attrition occurs, we will be losing both experienced technical staff and some of the business subject-matter experts who now support our legacy systems. The modernization process will enable us to maintain the capability of our business function in the face of expected staff turnover, and to upgrade our systems based on the improvements that we have already completed. Through these initiatives, we will eliminate or reduce unnecessary or redundant activities, improve the accuracy and security of our systems and their transactions, make the systems more user-friendly for agency employees and our customers, improve the interoperability and flexibility of systems, and improve the RRB's ability to collaborate with agency partners. These improvements will ultimately decrease the time and cost to develop and operate RRB systems and allow an increased focus on new initiatives.

We plan to begin this process in fiscal year 2009, with selection of the agency's first system to modernize and development of a project plan. The selected system will serve as a pilot for further modernization. In fiscal year 2010, we will use contractor services to evaluate the pilot project's business requirements, identify possible solutions, analyze them, and recommend one for implementation.

The President's proposed budget includes $64 million to fund the continuing phase-out of vested dual benefits, plus a 2 percent contingency reserve, $1,280,000, which "shall be available proportional to the amount by which the product of recipients and the average benefit received exceeds the amount available for payment of vested dual benefits."

In addition to the requests noted above, the President's proposed budget includes $150,000 for interest related to uncashed railroad retirement checks.

FINANCIAL STATUS OF THE TRUST FUNDS

Railroad Retirement Accounts.—The RRB continues to coordinate its activities with the National Railroad Retirement Investment Trust (Trust), which was established by the Railroad Retirement and Survivors' Improvement Act of 2001 (RRSIA) to manage and invest railroad retirement assets. Pursuant to the RRSIA, the RRB has transferred a total of $21.276 billion to the Trust. All of these transfers were made in fiscal years 2002 through 2004. The Trust has invested the transferred funds, and the results of these investments are reported to the RRB and posted periodically on the RRB's website. The market value of Trust-managed assets on September 30, 2008, was approximately $25.3 billion. Trust-managed assets have declined as a result of the general economic downturn in 2008 and the early part of 2009. The Trust reported that Trust-managed assets amounted to $19.1 billion as of March 31, 2009. The Trust has transferred to the RRB for payment of railroad retirement benefits approximately $7.3 billion since the inception of the Trust.

In June 2008, we released the annual report on the railroad retirement system required by section 22 of the Railroad Retirement Act of 1974, and section 502 of the Railroad Retirement Solvency Act of 1983. The report, which reflects changes in benefit and financing provisions under the RRSIA, addressed the 25-year period 2008–2032 and contained generally favorable information concerning railroad retirement financing. The report included projections of the status of the retirement trust funds under three employment assumptions. These indicated that, barring a sudden, unanticipated, large decrease in railroad employment or substantial investment losses, the railroad retirement system would experience no cash flow problems throughout the projection period. Our next report, which will be released in June 2009, will include updated projections reflecting the economic events of the past year.

Railroad Unemployment Insurance Account.—The equity balance of the Railroad Unemployment Insurance Account at the end of fiscal year 2008 was $99.9 million, a decrease of $0.8 million from the previous year. The RRB's latest annual report on the financial status of the railroad unemployment insurance system was issued in June 2008. The report indicated that even as maximum daily benefit rates rise 47 percent (from $59 to $87) from 2007 to 2018, experience-based contribution rates maintain solvency. The report did not recommend any financing changes. We will update this analysis in our next annual report on the system, which will be released in June 2009.

In conclusion, we want to stress the RRB's continuing commitment to improving our operations and providing quality service to our beneficiaries. Thank you for your consideration of our budget request. We will be happy to provide further information in response to any questions you may have.

PREPARED STATEMENT OF THE RAILROAD RETIREMENT BOARD

Mr. Chairman and members of the subcommittee: My name is Martin J. Dickman and I am the Inspector General for the Railroad Retirement Board (RRB). I would like to thank you, Mr. Chairman, and the members of the subcommittee for your continued support of the Office of Inspector General (OIG).

BUDGET REQUEST AND BACKGROUND INFORMATION

I wish to describe our fiscal year 2010 appropriations request and our planned activities. The OIG respectfully requests funding in the amount of $8,186,000 to ensure the continuation of its independent oversight of the RRB.

The RRB's central mission is to pay accurate and timely benefits. During fiscal year 2008, the RRB paid approximately $10.1 billion in retirement and survivor benefits to 598,000 beneficiaries. The RRB also paid $80 million in net unemployment and sickness insurance benefits to almost 30,000 claimants during the benefit year ending June 30, 2008.

The RRB contracts with a separate Medicare Part B carrier, Palmetto GBA, to process Railroad Medicare Part B claims. As of September 30, 2008, there were 469,442 Railroad Medicare Part B beneficiaries and during fiscal year 2008 Palmetto GBA paid more than $844 million in medical insurance benefits on their behalf.

During fiscal year 2010, the OIG will focus on areas affecting program performance; the efficiency and effectiveness of agency operations; and areas of potential fraud, waste, and abuse.

OFFICE OF AUDIT (OA)

The mission of the OA is to (1) promote economy, efficiency, and effectiveness in the administration of RRB programs, and (2) detect and prevent fraud and abuse in such programs. To accomplish its mission OA conducts financial, performance and compliance audits and evaluations of RRB programs. In addition, OA develops the OIG's response to audit-related requirements and requests for information.

During fiscal year 2010, OA will focus on areas affecting program performance, the efficiency and effectiveness of agency operations and areas of potential fraud, waste, and abuse. OA will continue its emphasis on long-term systemic problems and solutions, and will address major issues that affect the RRB's service to rail beneficiaries and their families. OA has identified four broad areas of potential audit coverage:

—Financial accountability;
—Railroad Retirement Act & Railroad Unemployment Insurance Act Benefit Program Operations;
—Railroad Medicare program operations; and
—Security, privacy, and information management.

During fiscal year 2010, OA must accomplish the following mandated activities with its own staff:

—Audit of the RRB's financial statements pursuant to the requirements of the Accountability of Tax Dollars Act of 2002; and
—Evaluation of information security pursuant to the Federal Information Security Management Act (FISMA).

During fiscal year 2010, OA will complete the audit of the RRB's fiscal year 2009 financial statements and begin its audit of the agency's fiscal year 2010 financial statements. OA contracts with a consulting actuary for technical assistance in auditing the RRB's "Statement of Social Insurance" which became basic financial information effective for fiscal year 2006.

In addition to performing the annual evaluation of information security, OA also conducts audits of individual computer application systems which are required to support the annual FISMA evaluation. Our work in this area is targeted toward the identification and elimination of security deficiencies and system vulnerabilities, including controls over sensitive personally identifiable information.

OA undertakes additional projects with the objective of allocating available audit resources to areas in which they will have the greatest value. In making that determination, OA considers staff availability, current trends in management, congressional and Presidential concerns.

OFFICE OF INVESTIGATIONS (OI)

The OI focuses its efforts on identifying, investigating and presenting benefit fraud cases for prosecution. OI conducts investigations, throughout the United States, relating to the fraudulent receipt of RRB disability, unemployment, sickness, retirement/survivor, and Railroad Medicare benefits. OI investigates railroad employers and unions when there is an indication that they have submitted false reports to the RRB. OI also investigates allegations regarding agency employee misconduct and threats against RRB employees. Investigative efforts can result in criminal convictions, administrative sanctions, civil penalties and/or the recovery of program benefit funds.

OI initiates cases based on information from a variety of sources. The agency conducts computer matching of employment and earnings information reported to State governments with RRB benefits paid. Referrals are made to OI if a match is found. OI also receives allegations of fraud through the OIG Hotline, contacts with State, local and Federal agencies, and information developed through audits conducted by the OIG's OA.

OI's investigative results from October 1, 2008 through March 31, 2009 are:

Civil judgments	Indictments/information	Convictions	Recoveries/collections
12	16	29	$5,125,573

OI anticipates an ongoing caseload of approximately 450 investigations in fiscal year 2010. At present, OI has cases open in 47 States, the District of Columbia, and Canada with estimated fraud losses totaling almost $16 million.

OI will continue to concentrate its resources on cases with the highest fraud losses. Typically, these cases are related to the RRB's disability program. Disability fraud cases currently constitute approximately 50 percent of OI's total caseload. These cases involve more complicated schemes and result in the recovery of substan-

tial funds for the agency's trust funds. They also require considerable time and resources such as travel by special agents to conduct sophisticated investigative techniques such as surveillance and witness interviews. These fraud investigations are extremely document-intensive and involve complicated financial analysis.

Since March 2008, OI has added Railroad Medicare fraud investigations to its caseload and has identified 35 cases which involve losses to the Railroad Medicare program. Similar to the disability fraud matters, Medicare fraud cases are extremely complex in nature and often involve extensive document/data reviews that demand significant resources.

OI will continue to investigate fraud violations of railroad employees collecting unemployment or sickness insurance benefits while working and receiving wages from an employer. OI will also investigate retirement fraud and will continue to use the Department of Justice's Affirmative Civil Enforcement Program to recover trust fund monies from cases that do not meet U.S. Attorney's guidelines for criminal prosecution.

OI will also investigate complaints involving administrative irregularities and any alleged misconduct by agency employees.

In fiscal year 2010, OI will continue to coordinate its efforts with agency program managers to address vulnerabilities in benefit programs that allow fraudulent activity to occur and will recommend changes to ensure program integrity. OI plans to continue proactive projects to identify fraud matters that are not detected through the agency's program policing mechanisms.

REQUESTED CHANGE IN OPERATIONAL AUTHORITY

Oversight of the National Railroad Retirement Investment Trust

The National Railroad Retirement Investment Trust (NRRIT) was established by the Railroad Retirement and Survivors' Improvement Act of 2001 (RRSIA) to manage and invest Railroad Retirement assets. As of February 28, 2009, the RRB's investments in the NRRIT were valued at approximately $18.3 billion. Although the Trust is a tax-exempt entity independent of the Federal Government, RRSIA requires the Trust to report to the RRB. This office has previously reported its concerns about the RRB's passive relationship with the NRRIT and has identified the RRB's oversight in this area as a critical issue. However, the RRSIA does not provide the OIG with oversight authority to conduct audits and investigations of the NRRIT. This office believes that independent oversight of the Trust's operations is necessary to ensure that sufficient reporting mechanisms are in place and to ensure that the Trustees are fulfilling their fiduciary responsibilities. The OIG respectfully requests oversight and enforcement authority to conduct audits and investigations of the NRRIT.

SUMMARY

In fiscal year 2010, the OIG will continue to focus its resources on the review and improvement of RRB operations and will conduct activities to ensure the integrity of the agency trust funds. This office will continue to work with agency officials to ensure the agency is providing quality service to railroad workers and their families. The OIG will also aggressively pursue all individuals who engage in activities to fraudulently receive RRB funds. The OIG will continue to keep the subcommittee and other members of Congress informed of any agency operational problems or deficiencies. The OIG sincerely appreciates it cooperative relationship with the agency and the ongoing assistance extended to its staff during the performance of their audits and investigations. Thank you for your consideration.

PREPARED STATEMENT OF THE RYAN WHITE MEDICAL PROVIDERS COALITION

Dear Chairman and Ranking Member: I am Dr. Kathleen Clanon, an HIV physician and director of the Tri-City Health Center's HIVACCESS program in Oakland, California. I am submitting public testimony on behalf of the Ryan White Medical Providers Coalition (RWMPC). I appreciate the opportunity to discuss the important HIV/AIDS care conducted at Ryan White Part C funded programs around the country and to request a dramatic increase in funds. Specifically, we recommend a $68.4 million increase for part C for fiscal year 2010 resulting in a total appropriation of $270,254,000.

Our coalition was formed in 2006 to be a voice for medical providers across the Nation delivering quality care to their patients through part C of the Ryan White program. We represent every kind of program from small and rural to large urban sites in every region in the country. Our membership has rapidly increased as word

spread that an advocacy group was forming to speak on behalf of the needs of part C programs.

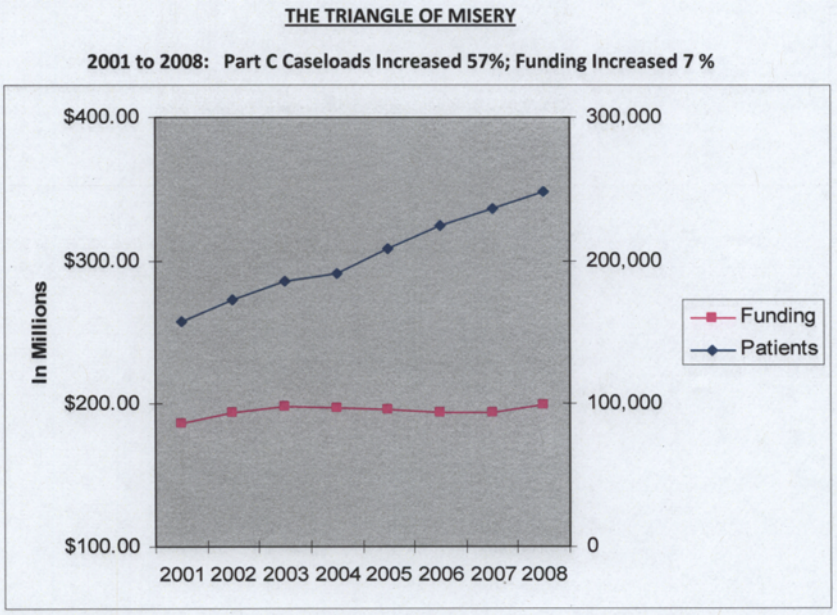
Ryan White Part C funds comprehensive HIV care and treatment—the services that are directly responsible for the dramatic decreases in AIDS-related mortality and morbidity over the last decade. We speak for those who often cannot speak for themselves and we advocate for a full range of primary care services for this unique population. Sufficient funding for part C is essential for the work that we do in service of those living with HIV/AIDS.

While the patient load in our programs is rising in number, funding for part C has effectively decreased. At the same time, we expect a continued increase in patients due to higher diagnosis rates and declining insurance coverage. The Centers for Disease Control and Prevention (CDC) reports that the number of HIV/AIDS cases increased by 15 percent from 2004 to 2007 in 34 States.[1] Our patients struggle in times of plenty; during this economic downturn they will rely on our comprehensive services more than ever. An increase in funding is critical to ensure that we are able to sustain and improve our current staffing levels, which is important to ensure access to healthcare for our patients, as well as, to provide security to our community. Part C of the Ryan White program has been under-funded for years, but new pressures are creating a crisis in our community. The HIV medical clinics funded through part C have been in dire of increased funding for years. An infusion of new funding would offer much needed assistance. Years of near flat funding, combined with large increases in the patient population, are negatively impacting the ability of part C providers to serve their patients.

With the rapid cost increases in all aspects of healthcare delivery, despite small funding increases programs are still operating at a funding deficit because we are serving more patients than ever. In 2008, part C programs will treat an estimated 248,070—a dramatic 30 percent increase in less than 10 years. Our clinics are laying off staff, discontinuing critical services such as laboratory monitoring, creating waitlists, and operating on a 4-day work week just to get by. All of this at a time when the new data reporting requirements resulting from the 2006 reauthorization of Ryan White are requiring even more staff and administrative time than the 10 percent allocation permitted.

Frankly, we can do better than this and the HIV/AIDS population served through part C deserves more support. I have included the following graph in my testimony to demonstrate the growing disparity between funding for part C and our patient population. I call the gap between funding and patients the "Triangle of Misery" because it represents the thousands of patients who deserve more than we can offer them and the part C programs around the Nation who are struggling to serve them with rapidly shrinking resources.

[1] Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report, 2007. Vol. 19. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2009:5 www.cdc.gov/hiv/topics/surveillance/resources/reports.



The purpose of my testimony is to urge you to respond to this crisis and ask that you commit to doubling funding for Ryan White Part C programs by fiscal year 2012. Through a careful process that determined the actual cost of our care for our patients, the Ryan White Medical Providers Coalition worked collaboratively with the CAEAR Coalition and the American Academy of HIV Medicine to calculate the funding demands for Ryan White Part C. We unanimously agreed that a Federal appropriation of $407,300,078 is needed for part C.

These are challenging fiscal times, and we recognize the multiple fiscal constraints you face as you determine how to allocate limited Federal dollars. That is why we are not asking for $407.3 million for Ryan White Part C for fiscal year 2010. Rather, we join with our partners in asking you to commit to doubling our funding by fiscal year 2012. Such an agreement would result in an increase of $68.4 million for part C for each year: fiscal years 2010, 2011, and 2012. We believe this is a reasonable approach to meeting the needs of HIV/AIDS patients served by part C around the country.

It is important for you to understand how we developed our request number. It is based on the following calculations:

—We assumed that 1,381,418 will be the number of people living with HIV/AIDS in 2012 based on the Centers for Disease Control and Prevention, New Estimates of HIV Prevalence, 2006. The estimate equals the CDC's 2006 estimated cases multiplied by their annual estimated prevalence increases for the years 2007–2012.

—Using data from the HRSA HIV/AIDS Bureau we estimated that 248,070 uninsured people living with HIV/AIDS were served by part C programs in 2008.

—Using data from a report by Julie Gerberding, MD, MPH and Elizabeth Duke, Ph.D. to the Honorable Henry Waxman (http://oversight.house.gov/story.asp?ID1675) we estimated that 168,688 PLWHA who were underinsured were served by part C programs in 2008.

—We estimate the cost of care per patient at $3,501 per year. (Gilman, BH, Green, JC. Understanding the variation in costs among HIV primary care providers. AIDS Care. 2008:20;1050–6.)

—We calculated the cost of providing care to uninsured part C patients to be $277,916,382 per year (79,382 patients × $3,501 cost of care).

—We calculated the costs of providing care to underinsured part C patients to be $129,383,696 per year (168,688 patients × $767 cost of care). The cost of care for underinsured patients is a conservative estimate based on Institute of Medicine figures.

—The total cost of care for all part C patients will be $407,300,078 in fiscal year 2012.

Our data demonstrate the undeniable. Our patient load is increasing as is the cost of their care. A substantial Federal investment is necessary to support part C sites around the country in their efforts to provide the comprehensive care that we know HIV/AIDS patients deserve and from which both they and our communities benefit.

I thank you for your attention to our request and urge you to commit to doubling the funding for Ryan White Part C in 3 years. We request a $68.4 million increase for part C for fiscal year 2010 resulting in a total appropriation of $270,254,000. By working together, we are hopeful that in fiscal year 2012 the full appropriation for Ryan White Part C will be $407,300,078.

PREPARED STATEMENT OF THE SPINA BIFIDA ASSOCIATION AND SPINA BIFIDA FOUNDATION

FUNDING REQUEST OVERVIEW

The Spina Bifida Association (SBA) and the Spina Bifida Foundation (SBF) respectfully request that the subcommittee provide the following allocations in fiscal year 2010 to help improve quality-of-life for people with Spina Bifida:

—$7 million for the National Spina Bifida Program at the National Center on Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention (CDC) to support existing program initiatives and allow for the further development of the National Spina Bifida Patient Registry.

—$4.818 million for the CDC's national folic acid education and promotion efforts to support the prevention of Spina Bifida and other neural tube defects.

—$25.623 million to strengthen the CDC's National Birth Defects Prevention Network.

—$77.059 million for the CDC's National Center on Birth Defects and Developmental Disabilities.

—$405 million for the Agency for Healthcare Research and Quality (AHRQ).

—$33.349 billion for the National Institutes of Health (NIH) to support biomedical research.

BACKGROUND ON SPINA BIFIDA

On behalf of the more than 185,000[1] individuals and their families who are affected by Spina Bifida—the Nation's most common, permanently disabling birth defect—SBA and SBF appreciate the opportunity to submit written testimony for the record regarding fiscal year 2010 funding for the National Spina Bifida Program and other related Spina Bifida initiatives. SBA is a national voluntary health agency working on behalf of people with Spina Bifida and their families through education, advocacy, research and service. The Spina Bifida Foundation assists SBA in its fundraising and advocacy efforts. SBA and SBF stand ready to work with Members of Congress and other stakeholders to ensure our Nation mounts and sustains a comprehensive effort to reduce and prevent suffering from Spina Bifida.

Spina Bifida, a neural tube defect, occurs when the spinal cord fails to close properly within the first few weeks of pregnancy and most often before the mother knows that she is pregnant. Over the course of the pregnancy—as the fetus grows—the spinal cord is exposed to the amniotic fluid, which increasingly becomes toxic. It is believed that the exposure of the spinal cord to the toxic amniotic fluid erodes the spine and results in Spina Bifida. There are varying forms of Spina Bifida occurring from mild—with little or no noticeable disability—to severe—with limited movement and function. In addition, within each different form of Spina Bifida the effects can vary widely. Unfortunately, the most severe form of Spina Bifida occurs in 96 percent of children born with this birth defect.

The result of this neural tube defect is that most people with it suffer from a host of physical, psychological, and educational challenges—including paralysis, developmental delay, numerous surgeries, and living with a shunt in their skulls, which seeks to ameliorate their condition by helping to relieve cranial pressure associated with spinal fluid that does not flow properly. As we have testified previously, the good news is that after decades of poor prognoses and short life expectancy, children with Spina Bifida are now living into adulthood and increasingly into their advanced years. These gains in longevity, principally, are due to breakthroughs in re-

---

[1] At the First World Congress on Spina Bifida Research and Care in March 2009 representatives from the CDC reported on new data indicating that there are an estimated 185,000 individuals living with Spina Bifida in the United States.

search, combined with improvements generally in healthcare and treatment. However, with this extended life expectancy, our Nation and people with Spina Bifida now face new challenges—education, job training, independent living, healthcare for secondary conditions, and aging concerns, among others. Individuals and families affected by Spina Bifida face many challenges—physical, emotional, and financial. Fortunately, with the creation of the National Spina Bifida Program in 2003, individuals and families affected by Spina Bifida now have a national resource that provides them with the support, information, and assistance they need and deserve.

As is discussed below, the daily consumption of 400 micrograms of folic acid by women of childbearing age prior to becoming pregnant and throughout the first trimester of pregnancy can help reduce the incidence of Spina Bifida, by up to 70 percent. However, 1,500 babies are still born each year with Spina Bifida, and, as such, with the aging of the Spina Bifida population and a steady number of affected births annually, the Nation must take additional steps to ensure that all individuals living with this complex birth defect can live full, healthy, and productive lives.

COST OF SPINA BIFIDA

It is important to note that the lifetime costs associated with a typical case of Spina Bifida—including medical care, special education, therapy services, and loss of earnings—are as much as $1 million. The total societal cost of Spina Bifida is estimated to exceed $750 million per year, with just the Social Security Administration payments to individuals with Spina Bifida exceeding $82 million per year. Moreover, tens of millions of dollars are spent on medical care paid for by the Medicaid and Medicare programs. The emotional, financial, and physical toll and costs of Spina Bifida on the individuals and families affected are extraordinary. Efforts to reduce and prevent suffering from Spina Bifida will help to not only save money, but will also save—and improve—lives.

IMPROVING QUALITY-OF-LIFE THROUGH THE NATIONAL SPINA BIFIDA PROGRAM

SBA has worked with Members of Congress to help improve our Nation's efforts to prevent Spina Bifida and diminish suffering—and enhance quality-of-life—for those currently living with this condition. With appropriate, affordable, and high-quality medical, physical, and emotional care, most people born with Spina Bifida likely will have a normal or near normal life expectancy. The CDC's National Spina Bifida Program works on two critical levels—to reduce and prevent Spina Bifida incidence and morbidity and to improve quality-of-life for those living with Spina Bifida. The program seeks to ensure that what is known by scientists is practiced and experienced by the individuals affected by Spina Bifida. Moreover, the National Spina Bifida Program works to improve the outlook for a life challenged by this complicated birth defect—principally, identifying valuable therapies from in-utero throughout the lifespan and making them available and accessible to those in need.

The National Spina Bifida Program serves as a national center for information and support to help ensure that individuals, families, and other caregivers, such as health professionals, have the most up-to-date information about effective interventions for the myriad primary and secondary conditions associated with Spina Bifida. Among many other activities, the program helps individuals with Spina Bifida and their families learn how to treat and prevent secondary health problems, such as bladder and bowel control difficulties, learning disabilities, depression, latex allergies, obesity, skin breakdown and social and sexual issues. Children with Spina Bifida often have learning disabilities and may have difficulty with paying attention, expressing or understanding language, and grasping reading and math. All of these problems can be treated or prevented, but only if those affected by Spina Bifida—and their caregivers—are properly educated and taught what they need to know to maintain the highest level of health and well-being possible. The National Spina Bifida Program's secondary prevention activities represent a tangible quality-of-life difference to the 185,000 individuals living with Spina Bifida with the goal being living well with Spina Bifida.

One way to enhance the knowledge base of Spina Bifida, improve quality of care, and save precious resources is to establish a patient registry for Spina Bifida. Plans are underway to create the National Spina Bifida Patient Registry. This registry is intended to determine the best clinical practices and the most cost-effective treatment for Spina Bifida, as well as, support the creation of quality measures to improve overall care. It is only through clinical research towards improved care that we can truly save lives, while also realizing a significant cost savings.

In fiscal year 2009, SBA requested $7 million be allocated to support and expand the National Spina Bifida Program. In the final fiscal year 2009 Omnibus Appropriations Act, Congress provided $5.468 million for this program, following 3 years

of essentially flat funding. SBA understands that the Congress and the Nation face unprecedented budgetary challenges and, as such, appreciates this modest increase. However, the progress being made by the National Spina Bifida Program must be sustained and expanded to ensure that people with Spina Bifida—over the course of their lifespan—have the support and access to quality care they need and deserve. To that end, SBA respectfully urges the subcommittee to Congress allocate $7 million in fiscal year 2010 to the program so it can continue and expand its current scope of work; further develop the National Spina Bifida Patient Registry; and sustain the National Spina Bifida Resource Center. Increasing funding for the National Spina Bifida Program will help ensure that our Nation continues to mount a comprehensive effort to prevent and reduce suffering from—and the costs of—Spina Bifida.

PREVENTING SPINA BIFIDA

While the exact cause of Spina Bifida is unknown, over the last decade, medical research has confirmed a link between a woman's folate level before pregnancy and the occurrence of Spina Bifida. Sixty-five million women of child-bearing age are at-risk of having a child born with Spina Bifida, and each year approximately 3,000 pregnancies in this country are affected by Spina Bifida, resulting in an estimated 1,500 births. As mentioned above, the daily consumption of 400 micrograms of folic acid prior to becoming pregnant and throughout the first trimester of pregnancy can help reduce the incidence of Spina Bifida, by up to 70 percent. There are few public health challenges that our Nation can tackle and conquer by nearly three-fourths in such a straightforward fashion. However, we must still be concerned with addressing the 30 percent of Spina Bifida cases that cannot be prevented by folic acid consumption, as well as ensuring that all women of childbearing age—particularly those most at-risk for a Spina Bifida pregnancy—consume adequate amounts of folic acid prior to becoming pregnant.

The good news is that progress has been made in convincing women of the importance of folic acid consumption and the need to maintain a diet rich in folic acid. Since 1968, the CDC has led the Nation in monitoring birth defects and developmental disabilities, linking these health outcomes with maternal and/or environmental factors that increase risk, and identifying effective means of reducing such risks. This public health success should be celebrated, but still too many women of childbearing age consume inadequate daily amounts of folic acid prior to becoming pregnant, and too many pregnancies are still affected by this devastating birth defect. The Nation's public education campaign around folic acid consumption must be enhanced and broadened to reach segments of the population that have yet to heed this call—such an investment will help ensure that as many cases of Spina Bifida can be prevented as possible.

SBA is the managing agent for the National Council on Folic Acid, a multi-sector partnership reaching more than 100 million people a year with the folic acid message. The goal is to increase awareness of the benefits of folic acid, particularly for those at elevated risk of having a baby with neural tube defects (those who have Spina Bifida themselves, or those who have already conceived a baby with Spina Bifida). With additional funding in fiscal year 2010, CDC's folic acid awareness activities could be expanded to reach the broader population in need of these public health education, health promotion, and disease prevention messages. SBA advocates that Congress provide additional funding to CDC to allow for a targeted public health education and awareness focus on at-risk populations (e.g., Hispanic-Latino communities) and health professionals who can help disseminate information about the importance of folic acid consumption among women of childbearing age.

In addition to a $7 million fiscal year 2010 allocation for the National Spina Bifida Program, SBA urges the subcommittee to provide $4.818 million for the CDC's national folic acid education and promotion efforts to support the prevention of Spina Bifida and other neural tube defects; $25.623 million to strengthen the CDC's National Birth Defects Prevention Network; and a total of $77.059 million for the National Center on Birth Defects and Developmental Disabilities.

IMPROVING HEALTHCARE FOR INDIVIDUALS WITH SPINA BIFIDA

As you know, AHRQ's mission is to improve the outcomes and quality of healthcare, reduce healthcare costs, improve patient safety, decrease medical errors, and broaden access to essential health services. AHRQ's work is vital to the evaluation of new treatments, which helps ensure that individuals living with Spina Bifida continue to receive state-of-the-art care and interventions. To that end, we request a $405 million fiscal year 2010 allocation for AHRQ, so it can continue to provide guidance and support to the National Spina Bifida Patient Registry.

SUSTAIN AND SEIZE SPINA BIFIDA RESEARCH OPPORTUNITIES

Our Nation has benefited immensely from our past Federal investment in biomedical research at the NIH. SBA joins with other in the public health and research community in advocating that NIH receive $33.349 billion in fiscal year 2010. This funding will support applied and basic biomedical, psychosocial, educational, and rehabilitative research to improve the understanding of the etiology, prevention, cure and treatment of Spina Bifida and its related conditions. In addition, SBA respectfully requests that the subcommittee include language in the report accompanying the fiscal year 2010 Labor, Health and Human Services, and Education, and related Agencies appropriations measure:

—Urging the National Institute of Child Health and Human Development to continue to support—and expand—a more comprehensive Spina Bifida research portfolio that focuses on addressing the myriad secondary effects and conditions associated with Spina Bifida;

—Commending the National Institute of Diabetes and Digestive and Kidney Diseases for its interest in exploring issues related to the neurogenic bladder and to encourage the Institute to forge ahead with its work in this important topic area; and

—Encouraging the National Institute of Neurological Diseases and Stroke to continue and expand its research related to the treatment and management of hydrocephalus.

CONCLUSION

Please know that SBA and SBF stand ready to work with the subcommittee and other Members of Congress to advance policies and programs that will reduce and prevent suffering from Spina Bifida. Again, we thank you for the opportunity to present our views regarding fiscal year 2010 funding for programs that will improve the quality-of-life for the 185,000 Americans and their families living with Spina Bifida.

PREPARED STATEMENT OF THE SCLERODERMA FOUNDATION

Mr. Chairman, I am Cynthia Cervantes, I am 12 and in the ninth grade. I live in southern California and in October 2006 I was diagnosed with scleroderma. Scleroderma means "hard skin" which is literally what scleroderma does and, in my case, also causes my internal organs to stiffen and contract. This is called diffuse scleroderma. It is a relatively rare disorder effecting only about 300,000 Americans.

About 2 years ago I began to experience sudden episodes of weakness, my body would ache and my vision was worsening, some days it was so bad I could barely get myself out of bed. I was taken to see a doctor after my feet became so swollen that calcium began to ooze out. It took the doctors (period of time) to figure out exactly what was wrong with me, because of how rare scleroderma is.

There is no known cause for scleroderma, which affects three times as many women as men. Generally, women are diagnosed between the ages of 25 and 45, but some kids, like me, are affected earlier in life. There is no cure for scleroderma, but it is often treated with skin softening agents, anti-inflammatory medication, and exposure to heat. Sometimes a feeding tube must be used with a scleroderma patient because their internal organs contract to a point where they have extreme difficulty digesting food.

The Scleroderma Foundation has been very helpful to me and my family. They have provided us with materials to educate my teachers and others about my disease. Also, the support groups the foundation helps organize are very helpful because they help show me that I can live a normal, healthy life, and how to approach those who are curious about why I wear gloves, even in hot weather. It really means a lot to me to be able to interact with other people in the same situation as me because it helps me feel less alone.

Mr. Chairman, because the causes of scleroderma are currently unknown and the disease is so rare, and we have a great deal to learn about it in order to be able to effectively treat it. I would like to ask you to please significantly increase funding for the National Institute of Health (NIH) so treatments can be found for other people like me who suffer from scleroderma. It would also be helpful to start a program at the Centers for Disease Control and Prevention to educate the public and physicians about scleroderma.

OVERVIEW OF THE SCLERODERMA FOUNDATION AND SCLERODERMA

Scleroderma Foundation

The Scleroderma Foundation is a nonprofit organization based in Danvers, Massachusetts with a three-fold mission of support, education, and research. The Foundation has 21 chapters nationwide and more than 175 support groups.

The Scleroderma Foundation was established on January 1, 1998 through a merger between two organizations, one on the west coast and one on the east coast, which can trace their beginnings back to the early 1970s. The Foundation's mission is to provide support for people living with scleroderma and their families through programs such as peer counseling, doctor referrals, and educational information, along with a toll-free telephone helpline for patients and a quarterly magazine, The Scleroderma Voice.

The Foundation also provides education about the disease to patients, families, the medical community, and the general public through a variety of awareness programs at both the local and national levels. More than $1 million in peer-reviewed research grants are awarded annually to institutes and universities to stimulate progress in the search for a cause and cure for scleroderma. Building awareness of the disease to patients, families, the medical community, and the general public to not only generate more funding for medical research, but foster a greater understanding of the complications faced by people living with the disease is a further major focus.

Among the many programs arranged by the Foundation is the Annual Patient Education Conference held each summer. The conference brings together an average of 500 attendees and experts for a wide range of workshops on such topics as the latest research initiatives, coping and disease management skills, caregiver support, and exercise programs.

Scleroderma Overview

Scleroderma is an autoimmune disease which means that it is a condition in which the body's immune system attacks its own tissues. In autoimmune disorders, this ability to distinguish foreign from self is compromised. As immune cells attack the body's own tissue, inflammation and damage result. Scleroderma (the name means "hard skin") can vary a great deal in terms of severity. For some, it is a mild condition; for others it can be life threatening. Although there are medications to slow down disease progression and help with symptoms, there is as yet no cure for scleroderma.

Who Gets Scleroderma?

There are many clues that define susceptibility to develop scleroderma. A genetic basis for the disease has been suggested by the fact that it is more common among patients whose family members have other autoimmune diseases (such as lupus). In rare cases, scleroderma runs in families, although for the vast majority of patients there is no other family member affected. Some Native Americans and African Americans get worse scleroderma disease than Caucasians.

Women are more likely to get scleroderma. Environmental factors may trigger the disease in the susceptible host. Localized scleroderma is more common in children, whereas scleroderma is more common in adults. However, both can occur at any age.

There are an estimated 300,000 people in the United States who have scleroderma, about one-third of whom have the systemic form of scleroderma. Diagnosis is difficult and there may be many misdiagnosed or undiagnosed cases as well.

Scleroderma can develop and is found in every age group from infants to the elderly, but its onset is most frequent between the ages of 25 to 55. There are many exceptions to the rules in scleroderma, perhaps more so than in other diseases. Each case is different.

Causes of Scleroderma

The cause is unknown. However, we do understand a great deal about the biological processes involved. In localized scleroderma, the underlying problem is the overproduction of collagen (scar tissue) in the involved areas of skin. In systemic sclerosis, there are three processes at work: blood vessel abnormalities, fibrosis (which is overproduction of collagen) and immune system dysfunction, or autoimmunity.

RESEARCH

Research suggests that the susceptible host for scleroderma is someone with a genetic predisposition to injury from some external agent, such as a viral or bacterial infection or a substance in the diet or environment. In localized scleroderma, the

resulting damage is confined to the skin. In systemic sclerosis, the process causes injury to blood vessels, or indirectly perturbs the blood vessels by activating the immune system.

Research continues to assemble the pieces of the scleroderma puzzle to identify the susceptibility genes, to find the external trigger and cellular proteins driving fibrosis, and to interrupt the networks that perpetuate the disease.

TYPES OF SCLERODERMA

There are two main forms of scleroderma: systemic (systemic sclerosis, SSc) that usually affects the internal organs or internal systems of the body as well as the skin, and localized that affects a local area of skin either in patches (morphea) or in a line down an arm or leg (linear scleroderma), or as a line down the forehead (scleroderma en coup de sabre). It is very unusual for localized scleroderma to develop into the systemic form.

Systemic Sclerosis

There are two major types of systemic sclerosis (SSc)—limited cutaneous SSc and diffuse cutaneous SSc. In limited SSc, skin thickening only involves the hands and forearms, lower legs, and feet. In diffuse cutaneous disease, the hands, forearms, the upper arms, thighs, or trunk are affected.

The face can be affected in both forms. The importance of making the distinction between limited and diffuse disease is that the extent of skin involvement tends to reflect the degree of internal organ involvement.

Several clinical features occur in both limited and diffuse cutaneous SSc. Raynaud's phenomenon occurs in both. Raynaud's phenomenon is a condition in which the fingers turn pale or blue upon cold exposure, and then become ruddy or red upon warming up. These episodes are caused by a spasm of the small blood vessels in the fingers. As time goes on, these small blood vessels become damaged to the point that they are totally blocked. This can lead to ulcerations of the fingertips.

People with the diffuse form of SSc are at risk of developing pulmonary fibrosis (scar tissue in the lungs that interferes with breathing, also called interstitial lung disease), kidney disease, and bowel disease.

The risk of extensive gut involvement, with slowing of the movement or motility of the stomach and bowel, is higher in those with diffuse rather than limited SSc. Symptoms include feeling bloated after eating, diarrhea, or alternating diarrhea and constipation.

Calcinosis refers to the presence of calcium deposits in, or just under, the skin. This takes the form of firm nodules or lumps that tend to occur on the fingers or forearms, but can occur anywhere on the body. These calcium deposits can sometimes break out to the skin surface and drain whitish material (described as having the consistency of toothpaste).

Pulmonary Hypertension (PH) is high blood pressure in the blood vessels of the lungs. It is totally independent of the usual blood pressure that is taken in the arm. This tends to develop in patients with limited SSc after several years of disease. The most common symptom is shortness of breath on exertion. However, several tests need to be done to determine if PH is the real culprit. There are now many medications to treat PH.

Localized Scleroderma

Morphea

Morphea consists of patches of thickened skin that can vary from one-half inch to 6 inches or more in diameter. The patches can be lighter or darker than the surrounding skin and thus tend to stand out. Morphea, as well as the other forms of localized scleroderma, does not affect internal organs.

Linear scleroderma

Linear scleroderma consists of a line of thickened skin down an arm or leg on one side. The fatty layer under the skin can be lost, so the affected limb is thinner than the other one. In growing children, the affected arm or leg can be shorter than the other.

Scleroderma en coup de sabre

Scleroderma en coup de sabre is a form of linear scleroderma in which the line of skin thickening occurs on the forehead or elsewhere on the face. In growing children, both linear scleroderma and en coup de sabre can result in distortion of the growing limb or lack of symmetry of both sides of the face.

FISCAL YEAR 2010 APPROPRIATIONS RECOMMENDATIONS

A 7 percent overall increase for NIH.

A 7 percent increase for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) at the NIH.

A subcommittee recommendation encouraging NIAMS to support a State of the Science Conference on Scleroderma in fiscal year 2010.

Subcommittee recommendation encouraging the Centers for Disease Control and Prevention to partner with the Scleroderma Foundation to promoting increased awareness of scleroderma among the general public and healthcare providers.

PREPARED STATEMENT OF THE SOCIETY FOR HEALTHCARE EPIDEMIOLOGY OF AMERICA

Society for Healthcare Epidemiology of America (SHEA) was founded in 1980 to advance the application of the science of healthcare epidemiology. SHEA works to achieve the highest quality of patient care and healthcare personnel safety in all health care settings by applying epidemiologic principles and prevention strategies to a wide range of quality-of-care issues. SHEA is a growing organization, strengthened by its membership in all branches of medicine, public health, and healthcare epidemiology.

SHEA and its members are committed to implementing evidence-based strategies to prevent healthcare-associated infections (HAIs). SHEA members have scientific expertise in evaluating potential strategies for eliminating preventable HAIs. We collaborate with a wide range of infection prevention and infectious disease societies, specialty medical societies in other fields, quality improvement organizations, and patient safety organizations in order to identify and disseminate evidence-based practices.

Our principal partners in the private sector are sister societies such as the Infectious Diseases Society of America and the Association of Professionals in Infection Control and Epidemiology. The Centers for Disease Control and Prevention (CDC), its Division of Healthcare Quality Promotion (DHQP) and the Federal Healthcare Infection Practices Advisory Committee (HICPAC), and the Council of State and Territorial Epidemiologists have been invaluable Federal partners in the development of guidelines for the prevention and control of HAIs and in their support of translational research designed to bring evidence-based practices to patient care. Further, collaboration between experts in the field (epidemiologists and infection preventionists), CDC and the Agency for Healthcare Research and Quality (AHRQ) plays a critical role in defining and prioritizing the research agenda. More recently, SHEA has aligned with the Joint Commission and the American Hospital Association to produce and promote the implementation of evidence-based recommendations in the Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals (http://www.shea-online.org/about/compendium.cfm). The organization also contributes expert scientific advice to quality improvement organizations such as the Institute for Healthcare Improvement (IHI), the National Quality Forum, and State-based task forces focused on infection prevention and public reporting issues.

The current swine flu emergency and the Obama administration's request for an additional $1.5 billion to address the situation highlights the need for ongoing congressional support of a national prevention strategy and dedicated funding stream for core public health programs. It is our hope that health reform can serve as an opportunity to strengthen our public health infrastructure and reorient our health system towards prevention and preparedness.

SHEA applauds the Congress for its support of HAI prevention and reduction activities through the American Recovery and Reinvestment Act (ARRA) and the fiscal year 2009 Omnibus Appropriations bill. The Society is collaborating with the Department of Health and Human Services (HHS) and the CDC to translate agency goals and objectives for these funds into actions at the bedside that can achieve meaningful reductions in preventable HAIs. However, SHEA believes that this level of funding is substantially insufficient to address a problem estimated by CDC to be one of the top 10 causes of death in the Nation and one that poses a significant economic burden on the Nation's healthcare system.

SHEA supports the conclusions of last year's GAO report on coordination among HHS agencies related to HAI prevention. We believe that coordinated action among CDC, the Centers for Medicare and Medicaid Services (CMS) and AHRQ is critical. CDC and its DHQP should function as the lead agency in surveillance and prevention activities related to HAIs at the Federal level because of its historic and successful role in this area. CDC has had an enviable track record of prevention and its development and management of the foremost surveillance system of its kind,

the National Healthcare Safety Network (NHSN) has created a national resource that many States have now mandated as their public reporting tool. Furthermore, guidelines developed by the HICPAC are widely regarded as the standards for the field. Coordinated activity among the agencies can lead to better informed public policy and payment reform.

Clearly, the CDC plays a critical role in public health protection through its health promotion, prevention, preparedness, and research activities. As you consider fiscal year 2010 funding levels for the CDC, SHEA urges your support of at least $8.6 billion for CDC's "core programs" (not including the mandatory funding provided for the Vaccines for Children Program) to ensure that the agency is able to carry out its prevention mission and to assure an adequate translation of new research into effective State and local programs. In addition to maintaining a strong public health infrastructure and protecting Americans from public health threats and emergencies, SHEA strongly believes that CDC programs play a vital role in reducing healthcare costs and improving the public's health.

Within this total, SHEA recommends a fiscal year 2010 funding level of $2.4 billion for CDC's Infectious Diseases program budget which supports vital management and coordination functions for infectious disease science, program, and policy, including infectious disease specific epidemiology and laboratory activities. In particular, SHEA believes that protecting and improving resources for implementation of programs that standardize measurement of appropriate HAI outcomes and performance measures should be a priority. Our most valuable resource in this regard is NHSN, a voluntary, secure, Internet-based surveillance system that integrates and expands patient and healthcare personnel safety surveillance systems. Many States consider NHSN to be the best option for implementing standardized reporting of HAI data. NHSN has now been adopted by 19 States and more than 2,100 U.S. hospitals for the surveillance and reporting of HAIs. It is an enormously important national resource and effective funding and support is essential to expand its implementation. Further, recognizing that multiple States mandate the use of NHSN for State public reporting, immediate efforts should be made to enable interfaces between electronic health records and NHSN. In this way, additional burdens are not placed upon healthcare entities from either an infection prevention and control or information technology perspective as the desirability for national database integration proceeds.

As already noted, SHEA believes that additional Federal dollars should be appropriated for HAI prevention and reduction to build upon the investment already made through the ARRA and fiscal year 2009 omnibus appropriations bill. It is SHEA's perspective that additional funding in this area will have the greatest impact when prioritized in the following ways:

—SHEA strongly encourages an emphasis on implementation of evidence-based practices, as supported by guidelines (CDC–HICPAC) and evidence-based recommendations (Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals). Protecting the health of our patients and preventing HAIs in the settings where healthcare is delivered in the United States will require a multi-faceted approach that includes identification and widespread adoption of evidence-based best practices. Where evidence does not exist, uniformity in practice should be adopted and studied to determine effectiveness. Failed practices should be discarded and successes widely disseminated. Prevention and control of HAIs also will require better tools in the form of new and novel antimicrobial agents, better knowledge of strategies to effect implementation and adherence to proven prevention methods, and accountability for performance.

—SHEA supports investment in training and education programs for both hospital-wide personnel, local public health personnel and patients/families in evidence-based prevention practices and development of educational materials /tools for patients and families with respect to HAI and multiple drug resistant organisms (MDRO).

—SHEA supports a broad context for use of dollars for HAIs rather than pathogen-specific targets or mandates (e.g., on MRSA or C. difficile). Ideally, funding should be tied to locally identified priorities emphasizing that implementation of best practice bundles for catheter-associated bloodstream infections (CLA–BSI), ventilator-associated pneumonia and catheter-associated urinary tract infection (CA–UTI) will have a greater impact on prevention of HAIs, including those due to MDRO, than pathogen-specific practices. This approach recognizes the influence of local conditions on the control of healthcare-associated infections, and allows rapid modification of strategies as new knowledge is gained. As an example, SHEA and CMS emphasize that a risk assessment must be the first step in any epidemiologic study or infection prevention and control pro-

gram in order to target preventive efforts effectively. We are pleased that the Joint Commission supports this critical step by developing it into a basic infection prevention standard. SHEA believes that this strategy allows healthcare facilities to use local information to develop and implement optimal and individualized prevention plans designed to reduce healthcare-associated infections that are identified as local problems. Goals should be written in such a way to allow hospitals the flexibility to identify and target their own safety threats within the domains that are considered critical, and healthcare facilities should be expected to be able to justify their infection prevention program based on local risk assessments.

—SHEA supports investment in hospital infrastructure and qualified personnel for infection prevention and control including epidemiologists, infection prevention and control professionals, NHSN implementation, and adequate microbiology/lab diagnostic capability as dictated by locally derived needs assessment and priority.

—SHEA believes that funds made available through CDC and AHRQ should be used, in part, for translational research projects that can allow more rapid integration of science into practice. As an example, this could involve use of funds to support positions through which large collaboratives could be supported in States not currently part of AHRQ or HRET projects (for example PHRI and Keystone, which have achieved successful reductions in device-associated infections). Experts in the field (Epidemiologists and Infection Preventionists), in collaboration with CDC and the AHRQ, should be engaged in order to further define and prioritize the research agenda. As we strive to eliminate all preventable HAIs, we need to identify the gaps in our understanding of what is actually preventable. This distinction is critical to help guide subsequent research priorities and to help set realistic expectations. SHEA believes in the importance of conducting basic, epidemiological and translational studies (to fill basic and clinical science gaps). While health services research (i.e., successful implementation of strategies already known or suspected to be beneficial) may provide some immediate short-term benefit, to achieve further success, a substantial investment in basic science, translational medicine, and epidemiology is needed to permit effective and precise, interventions that prevent HAIs.

—SHEA strongly favors local decision-making about priorities for use of funds; however, State efforts should be aligned with CDC priorities and should be carried out through collaboration with key stakeholders such as State hospital associations and local experts. CDC should lead the effort to measure and report on the success of State prevention efforts to HHS.

With respect to the National Institutes of Health (NIH), SHEA is very pleased that the ARRA infused the Institutes with billions of dollars for research projects that will enable growth and investment in biomedical research and development, public health and healthcare delivery. The NIH is the single-largest funding source for infectious diseases research in the United States and the life-source for many academic research centers. The NIH-funded work conducted at these centers lays the ground work for advancements in treatments, cures, and medical technologies. We applaud Congress for acknowledging the impact of scientific research in stimulating the economy.

SHEA believes that any national effort designed to address the problem of HAIs should begin with the following principles: scrutiny of the science base; development of an aggressive, prioritized research agenda; the conduct of studies that address the identified questions; creation and deployment of guidelines based on the outcomes of these studies, followed by studies that assess the efficacy of the intervention.

In order to determine the preventability of infections, we first need to understand how and why these infections occur. A comprehensive national research agenda on HAIs must include at least three major categories of research: pathogenesis, epidemiology, and infection prevention strategies. A fourth area of, perhaps, even greater importance is the development and use of improved approaches to the design of healthcare epidemiology studies. Carefully designed multicenter prospective clinical trials are needed to establish the effectiveness of prevention and control strategies.

Unfortunately, support for basic, translational, and epidemiological research on HAIs has not been a priority of major funding bodies. Despite the fact that HAIs are among the top 10 annual causes of death in the United States, scientists studying these infections have received relatively less funding than colleagues in many other disciplines. In 2008, NIH estimated that it spent more than $2.9 billion dollars on funding for HIV/AIDS research, about $2 billion on cardiovascular disease research, about $664 million on obesity research and, by comparison, National Institute of Allergy and Infectious Diseases provided $18 million for MRSA research. SHEA believes that as the magnitude of the HAI problem becomes part of the dia-

logue on healthcare reform, it is imperative that the Congress and funding organizations put significant resources behind this momentum.

The limited availability of Federal funding to study HAIs has the effect of steering young investigators interested in pursuing research on HAIs toward other, better-funded fields. While industry funding is available, the potential conflicts of interest, particularly in the area of infection-prevention technologies, make this option seriously problematic. These challenges are limiting professional interest in the field and hampering the clinical research enterprise at a time when it should be expanding.

Our discipline is faced with the need to bundle, implement, and adhere to interventions we believe to be successful while simultaneously conducting basic, epidemiological, pathogenetic, and translational studies that are needed to move our discipline to the next level of evidence-based patient safety. The current convergence of scientific, public, and legislative interest in reducing rates of HAIs can provide the necessary momentum to address and answer important questions in HAI research. SHEA strongly urges you to enhance NIH funding for fiscal year 2010 to ensure adequate support for the research foundation that holds the key to addressing the multifaceted challenges presented by HAIs.

SHEA thanks for the subcommittee for this opportunity to share our priorities with respect to fiscal year 2010 funding for HHS, CDC, and the NIH. SHEA is pleased to serve as a resource to the subcommittee going forward on issues related to healthcare epidemiology.

PREPARED STATEMENT OF THE SOCIETY FOR MATERNAL-FETAL MEDICINE

Mr. Chairman and members of the subcommittee: The Society for Maternal-Fetal Medicine (SMFM) is pleased to have the opportunity to submit testimony in support of the fiscal year 2010 budget for the National Institute of Child Health and Human Development (NICHD).

Established in 1977, SMFM is dedicated to improving maternal and child outcomes; and raising the standards of prevention, diagnosis, and treatment of maternal and fetal disease.

ISSUE

Preterm birth is a major public health priority and a major research priority for NICHD.

—Nearly 500,000 babies born in the United States (1 of every 8 births) are preterm and the number continues to rise.
—The annual cost due to preterm birth in the United States is estimated to be $26 billion.
—These infants are at high risk for a variety of disorders including mental retardation, cerebral palsy and vision impairment.
—They are also at high risk for long-term health issues including heart attack, stroke, and diabetes.

NICHD has been given the mandate of supporting almost all research into maternal, child, and fetal health problems. In 1986, the NICHD established the Maternal Fetal Medicine Units Network to achieve a greater understanding and pursue development of effective treatments for the prevention of preterm births, intrauterine fetal growth disorders, and medical complications during pregnancy. The Network currently funds 14 university-based clinical centers and one data coordinating center, located around the country. Each site is funded for 5 years and is renewed by open competition. The advantages of doing clinical trials within the Network include: having large populations with which to conduct studies (there are approximately 120,000 births per year within the Network); provides diverse populations across an array of ethnic and socioeconomic backgrounds—as a result, the study outcomes are more likely to prove effective in real-world clinical practice.

The Network has made a number of landmark contributions to obstetric practice. In particular, NICHD-supported research identified progesterone as a medication that can reduce premature deliveries significantly, and now patients are benefiting from this treatment. Another major advance is the use of magnesium sulfate—a common treatment to delay labor—to reduce the risk of cerebral palsy in preterm infants.

Building on information gathered in previous Network studies, the Network is currently addressing whether progesterone will also prevent preterm birth in first pregnancies found to have a short cervix. We have learned that:

—one of the largest segments of women at risk for preterm births are those having their first child.

—when an ultrasound exam shows a short cervix (the opening of a woman's uterus), the risk of preterm birth is much higher.
—progesterone injections reduce the risk for those women with a prior preterm birth.

If benefit can be shown, progesterone will then be an intervention for prematurity prevention to apply to the largest segment of pregnant women at risk for preterm birth.

While we are making progress, there are still many areas about maternal health, pregnancy, fetal well-being, labor, and delivery and the developing child that NICHD investigators must understand better. For example:

—Steroids for the prevention of respiratory distress syndrome (RDS) and neonatal complications in the late preterm infant (34–37 weeks).
—Evaluation of the STAN monitor as an adjunct to intrapartum fetal monitoring to improve outcome of labor.

However these areas are not being pursued due to a projected limited budget.

We urge the subcommittee, as you move forward with your deliberations on the fiscal year 2010 budget, to provide greater resources to National Institutes of Health and in particular to the NICHD. Without a substantial increase and sustained investment in the critical medical research being conducted by the NICHD, therapies and preventive strategies that have a significant impact on the health of mothers and their babies will be delayed.

RECOMMENDATION

SMFM recommends that Congress provide at least a 7 percent increase more than the fiscal year 2009 budget for NICHD in fiscal year 2010.

Within the funds appropriated to the NICHD, SMFM urges Congress to instruct NICHD to adequately fund the Maternal Fetal Medicine Units Network.

Thank you for the opportunity to submit our concerns to the subcommittee.

PREPARED STATEMENT OF THE SOCIETY OF TEACHERS OF FAMILY MEDICINE

Mr. Chairman, the Society of Teachers of Family Medicine, the Association of Departments of Family Medicine, the Association of Family Medicine Residency Directors, and the North American Primary Care Research Group thank you for the opportunity to provide this testimony in support of funding for family medicine training in health professions training, the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH).

HEALTHCARE REFORM REQUIRES A ROBUST PRIMARY CARE WORKFORCE

Healthcare reform without measures to address the need for more primary care physicians will never be comprehensive or effective; it will not be able to help the most vulnerable populations, and it will not address the significant cost and quality issues currently so problematic in the United States. Increased access for patients in terms of insurance coverage is critical, but not sufficient to resolve the growing shortage of primary care physicians. In fact increased coverage, without increased numbers of primary care physicians, is a recipe for disaster.

Solving the problem of the primary care crisis requires a multi-faceted solution. One key element is to increase the value of primary care, both in terms of payment rates and loan forgiveness, and through other avenues to make primary care an attractive specialty choice for medical students. A second is to change the incentives and rules surrounding training under the Medicare graduate medical education system. A third is to increase funding of programs that are effective in producing more primary care physicians, such as the primary care medicine and dentistry cluster of the health professions training programs. And the fourth is to support research regarding the clinical needs of most people seeking care, relating to the most common acute, chronic, and comorbid conditions routinely cared for by primary care physicians.

It is the latter two building blocks: funding for primary care physician training programs and funding for primary care research that come under this subcommittee's jurisdiction and that this testimony addresses

Health Professions: Primary Care Medicine and Dentistry (title VII, section 747)

We recommend that Congress build on the investment in primary care medicine training made in the American Recovery and Reinvestment Act (ARRA) by providing an appropriation of $215 million for primary care medicine and dentistry health professions training grants. The fiscal year 2009 omnibus appropriations bill only provided $500,000 more for these programs than in fiscal year 2008. This fund-

ing level ($48.4 million) is less than half of the funding these programs received in fiscal year 2003. We appreciate your efforts in that the House had proposed to double that account in the ARRA. We applaud the $300 million included for the National Health Service Corps, but we do not know how the remaining $200 million in workforce funds will be distributed between the many other workforce programs included in the ARRA.

KEY ADVISORY COMMITTEES KNOW THESE PROGRAMS ARE EFFECTIVE

The Institute of Medicine (IOM) calls the title VII program an "undervalued asset." Title VII, section 747, administered by HRSA, is the only program aimed directly at training primary care physicians. On December 12, 2008, the Institute of Medicine released "HHS in the 21st Century: Charting a New Course for a Healthier America," which points to the drastic decline in title VII funding. Within that report, the IOM terms title VII an "undervalued asset.

The HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry [1] recommends an annual minimum level of $215 million for the title VII, section 747 grant program. The Committee reasoned that:

Title VII funds are essential to support major primary care training programs that train the providers who work with vulnerable populations . . . additional funding is also necessary to prepare current and future primary care providers for their critical role in responding to healthcare challenges including demographic changes in the population, increased prevalence of chronic conditions, decreased access to care, and a need for effective first-response strategies in instances of acts of terrorism or natural disasters.

The Congressional Research Service also found that reduced funding for the primary care medicine and dentistry cluster had a deleterious impact on the effectiveness of these programs—at a time when more, rather than less primary care is needed. For example, "In fiscal year 2006, the program supported a total of 17,870 individuals in clinical training in underserved areas, a decrease from the support of 31,153 individuals in fiscal year 2005." [2] This is a decrease of almost 43 percent, in only 1 year.

A study in the Annals of Family Medicine (September/October 2008) shows that medical schools that receive primary care training dollars produce more physicians who work in Community Health Centers (CHCs) and serve in the National Health Service Corps compared to schools without title VII primary care funding. In spite of an effort to double the capacity of CHCs between 2002 and 2006, CHCs have found it difficult to recruit a sufficient number of primary care physicians and have hundreds of vacant positions.

PROGRAMS ARE ECONOMIC DRIVERS OF COST-SAVINGS AND HIGHER QUALITY

A Health Affairs (April 2004) article found a lower quality of care in States with higher levels of Medicare spending. The authors from the Dartmouth Center for the Evaluative Clinical Sciences found that States with more specialists and fewer primary care physicians had significantly higher costs and lower quality. A small increase in the number of primary care physicians in a State was associated with a large boost in that State's quality ranking. Indeed, States at the 75th percentile in number of primary care physicians per capita recorded Medicare costs $1,600 less per Medicare beneficiary per year and higher-quality indicators than States at the 25th percentile. If all States were to move to this level of primary care services, higher-quality care could be delivered at a savings of $60 billion or more per year for Medicare patients alone. Increased funding for title VII, section 747 could train more family doctors to be available to provide this much needed high-quality, lower-cost care.

The Government Accountability Office (GAO) and the Medicare Payment Advisory Commission have noted research indicating that access to primary care is associated with better health outcomes and lower healthcare costs. The GAO states "Ample research in recent years concludes that the nation's over reliance on specialty care services at the expense of primary care leads to a healthcare system that is less efficient. At the same time, research shows that preventive care, care coordination for

[1] *The Role of Title VII, Section 747 in Preparing Primary Care Practitioners to Care for the Underserved and Other High-Risk Groups and Vulnerable Populations*. Sixth Annual Report to the Secretary of the U.S. Department of Health and Human Services and to Congress.

[2] CRS Report to Congress. February 7, 2008 Title VII Health Professions Education and Training: Issues in Reauthorization (Order Code RL32546).

the chronically ill, and continuity of care—all hallmarks of primary care medicine—can achieve improved outcomes and cost savings."[3]

According to a report prepared by the National Association of Community Health Centers, The Robert Graham Center, and Capitol Link,[4] "There is a growing consensus among the Nation's political and industry leaders that the U.S. health care crisis has shifted from the realm of the poor and disenfranchised, to the doorstep of middle-class America." Additionally, they cite the following:

"If every American made use of primary care, the healthcare system would see $67 billion in savings annually. This reflects not only those who do not have access to primary care, but also those who rely extensively on costly specialists for most of their care, leading to inefficiencies in the system. More specifically, the expansion of Medical homes can even more dramatically facilitate effective use of health care, improve health outcomes, minimize health disparities, and lower overall costs of care."

Another study by the Robert Graham Center,[5] found that the economic impact of one family physician to his or her community was just more than $900,000 annually. Family physicians are the specialty most widely distributed throughout the United States. Using the data from their study on the economic impact of family physicians in their communities, they estimate that family physicians generate a nationwide economic impact of more than $46 billion per year. This is a conservative estimate, and does not include a number of intangible and other tangible economic benefits of family physicians, such as their contribution to the generation of income for other local healthcare organizations such as hospitals and nursing homes. In addition, while most medical specialties tend to cluster in urban areas and near academic health centers, family physicians are the specialists that are most likely to work in the poorest rural and urban areas. These underdeveloped geographies are also the ones most likely to be medically underserved.

Multiple studies from the Johns Hopkins Bloomberg School of Public Health have demonstrated that disparities in healthcare outcomes due to income inequality and socioeconomic status are reduced when there is an adequate supply of primary care.

AHRQ and NIH—Health Care Reform Requires New Areas of Endeavor Research related to the most common acute, chronic, and comorbid conditions that primary care clinicians care for on a daily basis is currently lacking. Primary care physicians are in the best position to design and implement research of the common clinical questions confronted in practice. Funding should be increased both for the training of primary care researchers and for this type of clinical research. Such training is necessary to impart critical research skills to the primary care workforce and to contribute to the body of knowledge necessary to put primary care on similar footing with other specialties that have established research infrastructures. We are pleased with the infusion of funding through the ARRA for comparative effectiveness research, but there is a need to provide new funding directly toward specific clinical and translational endeavors.

AHRQ

AHRQ supports research to improve healthcare quality, reduce costs, advance patient safety, decrease medical errors, and broaden access to essential services. While targeted funding increases in recent years have moved AHRQ in the right direction, more core funding is needed to help AHRQ fulfill its mission. We support the request of the Friends of AHRQ which recommends an fiscal year 2010 base funding level of $405 million, an increase of $32 million over the fiscal year 2009 level. This increase will preserve AHRQ's current initiatives and get the agency on track to a base budget of $500 million by 2013.

IOM's report, Crossing the Quality Chasm: A New Health System for the 21st Century (2001) recommended a much larger investment in AHRQ. It recommended $1 billion a year for AHRQ to "develop strategies, goals, and action plans for achieving substantial improvements in quality in the next 5 years." AHRQ is critical to retooling the American healthcare system.

---

[3] Testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate. Primary Care Professionals: Recent Supply Trends, Projections and Valuation of Services. Statement of A. Bruce Steinwald, Director Health Care, United States Accountability Office. February 12, 2008 GAO–08–472T.

[4] Access Granted: The Primary Care Payoff, August 2007, National Association of Community Health Centers, The Robert Graham Center, Capitol Link (pgs 1–2).

[5] The Family Physician as Economic Stimulus, http://www.graham-center.org/online/graham/home/tools-resources/directors-corner/dc-economic-stimulus.html.

One of the hallmarks of the Patient-Centered Medical Home is evidence-based medicine. Comparative effectiveness clinical research, compares the impact of different options for treating a given medical condition, and is vital to improving the quality of healthcare. Studies comparing various treatments (e.g., competing drugs) or differing approaches (e.g., surgery vs. drug therapy) can inform clinical decisions by analyzing not only costs, but the relative medical benefits and risks for particular patient populations.

NIH

Historically, the NIH has placed little emphasis on the research questions asked by primary care physicians and in primary care settings. We have been encouraged by the development of the NIH Roadmap and the Clinical and Translational Science Awards (CTSA), along with the establishment, in statute, of a funding stream that would make NIH more relevant to where most people receive care. We support an increase in NIH funding. In addition, we would like to see some report language that would help NIH ensure that the promise of "bench to bedside" research truly becomes "bench to bedside to community"—and community to bedside to bench.

We support the inclusion of the following language in the report to accompany the Labor, Health and Human Services, and Education, and Related Agencies appropriations bills for fiscal year 2010:

"Translational Research has been identified by the former Director of the National Institutes of Health (NIH) as a road map initiative. The committee supports this effort and encourages NIH to integrate such research as a permanent component of the research portfolio of each institute and center. The committee urges NIH to work with the primary care community to determine how best to facilitate progress in translating existing research findings and to disseminate and integrate research findings into community practice. Translational research should also include the discovery and application of knowledge within the practice setting using such laboratories as practice-based research networks. This research spans biological systems, patients, and communities, and arises from questions of importance to patients and their physicians, particularly those practicing primary care. The committee requests that the Director of NIH include a progress update in next year's Budget Justification."

CONCLUSION

As the United States moves toward major healthcare reform, we urge the subcommittee to support programs needed to ensure the proper supply of primary care physicians and the type of research that will work together to improve healthcare outcomes, enhance equity in care, and lower healthcare costs. We support increases in these three important programs: health professions primary care medicine and dentistry training, AHRQ, and NIH.

PREPARED STATEMENT OF THE STATE AND TERRITORIAL INJURY PREVENTION DIRECTORS ASSOCIATION

Thank you for the opportunity to offer written testimony to the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education and Related Agencies regarding the critical need for investments in State and territorial injury and violence prevention programs. It is well-recognized that injury and violence are a significant public health problem in terms of risk and costs to society. Injuries are the leading cause of death among persons 1–44 years of age, and a major cause of death, disability, and hospitalization for all age group. There are more than 170,000 injury-related deaths each year in the United States and approximately 30 million people seek emergency treatment as a result of injuries and violence annually.[1] Injury is the most common cause of premature deaths before age 65, accounting for 30 percent of years of potential life lost. In 2004, 1 in 14 deaths was caused by an injury, including 3 out of 4 deaths for adolescents and young adults.[2]

---

[1] National Center for Health Statistics. (2005). Deaths, Leading Causes. Center for Disease Control and Prevention. Retrieved December 2, 2008 from http://www.cdc.gov/nchs/FASTATS/lcod.htm.

[2] Injury in the United States: 2007 Chartbook.. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. March 2008.

In 2000 alone, Americans suffered injuries resulting in more than $117 billion in medical costs and an estimated $289 billion in productivity losses, approximately 10 percent of total U.S. medical expenditures.[3] Long-term disabilities from brain, spinal cord, and burn injuries, and fall-related hip fractures, frequently result in high costs for continued, long-term care. Additionally injuries, especially fractures, for persons age 65 and older make up a substantial proportion of Medicare expenditures. As the U.S. population continues to age, this problem will be an even more significant burden on the Medicare system.

Despite the enormous toll of injury and violence, dedicated and ongoing Federal or State funding to respond to these problems does not exist as it does for other major public health priorities. State governments have a responsibility to protect the public's health and safety. A comprehensive injury and violence prevention program at the State health department provides focus and direction, coordinates and finds common ground among the many prevention partners, and makes the best use of limited injury and violence prevention resources. State public health injury and violence prevention programs apply the public health approach to help understand, predict and prevent injuries and use a population-based approach to extend the benefits of prevention beyond individuals.

State and Territorial Injury Prevention Directors Association (STIPDA) believes that all State and territorial health departments in the United States must have a comprehensive injury surveillance and prevention programs. These programs must be adequately staffed and funded commensurate with the magnitude of the burden of injury and violence in each State. They must have programs and expertise to address the leading causes of unintentional and violent injuries; and have disaster and terrorism epidemiology and injury mitigation programs. State public health departments bring significant leadership to reduce injuries and injury-related healthcare costs by:

—Informing the development of public policies through data and evaluation.
—Designing, implementing, and evaluating injury and violence prevention programs in cooperation with other agencies and organizations.
—Collaborating with partners in healthcare and the community.
—Collecting and analyzing injury and violence data from a variety of sources to identify high-risk groups and geographic locations.
—Providing technical support and training to injury prevention partners.

State injury and violence prevention programs use surveillance data to determine how injuries occur, who is most at risk, and what other factors contribute to whether or not an individual will be injured and to what degree. State programs have come a long way in understanding of how to prevent injuries and look beyond just the personal behaviors that lead to an injury. They also investigate the products that people use, the physical and social environment, and how organizational and governmental policies affect the safety of our environments.

State programs have also contributed to the dissemination of effective practices through partnerships with injury control research centers, local health departments, local coalitions and other organizations. To ensure the widespread adoption of these interventions, State programs provide training and technical assistance to local injury prevention efforts every day and often financial and in-kind support, as well as implement interventions.

The following are some examples of how State public health departments have contributed to the declines we have seen in deaths due to injuries in this country:

—Washington State's Injury and Violence Prevention Program has seen a decline in youth suicide while the U.S. rates have remained static. Washington found that on average 2 young people were dying of suicide per week with another 16 attempts that required hospitalization. The program estimated that a 50 percent reduction in youth suicidal behavior would result in $12 million in healthcare savings alone. The program implemented a comprehensive prevention program including gatekeeper training, public awareness and strengthening community safety nets for youth.
—The Georgia State Injury and Violence Prevention Program have been able to document at least 56 lives potentially saved through a unique partnership with Emergency Medical Services since 2006 through a child safety seat education and distribution program for low-income families in 109 of 169 counties throughout the State.
—The New York Injury and Violence Prevention Program was able to document reductions in bicycle-related injuries and traumatic brain injuries following the

[3] Zaloshnja, E., Miller, T. R., Lawrence, B. A., & Romano, E. (2005). The costs of unintentional home injuries. *Am J Prev Med*, 28: 88–94.

implementation of a statewide comprehensive bicycle helmet program that culminated in a bicycle helmet law passing easily through the State legislature.

—The Oklahoma Injury Prevention Service was able to identify a high-risk area in Oklahoma City for house-related fire injuries. In response, they conducted a smoke alarm distribution program. After the program, Oklahoma saw an 81 percent decline in residential fire injury-related deaths in the target population while rates declined only 7 percent in the rest of Oklahoma during the same time period.

—After finding that its drowning rate was ten times the national average, Alaska's Department of Health and Human Services formed a unique partnership with the U.S. Coast Guard, State Office of Boating Safety, Alaska Safe Kids to develop the "Kids Don't Float" program. Following extensive analysis of the problem, the coalition found that 90 percent of fatality victims were not wearing a life jacket (personal flotation device), more than half occurred in lakes and rivers, and that children younger than 18 make up a significant proportion of the victims. The program consists of adult and youth education (including peer-to-peer education for teens) and a life jacket loaner program. At least 5 documented lives have been saved through this program that is now implemented in 200 locations throughout the State.

—California's Epidemiology and Prevention for Injury Control Branch-funded and -evaluated a statewide social marketing campaign designed to engage high school age males as allies in preventing sexual violence through a message "My Strength is Not for Hurting." Through media efforts and "Men of Strength (MOST)" clubs in six pilot sites, California found that campaign appear promising, particularly when it involves MOST clubs, for favorably influencing high-school age males towards more respectful attitudes and affecting a healthier social climate in high schools.

When evidence-based injury prevention strategies are implemented, the estimated return on investment is substantial. For instance, home visitation programs have been demonstrated to be particularly effective in reducing child abuse and injury, and provide a cost savings of nearly $2.88 to $5.70 per $1 spent. Other proven cost-effective injury prevention strategies include:

Intervention	Cost per unit	Total benefits to society [1]
Booster seat	$31/seat	$2,200
Child bicycle helmet	$11/helmet	$570
Motorcycle helmets	$240/helmet	$4,300
Sobriety checkpoints	$9,600/checkpoint	$73,000
Midnight curfew and provisional licensing for teen drivers	$74/driver	$600
Smoke alarm purchases	$33/smoke alarm	$940
Fall prevention for high-risk elderly	$1,250/person	$10,800
Youth suicide prevention, native american	$175/youth	$6,700

[1] The total benefit to society is defined as the amount injury prevention interventions saved by preventing injuries, including medical costs, other resource costs (police, fire services, property damages, etc.), work loss, and quality of life costs. These benefits are calculated in 2004 dollars.

Currently, the National Center for Injury Prevention and Control (NCIPC)provides very minimal funding to 30 States through the Public Health Injury Surveillance and Prevention Program (PHISPP). According to STIPDA's 2007 State of the States survey, States with PHISPP funding were more likely to have a centralized program, a full-time director, and greater access to key injury data sets. They were also more likely to provide support to local injury efforts and provide surveillance data and technical assistance to inform public policy related to injury and violence. States with PHISPP funding are well-positioned to leverage additional resources, implement interventions for major injury issues, evaluate interventions, gain political support for specific injury topics, and raise awareness of injury trends.

We are asking the Senate to provide an additional $10 million to the NCIPC at the Centers for Disease Control and Prevention to supplement current investments for State injury and violence prevention programs. This funding would allow for:

—Expansion and stabilization of resources for State injury and violence prevention programs;

—Strengthening the ability of States to improve the collection and analysis of injury data, build coalitions and establish partnerships to promote programs and policies; and

—Disseminating proven injury and violence prevention strategies, with a focus on persons at highest risk.

Preventable injuries exact a heavy burden on Americans through premature deaths and disabilities, pain and suffering, healthcare costs, rehabilitation costs, disruption of quality of life for families and disruption of productive for employers. Strengthening the investments made to public health injury and violence prevention programs is a critical step to keep Americans safe and productive for the 21st century.

ABOUT STIPDA

Formed in 1992, STIPDA, is the only organization that represents public health injury prevention professionals in the United States. STIPDA has a membership of more than 300 professionals committed to strengthening the ability of State, territorial, and local health departments to reduce death and disability associated with injuries and violence. STIPDA engages in activities to increase awareness of injury, including violence, as a public health problem and works to enhance the capacity of public health agencies to conduct injuries and violence prevention.

PREPARED STATEMENT OF THE SOCIETY FOR WOMEN'S HEALTH RESEARCH AND THE WOMEN'S HEALTH RESEARCH COALITION

On the behalf of the Society for Women's Health Research and the Women's Health Research Coalition, we are pleased to submit the following testimony in support of Federal funding of biomedical research, and in particular women's health research.

The Society for Women's Health Research is the Nation's only nonprofit organization whose mission is to improve the health of all women through advocacy, research, and education. Founded in 1990, the Society brought to national attention the need for the appropriate inclusion of women in major medical research studies and the need for more information about conditions affecting women exclusively, disproportionately, or differently than men. The Society advocates increased funding for research on women's health; encourages the study of sex differences that may affect the prevention, diagnosis and treatment of disease; promotes the inclusion of women in medical research studies; and informs women, providers, policy makers and media about contemporary women's health issues. In 1999, the Women's Health Research Coalition was created by the Society as a grassroots advocacy effort consisting of scientists, researchers, and clinicians from across the country that are concerned and committed to improving women's health research.

The Society and Coalition are committed to advancing the health of women through the discovery of new and useful scientific knowledge. We believe that sustained funding for biomedical and women's health research programs conducted and supported across the Federal agencies are absolutely essential if we are to meet the health needs of the population and advance the Nation's research capability.

NATIONAL INSTITUTES OF HEALTH (NIH)

Congressional investment and support for NIH continues to make the United States the world leader in biomedical research and has provided a direct and significant impact on women's health research and the careers of women scientists over the last decade. Great strides and advancements were made through the doubling of the NIH budget from $13.7 billion in 1998 to $27 billion in 2003, though the momentum driving new research in recent years was eroded under budgetary constraints. The 111th Congress saw the importance of increasing funds to NIH in the fiscal year 2009 omnibus bill providing the NIH with $30.317 billion, $937.5 million over fiscal year 2008, (a 3.2 percent increase.) Thankfully, Congress also sought fit to include the NIH in the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) (ARRA) providing it with an infusion of short-term funding of $10.4 billion. This funding will have and is having an enormous impact on research and research facilities throughout the United States, creating new jobs, new innovations and improved technologies.

Without a robust budget, NIH has shown that it is forced to reduce the number of grants it is able to fund. The number of new grants funded by NIH has dropped steadily since fiscal year 2003 and this trend must stop. This shrinking pool of available grants has a significant impact on scientists who depend upon NIH support to cover their salaries and laboratory expenses to conduct high-quality biomedical research. Failure to obtain a grant results in reduced likelihood of achieving tenure. This means that new and less established researchers are forced to consider other careers, the end result being the loss of the critical workforce so desperately needed to sustain America's cutting edge in biomedical research.

In order to continue the momentum of scientific advancement and expedite the translation of research findings from the laboratory to the patients who depend on these advances for improved health and welfare, the Society proposes a 10 percent increase more than fiscal year 2009, and establishing a goal of reaching an annual appropriation of $40 billion in the next 3 years. In addition, we request that Congress strongly encourage the NIH to utilize ARRA funding as well as appropriated dollars to assure that women's health research receives resources sufficient to meet the health needs of all women. Further, the Society recommends that NIH support the advances being discovered in sex-based biology research.

Scientists have long known of the anatomical differences between men and women, but only within the past decade have they begun to uncover significant biological and physiological differences. Sex-based biology, the study of biological and physiological differences between men and women, has revolutionized the way that the scientific community views the sexes.

Sex differences play an important role in disease susceptibility, prevalence, time of onset and severity and are evident in cancer, obesity, heart disease, immune dysfunction, mental health disorders, and many other illnesses. It is imperative that research addressing these important differences between males and females be supported and encouraged. Congress clearly recognizes these important sex differences and NIH should as well.

OFFICE OF RESEARCH ON WOMEN'S HEALTH (ORWH)

The NIH ORWH has a fundamental role in coordinating women's health research at NIH, advising the NIH Director on matters relating to research on women's health and sex and gender research; strengthening and enhancing research related to diseases, disorders, and conditions that affect women; working to ensure that women are appropriately represented in research studies supported by NIH; and developing opportunities for and support of recruitment, retention, re-entry, and advancement of women in biomedical careers. ORWH is currently implementing recommendations from the NIH working Group on Women in Biomedical Careers to maximize the potential of women biomedical scientists and engineers in both the NIH and extramural community.

Two highly successful programs supported by ORWH that are critical to furthering the advancement of women's health research are Building Interdisciplinary Research Careers in Women's Health (BIRCWH) and Specialized Centers of Research on Sex and Gender Factors Affecting Women's Health (SCOR). These programs benefit the health of both women and men through sex and gender research, interdisciplinary scientific collaboration, and provide tremendously important support for young investigators in a mentored environment.

The BIRCWH program is an innovative, trans-NIH career development program that provides protected research time for junior faculty by pairing them with senior investigators in an interdisciplinary mentored environment. It is expected that each scholar's BIRCWH experience will culminate in the development of an established independent researcher in women's health. The BIRCWH program has released four RFAs (1999, 2001, 2004, and 2006). Since 2000, 335 scholars have been trained (76 percent women) in the 24 centers resulting in more than 1,300 publications, 750 abstracts, 200 NIH grants and 85 awards from industry and institutional sources. Each BIRCWH receives approximately $500,000 a year, most of which comes from the ORWH budget but is also supported by many NIH Institutes and Centers.

The SCOR program was developed by ORWH in 2002. SCORs are designed to increase the transfer of basic research findings into clinical practice by housing laboratory and clinical studies under one roof. The eleven SCOR programs are conducting interdisciplinary research focused on major medical problems affecting women and comparing gender differences to health and disease. Each SCOR works hard to transfer their basic research findings into the clinical practice setting. In 2007, seven SCORS competed successfully for renewal and four new SCORS were added. In 2008, the 11 SCORs report publishing 113 journal articles, 144 abstracts, and 30 other publications. Each program costs approximately $1 million per year and results in research that would not have taken place without this program.

Advancing Novel Science in Women's Health Research (ANSWHR) was created by ORWH in 2007 and funding starting in July 2008 to promote innovative new concepts and interdisciplinary research in women's health research and sex/gender differences. This program has had broad appeal and is evolving into an important scientific tool for both early-stage investigators and veteran researchers to test nascent scientific concepts relevant to women's health research and the study of sex and gender differences. Researchers can apply for support to promote innovative, interdisciplinary research to answer unresolved questions and expand the knowledge

base in a host of areas relevant to women's health research. In fiscal year 2009, 13 ICs have one or more applications that have been scientifically reviewed and are considered competitive for funding. These applications, and the fiscal year 2008 awards, represent a wide range of scientific areas as well as junior investigators and experienced researchers. ANSWHR serves as a way for interested researchers to compete for funding that is expanding the scientific basis for women's health research and the study of sex and gender differences.

ORWH also has the Research Enhancement Awards Program (REAP) to support meritorious research on women's health that just missed the IC pay line and a Partnership with the National Library of medicine to identify overarching themes, specific health topics, and research initiatives into women's health.

ORWH, through successful collaboration with the NIH ICs provides research funding for: breast cancer pharmacogenomics, HPV vaccines, uterine leiomyoma, vulvodynia, irritable bowel syndrome, stroke, substance abuse, eating disorders including obesity, menopause, microbicides, chronic pain syndromes, autoimmune disorders, muscular skeletal disorders, and health disparities among many other issues.

Despite all of ORWH's advancements of women's health research and its innovative programs to advance women scientists, the office has seen its budget flat lined at $40.9 million for fiscal year 2008 and 2009 after having also received a cut of $249,000 in fiscal year 2006 and no additional funding in fiscal year 2007. Flat funding is the same as receiving a decrease in budget and must not continue to happen. In order for ORWH's programs and research grants to thrive Congress must direct that NIH to continue its support of ORWH and provide it with $2 million budget increase.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Under the HHS several agencies have Federal offices on women's health, in addition to ORWH described above. Agencies with offices, advisors, or coordinators for women's health or women's health research are HHS, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Agency for Healthcare Quality and Research (AHQR), the Indian Health Service, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services. It is imperative that these offices are funded at levels adequate for them to perform their assigned missions. We ask that the Committee Report clarify that Congress supports the permanent existence of these various Federal women's health offices and recommends that they are appropriately funded to ensure that their programs can continue and be strengthened in the coming fiscal year.

HHS OFFICE OF WOMEN'S HEALTH

The HHS Office of Women's Health (OWH) is the Government's champion and focal point for women's health issues. It works to redress inequities in research, healthcare services, and education that have historically placed the health of women at risk. The OWH coordinates women's health efforts in HHS to eliminate disparities in health status and supports culturally sensitive educational programs that encourage women to take personal responsibility for their own health and wellness. OWH has a central role in communicating the appropriate messages to patients and healthcare providers, helping to move forward recent research discoveries. Without OWH's actions the task of translating research into practice would and will be only more difficult and delayed.

Over the years OWH has been active in various efforts such as: joining with NIH to launch the "The Heart Truth" campaign, a prevention and awareness campaign concerning heart disease and women; leading a series of Women's Heart Health Fairs nationwide; partnering with the Lupus Foundation of America and the Advertising Council to launch a new lupus public awareness campaign targeted toward young minority women of childbearing age who are at most risk for developing the disease to identify early warning signs.

OWH created a new training program "Body Works" for parents and caregivers designed to improve family eating and activity habits and is available in both English and Spanish. They collaborated with other organizations to lead a conference on "Charting New Frontiers in Rural Women's Health," as well as hosting the third Minority Women's Health Summit to address the unique health issues many women of color experience. In addition, OWH has continued its efforts to improve the health of young women by providing information on their Web site to address eating disorders and HIV/AIDS prevention for adolescent girls, in conjunction with conducting their HIV/AIDS National Awareness Day. Further, OWH is leading

efforts to improve breastfeeding information available to women of all cultures by offering multilingual Web sites and help-lines.

This year marks the 10th anniversary of the launch of the womenshealth.gov Web site and care center and National Women's Health Week. As part of the annual celebration, OWH is sponsoring many events with communities, businesses and other governmental and health organizations to educate women on how they can improve their physical and mental health. Further, this year OWH is celebrating the publication of "The Healthy Women" a book with wonderful health information and tips for women of all ages.

It is only through continued and increased funding that the OWH will be able to achieve its goals. While the budget for fiscal year 2008 increased the OWH budget by $2 million to a total of $30 million, its budget was flat lined for fiscal year 2009. This is, in essence, a decrease due to inflation. Considering the amount and impact of women's health programs from OWH, we urge Congress to provide an increase of $2 million for the HHS OWH for fiscal year 2010.

AHQR

AHQR is the lead public health service agency focused on healthcare quality, including coordination of all Federal quality improvement efforts and health services research. AHRQ's work serves as a catalyst for change by promoting the results of research findings and incorporating those findings into improvements in the delivery and financing of healthcare. This important information provided by AHRQ is brought to the attention of policymakers, healthcare providers, and consumers all of whom make a difference in the quality of healthcare women receive. Through AHRQ's research projects and findings, lives have been saved and underserved populations have been treated. For example, women treated in emergency rooms are less likely to receive life-saving medication for a heart attack. AHRQ funded the development of two software tools, now standard features on hospital electrocardiograph machines, which have improved diagnostic accuracy and dramatically increased the timely use of "clot-dissolving" medications in women having heart attacks.

While AHRQ has made great strides in women's health research, its budget has been dismally funded for years though targeted funding increases in recent years for dedicated projects are moving AHRQ in the right direction. However, more core funding is needed to help AHRQ fulfill its mission. AHRQ's budget for fiscal year 2009 was $372 million. This must change for fiscal year 2010. The Society recognizes that AHRQ received a dramatic boost under ARRA of $400 million of dedicated stimulus funding for the comparative effectiveness project this amount does not add to AHRQ's base numbers. This Agency has been operating under a major shortfall for years. Decreased funding seriously jeopardizes the research and quality improvement programs that Congress mandates from AHRQ.

We recommend Congress fund AHRQ at $405 million for fiscal year 2010, an increase of $32 million more than the fiscal year 2009 level. This will ensure that adequate resources are available for high-priority research, including women's healthcare, sex and gender-based analyses, Medicare, and health disparities.

In conclusion, Mr. Chairman, we thank you and this subcommittee for its strong record of support for medical and health services research and its unwavering commitment to the health of the Nation through its support of peer-reviewed research. We look forward to continuing to work with you to build a healthier future for all Americans.

PREPARED STATEMENT OF THE TRUST FOR AMERICA'S HEALTH

My name is Jeff Levi, and I am Executive Director of Trust for America's Health (TFAH), a nonprofit, nonpartisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. I am grateful for the opportunity to submit testimony to the subcommittee about public health appropriations.

Americans deserve a well-financed, modern, and accountable public health system. Funding for public health and disease prevention is a down payment toward reducing healthcare costs over the long term. As you craft the fiscal year 2010 Labor, Health and Human Services, and Education, and Related Agencies appropriations bill, I hope that you will include robust funding for prevention and preparedness programs at the Centers for Disease Control and Prevention (CDC) and the Office of the Assistant Secretary for Preparedness and Response (ASPR) in order to promote health and help protect Americans from natural and manmade threats and disasters.

CASE FOR SUPPORT

There is increasing evidence that community level interventions, the kind of programs that CDC funding supports, make a difference in health outcomes and costs. In 2008, TFAH released a report, Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities, which examines how much the country could save by strategically investing in community-based disease prevention programs. The report concludes that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than $16 billion annually within 5 years. This is a return of $5.60 for every $1 spent. The findings are based on a model developed by researchers at the Urban Institute and a review of evidence-based studies conducted by the New York Academy of Medicine. The evidence shows that implementing these programs in communities reduces rates of type 2 diabetes and high blood pressure by 5 percent within 2 years; reduces heart disease, kidney disease, and stroke by 5 percent within 5 years; and reduces some forms of cancer, arthritis, and chronic obstructive pulmonary disease by 2.5 percent within 10 to 20 years, which, can save money through reduced health care costs to Medicare, Medicaid and private payers.

CHRONIC DISEASES

Chronic diseases, most of which are preventable, account for 70 percent of deaths in the United States and approximately 75 percent of healthcare spending. CDC's Division of Nutrition, Physical Activity, and Obesity (DNPAO) provides funding to States to create, implement, and monitor a nutrition, physical activity, and obesity State plan. In the previous grant cycle, 28 grantees were supported, but CDC is only able to award funds to 25 States in fiscal year 2009. The Division of Adolescent and School Health's (DASH) Coordinated School Health Program assists States in improving the health of children through a program that engages families and communities and develops healthy school environments. The President's fiscal year 2010 budget proposes to increase funding for DASH by $5 million to fund 10 additional State educational agencies to assist them in meeting the needs of their K–12 children. TFAH strongly supports this request. In the coming years, we will ultimately need chronic disease prevention and promotion programs in all 50 States. That will require $90 million for DNPAO to fund all approved States at the level at which they applied for funds and at least an additional $20 million for DASH's School Health program to fund all States that have been approved.

Another important anti-obesity program is the Healthy Communities Program. Healthy Communities grants support communities, cities, States, and tribal entities to implement health promotion programs and community initiatives. TFAH supports at least $30 million for the Healthy Communities Program. Yet, funding for this program has decreased dramatically over recent years, from $43 million in fiscal year 2007 to $22.7 million in the fiscal year 2009 omnibus appropriations bill. We support restoration of Healthy Communities funding because action at the local level is essential if we are to begin to mitigate the obesity epidemic.

PREPARING FOR PUBLIC HEALTH EMERGENCIES

In December of last year, TFAH released its annual "Ready or Not" report on the Nation's preparedness for a catastrophic event. Unfortunately, there are many areas where the United States remains underprepared. Funding for the Public Health Emergency Preparedness Cooperative Agreements to States and localities—where public health actually happens—has been cut in recent years. With these funds, local health departments have enhanced their disease surveillance systems and trained their staff in emergency response, including the recent H1N1 outbreak. More than 90 percent of local health departments have developed mass vaccination and prophylaxis planning, conducted all-hazards preparedness training, and implemented new or improved communication systems. All States have established the infrastructure necessary to evaluate urgent disease reports and to activate emergency response operations 24 hours a day. Yet despite this progress, challenges remain. In its 2008 progress report, CDC noted that 31 State public laboratories reported difficulty recruiting qualified laboratory scientists, and no State public health laboratory can rapidly identify priority radioactive materials in clinical samples. To continue our commitment to emergency preparedness, sustainable funding is necessary. TFAH recommends $1 billion for upgrading State and local capacity, an increase of $253 million more than the fiscal year 2009 level. We also recommend $596 million for ASPR's Hospital Preparedness Program, an increase of $208 million over the fiscal year 2009 level, to improve the capacity of our hospitals and other

supporting healthcare entities to respond to bioterrorist attacks, infectious disease epidemics, and other large-scale emergencies by enabling hospitals, EMS, and health centers to plan a coordinated response. To begin to build toward these funding levels, TFAH is very supportive and appreciative of the $14.5 million increase included in the President's budget proposal for upgrading state and local capacity, as well as for the $32 million increase for the Hospital Preparedness Program.

Another important program for our Nation's preparedness is the Biomedical Advanced Research and Development Authority (BARDA). BARDA was established in 2006 to help jumpstart innovation in vaccines, diagnostics, and therapeutics to combat health threats; yet limited funds have prevented BARDA from fulfilling its mission. BARDA provides incentives and guidance for research and development of products to counter bioterrorism and pandemic flu and manages Project BioShield, which includes the procurement and advanced development of medical countermeasures for chemical, biological, radiological, and nuclear agents. The fiscal year 2009 omnibus appropriations bill provided $275 million for BARDA, an increase of approximately $173 million more than fiscal year 2008 levels. TFAH applauds Congress' commitment to BARDA, as well as the President's proposed $30 million increase, but notes that a significant increase in funding would be necessary to support the successful development of medical countermeasures. TFAH requests $500 million for BARDA in fiscal year 2010, with 2 years of fiscal availability, noting that over the next few years, higher funding levels must be allocated and sustained.

BOLSTERING THE NATION'S ABILITY TO DETECT AND CONTROL INFECTIOUS DISEASES SUCH AS PANDEMIC INFLUENZA

In fiscal year 2006, Congress appropriated $5.6 billion to the Department of Health and Human Services (HHS) for emergency and agency funding for pandemic preparedness. The funding has been used for stockpiling enough antiviral drugs for the treatment of more than 50 million Americans, licensing a prepandemic influenza vaccine, developing rapid diagnostics and completing the sequencing of the entire genetic blueprints of 2,250 human and avian influenza viruses. The recent H1N1 influenza outbreak clearly demonstrates the importance of this investment.

TFAH was pleased that the fiscal year 2009 omnibus provided $507 million in no-year funding to be used to build vaccine production capacity, maintain a ready supply of eggs for the production of vaccine, and enable HHS to purchase medical countermeasures for its critical employees and contractors, as well as the Indian Health Service population. We are also appreciative that the House and Senate versions of the supplemental appropriations legislation include significant funding to address the H1N1 outbreak. In light of the challenges that could be posed if H1N1 resurfaces this fall, TFAH urges you to include $350 million for State and local preparedness activities, as proposed by the House, in the final version of the supplemental and to continue support for State and local preparedness through the annual appropriations process. Additionally, TFAH is hopeful that Congress will create a contingency fund to cover the production costs for a potential H1N1 vaccine, should health officials determine that mass production is necessary.

In fiscal year 2010, we urge Congress to fully fund the President's request for pandemic preparedness activities, including $354 million to the Public Health and Social Services Emergency Fund for vaccine, antivirals, ventilators, and countermeasures and personal protective equipment for HHS clinical and patient populations, and $230 million for agency budgets.

ENVIRONMENTAL HEALTH

An additional area of interest for TFAH is the connection between our environment and our health. CDC's Environmental Health Laboratory performs biomonitoring measurements—the direct measurement of people's exposure to toxic substances in the environment. By analyzing blood, urine, and tissues, scientists can measure actual levels of chemicals in people's bodies, and determine which population groups are at high risk for exposure and adverse health effects, assess public health interventions, and monitor exposure trends over time. In fiscal year 2009, the Environmental Health Laboratory was funded at $42.7 million. Additional funds are needed to upgrade facilities and equipment and to bolster the workforce. Of the suggested $19.6 million increase, $10 million would be used extramurally to support State public health laboratory biomonitoring capabilities. An additional $7.6 million would be used for intramural activities, including increasing the number of chemicals CDC measures, providing training and quality assurance for State laboratories; and increasing the number of studies used to assess health effects associated with exposure to environmental chemicals. Additionally, $2 million would support the

National Report on Biochemical Indicators of Diet and Nutrition in the U.S. Population.

TFAH is also concerned about the potential health effects of climate change, including injuries and fatalities related to severe weather events and heat waves; infectious diseases; allergic symptoms; respiratory and cardiovascular disease; and nutritional and water shortages. TFAH was appreciative of the $7.5 million included in the omnibus for a Climate Change Program at CDC. To expand this program, for fiscal year 2010, TFAH recommends $17,500,000 to enable CDC to bolster its climate change staff, conduct climate change research and begin to work with State and local health departments on capacity building for climate change and health preparedness. Ultimately, $50 million is needed to develop a credible and effective Climate Change Program.

Another important program, the National Environmental Health Tracking Network, enhances our understanding of the relationship between environmental exposures and the incidence and distribution of disease. Health tracking, through the integration of environmental and health outcome data, enables public health officials to better target preventive services so that health care providers can offer better care, and the public will be able to develop a clear understanding of what is occurring in their communities and how overall health can be improved. Since 2002, Congress has provided funding for pilot programs in some States and cities. The National Network is launching in 2009. With that in mind, TFAH recommends providing $50 million for CDC's Environmental and Health Outcome Tracking Network, an increase of $19 million more than the fiscal year 2009 level, to expand it to additional States and support the continued development of a sustainable Network.

Finally, TFAH supports the expansion of CDC's Global Disease Detection (GDD) Program. Despite remarkable breakthroughs in medical research and advancements in immunization and treatments, infectious diseases are undergoing a global resurgence that threatens health. Worldwide, infectious diseases are the leading killer of children and adolescents and are one of the leading causes of death for adults. It is estimated that newly emerging and re-emerging infectious diseases will continue to kill at least 170,000 Americans annually. CDC's GDD Program helps recognize infectious disease outbreaks, improve the ability to control and prevent outbreaks, and detect emerging microbial threats. To address the magnitude and urgency of emerging and resurging diseases, TFAH recommends $56 million for the GDD Program, an increase of $22 million over the fiscal year 2009 level. Funding will increase the number of GDD centers across the globe and bring some existing centers to full capacity.

Mr. Chairman, thank you again for the opportunity to submit testimony on the urgent need to enhance Federal funding for public health programs which can save countless lives and protect our communities and our Nation.

PREPARED STATEMENT OF THE TB COALITION

TUBERCULOSIS

The TB Coalition is a network of public health, research, professional, and advocacy organizations working to support policies to eliminate tuberculosis (TB) in the United States and around the world. The TB Coalition is pleased to submit our recommendations for programs in the Labor, Health and Human Services, and Education, and Related Agencies Subcommittee purview. The TB Coalition, in collaboration with Stop TB USA, recommends a funding level of $210 million in fiscal year 2010 for CDC's Division of TB Elimination, as authorized under the Comprehensive TB Elimination Act.

TUBERCULOSIS

Tuberculosis (TB) is an airborne infection caused by a bacterium, Mycobacterium tuberculosis. TB primarily affects the lungs but can also affect other parts of the body, such as the brain, kidneys or spine. TB is the second leading global infectious disease killer, claiming 1.8 million lives each year. Currently, about a one-third of the world's population is infected with the TB bacterium. It is estimated that 9–14 million Americans have latent TB. Tuberculosis is the leading cause of death for people with HIV/AIDS in the developing world. According to a 2009 World Health Organization (WHO) report on global TB control, about 5 percent of all new TB cases are drug resistant. The global TB pandemic and spread of drug resistant TB present a persistent public health threat to the United States.

The major factors that have caused the spread of drug resistant TB—including multi-drug resistant TB (MDR) and extensively drug resistant (XDR) TB—are inadequate attention to and funding for basic TB control measures in high TB burden; resource-limited settings, which also have high HIV prevalence; as well as the lack of investment in new drugs, diagnostics and vaccines for TB. While most TB prevalent today is a preventable and curable disease when international prevention and treatment guidelines are used, many parts of the world—such as Africa and Eastern Europe—are struggling to implement them, giving rise to more drug resistant TB and increasingly, XDR–TB.

XDR–TB AS A GLOBAL HEALTH CRISIS

XDR–TB has been identified in all regions of the world, including the United States. The strain is resistant to two main first-line drugs and to at least 2 of the 6 classes of second-line drugs. Because it is resistant to many of the drugs used to treat TB, XDR–TB treatment is severely limited and the strain has an extremely high-fatality rate. In an outbreak in the Kwazulu-Natal province of South Africa from late 2005 through early 2006, XDR TB killed 52 out of 53 infected HIV-infected patients within just 3 weeks of diagnosis. According to the CDC, there have been 83 cases of XDR–TB in the United States between 1998 and 2008. While the treatment success rate for XDR–TB in the United States is about 64 percent, the extremely high costs of treating XDR–TB, coupled with high fatality rates associated with the strain make XDR–TB a significant public health concern for the United States.

NEW TB TOOLS NEEDED

Although drugs, diagnostics, and vaccines for TB exist, these technologies are antiquated and are increasingly inadequate for controlling the global epidemic. The most commonly used TB diagnostic in the world, sputum microscopy, is more than 100 years old and lacks sensitivity to detect TB in most HIV/AIDS patients and in children. Skin tests used in the United States are more effective at detecting TB, but take up to 3 days to complete. Current diagnostic tests to detect drug resistance take at least 1 month to complete. Faster drug susceptibility tests must be developed to stop the spread of drug resistant TB. The TB vaccine, BCG, provides some protection to children, but it has little or no efficacy in preventing pulmonary TB in adults.

There is an urgent need for new anti-TB treatments, and particularly for a shorter drug regimen. Currently, the drug regime for TB treatment is 6–9 months. A shorter drug regimen with new classes of drugs active against susceptible and drug-resistant strains would increase compliance, prevent development of more extensive drug resistance, and save program costs by reducing the time required to directly observe therapy for patients. There is also a critical need for drugs that can safely be taken concurrently with antiretroviral therapy for HIV. The good news is that new drugs in development hold the promise of shortening treatment from 6–9 months to 2–4 months.

TB IN THE UNITED STATES

Although the numbers of TB cases in the United States continue to decline, with 12,898 new cases reported in 2008, progress towards TB elimination has slowed. The average annual percentage decline in the TB rate slowed from 7.3 percent per year during 1993–2000 to 3.8 percent during 2000–2008. Foreign-born and ethnic minorities bear a disproportionate burden of U.S. TB cases. The proportion of TB cases in foreign-born people has increased steadily in the last decade, from 27 percent of all cases in 1992 to 58 percent of all cases in 2008. Border States and States with high immigration levels such as California, Texas, and New York are among the highest-burdened TB States. U.S.-born blacks make up almost half (45percent) of all TB cases among U.S.-born persons.

In the 1970s and early 1980s, the United States began significantly reducing the TB control infrastructure. Consequently, the trend towards TB elimination was reversed and the Nation experienced an unprecedented resurgence of TB, including many MDR–TB cases. There was a 20 percent increase in cases reported between 1985 and 1992. In just one city, New York City, the cost to regain control of TB was more than $1 billion. The 2000 Institute of Medicine (IOM) report, Ending Neglect: the Elimination of Tuberculosis in the United States, found that the resurgence of TB in the United States between 1985 and 1992 was due in large part to funding reductions and concluded that with proper funding, organization of prevention and control activities, and research and development of new tools, TB could be eliminated as a public health problem in the United States.

Drug-resistant TB poses a particular challenge to domestic TB control, owing to the high costs of treatment and intensive healthcare resources required. Treatment costs for multidrug-resistant (MDR) TB range from $100,000 to $300,000, which can cause a significant strain on State public health budgets. Inpatient care has been estimated for California XDR TB patients from 1993–2006 at an average of approximately $600,000 per patient.

STRONG STATE AND LOCAL TB CONTROL PROGRAMS

The best defense against the development of drug-resistant tuberculosis is a strong network of State and local public health programs and laboratories. State, local, and territorial health departments provide important TB control services such as directly observed therapy (DOT, a proven method to improve adherence and thus prevent drug resistance), laboratory support, surveillance, contact tracing, and patient counseling. CDC provides about $100 million annually in support to State, local and territorial health departments to prevent and control TB.

According to the National Tuberculosis Controller's Association, for every confirmed case of TB, State and local health department must identify and test an estimated 14 persons who may have been exposed. Yet after almost a decade of stagnant funding, many State TB programs have been left seriously under-resourced at a time when TB cases are growing more complex to diagnose and treat. The higher percentage of foreign-born TB patients adds to the need for specially trained TB professionals. According to a recent assessment by CDC's Division of TB Elimination, more than 1,077 jobs have been lost in State TB control programs over the last 3 years—ranging from doctors and nurses to lab personnel and outreach workers.

Despite low rates, persistent challenges to TB control in the United States remain. Specifically: (1) racial and ethnic minorities continue to suffer from TB more than majority populations; (2) foreign-born persons are adversely impacted; (3) sporadic outbreaks/clusters occur, outstripping local capacity; (4) continued emergence of drug resistance threaten our ability to control TB; and (5) there are critical needs for new tools for rapid and reliable diagnosis, short, safe, and effective treatments, and vaccines.

CONGRESSIONAL RESPONSE TO TB

In recognition of the need to strengthen domestic TB control, the Congress passed the Comprehensive Tuberculosis Elimination Act (CTEA) (Public Law 110–392) in October 2008. This historic legislation was based on the recommendations of the Institute of Medicine and revitalized programs at CDC and the NIH with the goal of putting the United States back on the path to eliminating TB. The new law authorizes an urgently needed reinvestment into new TB diagnostic treatment and prevention tools. The TB Coalition, in collaboration with Stop TB USA, recommends a funding level of $210 million in fiscal year 2010 for CDC's Division of TB Elimination, as authorized under the CTEA. The CTEA, as introduced, included a separate authorization of $100 million through CDC's TB elimination program for the development of urgently needed new TB diagnostic, treatment and prevention tools to ease the global TB pandemic. We hope that this unique area of need will also be considered in the final fiscal year 2010 funding levels.

NATIONAL INSTITUTES OF HEALTH (NIH)

The NIH has a prominent role to play in the elimination of tuberculosis through the development of new tools to fight the disease. However, the Coalition is concerned that the NIH has reduced funding for TB research from $211 million in 2007 to $160 million in 2008. We encourage the NIH to expand efforts, as requested under the Comprehensive TB Elimination Act, to develop new tools to reduce the rising global TB burden, including faster diagnostics that effectively identify TB in all populations, new drugs to shorten the treatment regimen for TB and combat drug resistance, and an effective vaccine.

CONCLUSION

The global TB epidemic endangers TB control efforts in the U.S. TB case rates in the United States reflect the global situation. The best way to prevent the future development of drug-resistant strains of tuberculosis is through establishing and supporting effective global and domestic tuberculosis control programs and research programs through the CDC, NIH, and U.S. Agency for International Development (USAID). The TB Coalition appreciates this opportunity to provide testimony.

PREPARED STATEMENT OF THE TRI-COUNCIL FOR NURSING

The Tri-Council for Nursing, a long-standing alliance focused on leadership and excellence in the nursing profession, is composed of the American Association of Colleges of Nursing (AACN), the American Nurses Association, the American Organization of Nurse Executives, and the National League for Nursing (NLN). The collaborative leadership of these four professional organizations impacts the breadth of nursing practice, including nurse executives, educators, researchers, and nurses providing direct patient care. The Tri-Council asks the subcommittee to provide $263.4 million in fiscal year 2010 for the Nursing Workforce Development Programs under title VIII of the Public Health Service Act, administered by the Health Resources and Services Administration (HRSA).

In light of the economic challenges facing our country today, the Tri-Council urges the subcommittee to focus on the larger context of building the capacity needed to meet the increasing healthcare demands of our Nation's population. Such public policy will require sustained investments aimed at refocusing the current healthcare system toward promoting health, while simultaneously improving value for our dollars. The title VIII Nursing Workforce Development Programs are proven policy instruments that help assure an adequately prepared nursing workforce. These programs—

—Increase access to healthcare in underserved areas through improved composition, diversity, and retention of the nursing workforce;
—Advance quality care by strengthening nursing education and practice; and
—Develop the identification and use of data, program performance measures, and outcomes to make informed decisions on nursing workforce matters.

The Tri-Council applauds the subcommittee for the emergency supplement provided across all the health professions programs via the American Recovery and Reinvestment Act (Public Law 111–5). We also value the enacted fiscal year 2009 Omnibus Appropriations bill (Public Law 111–8) providing $171.031 million specifically for the title VIII Nursing Workforce Development Programs. These investments are a critical component supporting our healthcare infrastructure.

Examining the broad context, the healthcare industry remains the largest industrial complex in the United States. Studies of the Nation's gross domestic product (GDP) show healthcare spending achieving a relatively high rate of real growth, with the portion of GDP devoted to healthcare growing from 8.8 percent in 1980 to 16.2 percent of GDP in 2007. While healthcare spending demands greater efficiencies, it also has helped to sustain our Nation's sagging economy.

Since 2001, healthcare is virtually the only sector that added jobs to the economy on a net basis. In March 2009, the U.S. Bureau of Labor Statistics (BLS) reported continued growth in the healthcare sector, despite our economy's freefall in a down cycle with unemployment reaching 8.1 percent in February 2009. With that month's job loss of 681,000 realized in nearly all major industries, BLS also reported the addition of 27,000 new jobs at hospitals, long-term care facilities, and other ambulatory care settings.

As the predominant occupation in the healthcare industry, the nurse workforce likely is filling most of the noted job openings. Nurses are the front line of healthcare delivery throughout the Nation, and the BLS numbers support that description showing the nurse workforce at well more than four times the size of the medical workforce. Increased fiscal year 2010 investments in title VIII will help counterbalance the economic meltdown threatening nursing programs operating in congressional districts and serving communities by supporting nursing education—providing title VIII loans, scholarships, traineeships, and programmatic funding.

NURSING SHORTAGE OUTPACES CAPACITY BUILDING

The Tri-Council contends that an episodic increased funding of title VIII will not fully fill the gap generated by an 11-year nursing shortage felt throughout the entire U.S. health system and projected to continue. The BLS projections estimate that RNs will have the greatest growth rate of all U.S. occupations in the period spanning 2006–2016, with more than 1 million new and replacement nurses needed by 2016. Despite this projected expansion in the profession, numerous other studies anticipate a growing national nurse workforce shortage to intensify as the baby boomer cohort ages, the current nurse workforce retires, and the demand for healthcare accrues.

Funding levels for the HRSA title VIII Nursing Workforce Programs are failing to support the numerous qualified applicants seeking assistance from these programs. In the last 3 years, virtually flat title VIII funding, along with inflation and increased educational and administrative costs, has decreased purchasing power. According to HRSA statistics, in fiscal year 2006 the title VIII programs directly or

indirectly supported 91,189 nurses and nursing students. In fiscal year 2007, the number of grantees dropped by 21 percent and in 2008 the grantees dropped by 28 percent to support only 51,657 nurses and nursing students.

Additionally, schools of nursing continue to suffer from a growing shortage of faculty, a troubling infrastructure trend that exacerbates the nurse workforce demand-supply gap. According to a study conducted by the AACN in 2008, schools of nursing turned away 49,948 qualified applicants to baccalaureate and graduate nursing programs. The top reasons cited for not accepting these potential students was a lack of qualified nurse faculty and resource constraints. Without faculty, nursing education programs are prevented from admitting many qualified students who are applying to their programs. (Data are Internet accessible at http://www.aacn.nche.edu/Media/NewsReleases/2009/ workforcedata.html.)

The AACN survey results are reinforced by the NLN study of all types of prelicensure RN programs, which prepare students to sit for the RN licensing exam (i.e., baccalaureate, associate, and diploma degree). The NLN statistics indicate more than 1,900 unfilled full-time faculty positions existed nationwide in 2007, affecting more than one-third (36 percent) of all schools of nursing. Significant recruitment challenges were found with 84 percent of nursing schools at-tempting to hire new faculty in 2007–2008, more than three-quarters (79 percent) reporting recruitment as "difficult" and almost 1 in 3 schools found it "very difficult." The two main difficulties cited were "not enough qualified candidates" (cited by 46 percent of schools), followed by inability to offer competitive salaries—cited by 38 percent. (Data are Internet accessible at www.nln.org/research/slides/index.htm.)

THE FUNDING REALITY

If the United States is to reverse the eroding trends in the nurse and nurse faculty workforce, the Nation must make a significant investment in the title VIII programs, which are charged to favor institutions educating nurses for practice in rural and medically underserved communities. At adequate funding levels the title VIII programs supporting the education of registered nurses, advanced practice registered nurses, nurse faculty, and nurse researchers have demonstrated successful intervention strategies to solving past nursing shortages.

A brief examination of the HRSA title VIII illustrates the robust nature of these programs:

Section 811.—The Advanced Education Nursing (AEN) Program funds traineeships for individuals preparing to be nurse practitioners, nurse midwives, nurse administrators, public health nurses, and nurse educators, among other graduate-level education nursing roles. The AEN awards assisted nurse education programs to support 3,419 graduate nursing students in fiscal year 2008.

Section 821.—The Nursing Workforce Diversity Program funds grants and contracts to schools of nursing, nurse-managed health centers (NMCs), academic health centers, State and local governments, and nonprofit entities to increase nursing education opportunities for individuals from disadvantaged backgrounds and under-represented populations among RNs. This program—of proven intervention strategies—supported 18,741 students in fiscal year 2008, seeking to ensure a culturally diverse workforce to provide healthcare for a culturally diverse patient population.

Section 831.—The Nurse Education, Practice and Retention Program provides support for academic and continuing education projects designed to strengthen the nursing workforce. Several of this program's priorities apply to quality patient care including developing cultural competencies among nurses and providing direct support to establishing or expanding NMCs in noninstitutional settings to improve access to primary healthcare in medically underserved communities. The program also provides grants to improve retention of nurses and enhanced patient care. In fiscal year 2008, approximately 6,000 nurses and nursing students were supported.

Section 846.—The Nurse Loan Repayment and Scholarship Programs is divided into two primary elements. The Nursing Education Loan Repayment Program (NELRP) assists individual RNs by re-paying up to 85 percent of their qualified educational loans over 3 years in return for their commitment to work at health facilities with a critical shortage of nurses, such as departments of public health, community health centers, and disproportionate share hospitals. In fiscal year 2008, of the 5,875 applications reviewed by HRSA, only 435 students (7.4 percent) received NELRP awards. Similarly, the Nurse Scholarship Program (NSP) provides financial aid to individual nursing students in return for working a minimum of 2 years in a healthcare facility with a critical nursing shortage. In fiscal year 2008, NSP turned away most of the applicants owing to a lack of adequate funding, resulting in the distribution of only 169 student awards.

Section 846A.—The Nurse Faculty Loan Program (NFLP) supports the establishment and operation of a loan fund within participating schools of nursing to assist RNs to complete their education to become nursing faculty. The NFLP grants provide a cancellation provision in which 85 percent of the loan, plus interest, may be cancelled over 4 years in return for serving as full-time faculty in a school of nursing. NFLP granted 729 awards in fiscal year 2008.

Section 855.—The Comprehensive Geriatric Education Grant Program focuses on training, curriculum development, faculty development, and continuing education for nursing personnel caring for the elderly. In fiscal year 2008, 18 awards were made in this program.

While title VIII is the largest source of Federal funding for nursing, the current level of investment falls short of remedying a chronic underfunding of the Nursing Workforce Development Programs, compared to the existing and imminent shortages these programs address. The title VIII authorities are capable of providing flexible and effective support to assist students, schools of nursing, and health systems in their efforts to recruit, educate, and retain registered nurses. Recent efforts have shown that aggressive and innovative strategies can help avert the nurse and nurse faculty shortages. The Tri-Council for Nursing understands the competing priorities faced by this Congress, but we also maintain that title VIII Nursing Workforce Development Programs must be funded at an adequate level to begin to impact the shortage and to address the complex health needs of the Nation. The contributions of nurses in our healthcare system are multifaceted, and are impacted directly by the level of Federal funding that supports nursing programs.

PREPARED STATEMENT OF THE ENDOCRINE SOCIETY

The Endocrine Society is pleased to submit the following testimony regarding fiscal year 2010 Federal appropriations for biomedical research, with an emphasis on appropriations for the National Institutes of Health (NIH). The Endocrine Society is the world's largest and most active professional organization of endocrinologists representing more than 14,000 members worldwide. Our organization is dedicated to promoting excellence in research, education, and clinical practice in the field of endocrinology. The Society's membership includes thousands of researchers who depend on Federal support for their careers and their scientific advances.

Since the doubling of its budget, the NIH has received annual funding increases below the rate of biomedical inflation. Fiscal year 2009 appropriations resulted in the first real-dollar increase in NIH funding since fiscal year 2003. This decline in useable dollars has resulted in a significant decrease in the number of R01 grants funded. In 2003, the number of new and continuing R01s was 7,211; the number of grants awarded in 2008 dropped to 5,886. As a result of the decreasing number of grants awarded, the success rate for new R01 grants dropped from 25.5 percent in 1999 to a low of 16.3 percent in 2006 (the 2008 success rate was 19 percent). Not only does the decline in grants affect the number of scientists who are able to continue their research and discover new treatments and cures, it also has a significant impact on the U.S. economy.

In fiscal year 2007, every $1 million that the public invested in NIH research generated $2.21 million in new business activity across the Nation. At a recent House Energy and Commerce Committee hearing, Dr. Raynard Kington, Acting Director of the NIH, stated that each NIH grant supports seven jobs on average. Since grants are dispersed to all 50 States and 90 percent of Congressional Districts, increasing funding for science will have a significant positive impact on job growth. And unlike many other proposals to stimulate the economy, funding NIH grants can have an immediate impact on the economy because these grants can be funded in a matter of weeks, stimulating local economies through salaries and purchase of equipment, laboratory supplies, and vendor services.

Members of Congress and President Obama recognized the positive impact that funding NIH research can have on the economy and allocated more than $10 billion to the NIH in the American Recovery and Reinvestment Act of 2009. These funds will go a long way towards increasing the success rate of new R01 applications, keeping scientists employed, and creating new jobs. The Endocrine Society thanks Congress for the support of biomedical research funding in the ARRA.

However, the Federal Government needs to make a long-term, sustainable commitment to biomedical research funding. The money allocated to the NIH in the ARRA is a one-time infusion of money, and it is unclear how much NIH's budget will be when the stimulus funds run out at the end of fiscal year 2010. These funds will create thousands of new jobs, most of which will end when fiscal year 2011 begins if Congress does not bring NIH's budget closer to $40 billion than to $30 billion.

The loss of these jobs could have a drastic effect on our economy and counteract the benefits realized during fiscal year 2009 and 2010 as a result of the stimulus funding.

While the Nation is struggling with a failing economy, health reform is also on the top of the minds of Members of Congress and the American people. With the aging of the Baby Boomer generation, the incidence of costly, chronic conditions will significantly increase, and a large portion of the projected increase in healthcare costs will be as a result of escalating costs associated with diabetes, obesity, hypertension, Alzheimer's disease, muscular dystrophy, cystic fibrosis, and stroke. In order to prevent and treat these diseases, and save the country billions in healthcare costs, significant investment in biomedical research will be needed. For instance, treatments that delay or prevent diabetic retinopathy save the country $1.6 billion a year, and new treatments that delay the onset and progression of Alzheimer's disease by 5 years can save $50 billion a year in healthcare costs.

The Endocrine Society remains deeply concerned about the future of biomedical research in the United States without sustained support from the Federal Government. The Society strongly supports the continued increase in Federal funding for biomedical research in order to provide the additional resources needed to enable American scientists to address the burgeoning scientific opportunities and new health challenges that continue to confront us. The Endocrine Society supports President Obama's campaign pledge to double the NIH budget over 10 years. We therefore recommend that NIH receive an increase of at least 7 percent in fiscal year 2010 to prepare for the poststimulus era and ensure the steady, sustainable growth necessary to complete the President's vision of doubling the investment in basic and clinical research.

PREPARED STATEMENT OF THE MENDED HEARTS, INCORPORATED

I am Robert A. Scott, National Advocacy Chairman for The Mended Hearts, Incorporated, a heart disease support group with more than 300 chapters across the United States and Canada. In 2008, accredited Mended Hearts volunteers visited about 3,000 heart patients in more than 400 hospitals throughout the United States.

As a walking testimony of the benefits of the National Institutes of Health (NIH)-supported heart research, I would like to share my story. In 1998, at age 48, I suffered my first heart attack while playing volleyball. While at Woonsocket, Rhode Island's Landmark Medical Center, doctors diagnosed me as suffering a so-called silent heart attack. I learned that as many as 4 million Americans experience this type of episode—a heart attack with no warning.

After being stabilized, I was transferred to Roger Williams Hospital, in Providence, Rhode Island for a heart catheterization—the gold standard for diagnosis of heart problems. The procedure showed that I had a blockage in my artery that required a stent to open it. Also, it showed that the lower chamber of my heart was damaged, resulting in congestive heart failure that could be controlled with medicine. A stent was inserted in my artery in Rhode Island Hospital.

In 1999, I received another heart catheterization in Miriam Hospital because of the damage to my heart from the silent heart attack. However, this time, I was told that my artery could not be repaired with a stent and that I needed heart bypass surgery the next morning. Calling me a high-risk patient because of my age and my weakened heart, my surgeon encouraged me to find a doctor in Boston because my heart might not start again. However, he assured me that if this happens they had a device that could keep me alive for only 7 hours. Thank goodness, he told me that in Boston they had another device that could keep me alive for 7 months while they located a replacement heart. In less then 10 hours, I went from the possibility of needing another stent, heart bypass surgery, and a heart transplant. My journey with heart disease continued.

My next stop was to visit my local cardiologist in Woonsocket who estimated my survival rate at 20 percent, but he thought I would survive the heart bypass surgery. Thankfully, he was right and I survived heart bypass surgery.

But my journey didn't end there. My congestive heart failure was causing my heart to beat irregularly, so an implantable defibrillator was inserted to control the problem in 2002. However, this device had to be replaced nearly 4 years later. My story continues in 2007 where I started experiencing daily chest pain and shortness of breath. Yet another heart catheterization showed that I needed an additional stent, but this time in Miriam Hospital. After the procedure, the doctor told me the original heart bypass surgery was no longer effective. Although I was scared, my doctors comforted me by explaining that a new medical innovation could save my life-a drug eluting stent. They explained that it could open up the original blockage

from my silent heart attack. My doctor explained that if these state-of-the art stents had been available in 1998, I would not have had to have heart bypass surgery.

Today, heart attack, stroke, and other cardiovascular diseases remain our Nation's most costly and No. 1 killer and a major cause of disability. Thanks to medical research supported by the NIH, I am alive today. I am concerned that NIH continues to invest only 4 percent of its budget on heart research and a mere 1 percent on stroke research when there are so many people in our country just like I am. Enhanced NIH funding dedicated to heart and stroke research will bring us closer to a cure for these often deadly and disabling diseases.

PREPARED STATEMENT OF THE UNITED TRIBES TECHNICAL COLLEGE

For 40 years, United Tribes Technical College (UTTC) has provided postsecondary career and technical education, job training, and family services to some of the most impoverished Indian students from throughout the Nation. We are governed by the five tribes located wholly or in part in North Dakota. We have consistently had excellent results, placing Indian people in good jobs and reducing welfare rolls. The Perkins funds constitute about half of our operating budget and provide for our core instructional programs for many of our Associate of Applied Science degrees. We do not have a tax base or State-appropriated funds on which to rely.

The request of the UTTC Board is for the following authorized programs:

—$8.5 million or $727,000 above the fiscal year 2009 enacted level for section 117 of the Carl Perkins Act. These funds are shared via a formula by UTTC and Navajo Technical College.

—Provision of additional funding for title III and title III–A of the Higher Education Act (HEA) that provide construction funds for facilities at institutions of higher education (title III) and at tribally controlled colleges (title III–A). For example, UTTC needs an additional $10.9 million to complete the construction of a new science and technology building towards which UTTC already has obtained $3 million.

The students who attend UTTC are from Indian reservations from throughout the Nation, with a significant portion of them being from the Great Plains area. Our students come from impoverished backgrounds or broken families. They may be overcoming extremely difficult personal circumstances as single parents. They often lack the resources, both culturally and financially, to go to other mainstream institutions. Through a variety of sources, including funds from section 117 of the Carl Perkins Act, UTTC provides a set of family and culturally based campus services, including: an elementary school for the children of students, housing, day care, a health clinic, a wellness center, several on-campus job programs, student government, counseling, services relating to drug and alcohol abuse and job placement programs. The Carl Perkins funds we receive are essential to our students' success.

Perkins Authorization.—Section 117 of the Carl D. Perkins Career and Technical Education Act (20 U.S.C. section 2327) is the source of authorization of Perkins funding for UTTC. Section 117 is entitled "Tribally Controlled Postsecondary Career and Technical Institutions." First authorized in 1991, Congress has continued this authorization in the subsequent reauthorizations of the Perkins Act. Funding under this act has in recent years been distributed on a formula basis to UTTC and to Navajo Technical College.

Despite the explicit congressional authorization for Carl Perkins funding for section 117, and despite the administration's requests for funding for section 117 in all previous years, the Bush administration requested nothing for this program for fiscal year 2009. We are pleased that Congress recognized the value of UTTC's programs, and instead gave a priority to UTTC and Navajo Technical College by appropriating a $227,000 increase for section 117 Perkins in the recently enacted Omnibus appropriations bill for fiscal year 2009. However, in the process our section 117 program was listed as an earmark, despite the authorization for the appropriated amount. As a continuing, authorized Native American serving program, we should not be considered an earmark.

UTTC Performance Indicators.—UTTC has:

—An 80 percent retention rate.

—A placement rate of 94 percent (job placement and going on to 4-year institutions).

—A projected return on Federal investment of 20 to 1 (2005 study comparing the projected earnings generated over a 28-year period of UTTC associate of applied science and bachelor degree graduates of June 2005 with the cost of educating them).

—The highest level of accreditation. The North Central Association of Colleges and Schools has accredited UTTC again in 2001 for the longest period of time allowable—10 years or until 2011—and with no stipulations. We are also 1 of only 2 tribal colleges accredited to offer accredited on-line (Internet-based) associate degrees.

—More than 20 percent of our graduates go on to 4-year or advanced degree institutions.

We also note the January 13, 2009, report of the Department of Education's Office of Vocational and Adult Education on its recent site visit to UTTC (October 7–9, 2008). While some suggestions for improvements were made, the Department commended UTTC in many areas: for efforts to improve student retention; the commitment to data-driven decisionmaking, including the implementation of the Jenzabar system throughout the institution; the breadth of course offerings; collaboration with 4-year institutions; expansion of online degree programs; unqualified opinions on both financial statements and compliance in all major programs; being qualified as a low-risk grantee; having no reportable conditions and no known questioned costs; clean audits; and use of the proposed measurement definitions in establishing institutional performance goals.

The demand for our services is growing and we are serving more students. For the 2008–2009 year we enrolled 1,023 students (an unduplicated count), nearly four times the number served just 6 years ago. Most of our students are from the Great Plains, where the Indian reservations have a jobless rate of 76 percent (Source: 2003 BIA Labor Force Report), along with increasing populations. These statistics dramatically demonstrate the need for our services at increased levels for at least the next 10 years.

In addition, we are serving 141 students during school year 2008–2009 in our Theodore Jamerson Elementary school and 202 children, birth to 5, are being served in our child development centers.

UTTC course offerings and partnerships with other educational institutions. We offer 17 accredited vocational/technical programs that lead to 17, 2-year degrees (Associate of Applied Science (AAS)) and 11, 1-year certificates, as well as a 4-year degree in elementary education in cooperation with Sinte Gleska University in South Dakota.

Licensed Practical Nursing.—This program has one of the highest enrollments at UTTC and results in the greatest demand for our graduates. Our students have the ability to transfer their UTTC credits to the North Dakota higher educational system to pursue a 4-year nursing degree.

Medical Transcription and Coding Certificate Program.—This program provides training in transcribing medical records into properly coded digital documents. It is offered through the college's Exact Med Training program and is supported by Department of Labor funds.

Tribal Environmental Science.—Our Tribal Environmental Science program is supported by a National Science Foundation Tribal College and Universities Program grant. This 5-year project allows students to obtain a 2-year AAS degree in Tribal Environmental Science.

Community Health/Injury Prevention/Public Health.—Through our Community Health/Injury Prevention Program we are addressing the injury death rate among Indians, which is 2.8 times that of the U.S. population, the leading cause of death among Native Americans ages 1–44, and the third leading cause of death overall. This program has in the past been supported by the Indian Health Service, and is the only degree-granting Injury Prevention program in the Nation. Given the overwhelming health needs of Native Americans, we continue to seek new resources to increase training opportunities for public health professionals.

Online Education.—Our online education courses provide increased opportunities for education by providing web-based courses to American Indians at remote sites as well as to students on our campus. These courses provide needed scheduling flexibility, especially for students with young children. They allow students to access quality, tribally focused education without leaving home or present employment. However, we also note the lack of on-line opportunities for Native Americans in both urban and rural settings, and encourage the Congress to devote more resources in this area.

We offer online fully accredited degree programs in the areas of Early Childhood Education, Community Health/Injury Prevention, Health Information Technology, Nutrition and Food Service and Elementary Education. More than 80 courses are currently offered online, including those in the Medical Transcription and Coding program. We presently have 50 online students in various courses and 137 online students in the Medical Transcription program.

We also provide an online Indian Country Environmental Hazard Assessment program, offered through the Environmental Protection Agency. This is a training course designed to help tribes understand how to mitigate environmental hazards in reservation communities.

Computer Information Technology.—This program is at maximum student capacity because of limitations on resources for computer instruction. In order to keep up with student demand and the latest technology, we need more classrooms, equipment and instructors. We provide all of the Microsoft Systems certifications that translate into higher income earning potential for graduates.

Nutrition and Food Services.—UTTC helps meet the challenge of fighting diabetes and other health problems in Indian Country, such as cancer, through education and research. Indians and Alaska natives have a disproportionately high rate of type 2 diabetes, and have a diabetes mortality rate that is three times higher than the general U.S. population. The increase in diabetes among Indians and Alaska natives is most prevalent among young adults aged 25–34, with a 160 percent increase from 1990–2004. (Source: Fiscal Year 2009 Indian Health Service Budget Justification). Our research about native foods is helping us learn how to reduce the high levels of diseases in our communities.

As a 1994 Tribal Land Grant institution, we offer a Nutrition and Food Services AAS degree in order to increase the number of Indians with expertise in nutrition and dietetics. Currently, there are very few Indian professionals in the country with training in these areas. Our degree places a strong emphasis on diabetes education, traditional food preparation, and food safety. We have also established the United Tribes Diabetes Education Center that assists local tribal communities, our students and staff to decrease the prevalence of diabetes by providing educational programs, training and materials. We publish and make available tribal food guides to our on-campus community and to tribes.

Business Management/Tribal Management.—Another critical program for Indian country is business and tribal management. This program is designed to help tribal leaders be more effective administrators and entrepreneurs. As with all our programs, curriculum is constantly being updated.

Job Training and Economic Development.—UTTC continues to provide economic development opportunities for many tribes. We are a designated Minority Business Development Center serving South and North Dakota. We administer a Workforce Investment Act program and an internship program with private employers in the region.

South Campus Development.—The bulk of our current educational training and student housing is provided in 100-year-old buildings, part of a former military base used by UTTC since its founding in 1969 and donated to us by the United States in 1973. They are expensive to maintain, do not meet modern construction and electrical code requirements, are mostly not ADA compliant, and cannot be retrofitted to be energy efficient.

As a result, UTTC has developed plans for serving more students in new facilities that will provide training and services to meet future needs. We are now developing land purchased with a donation that will become our south campus. Infrastructure for one-fourth of the new campus has been completed, and we have now obtained partial funds for a new, and badly needed, science, math, and technology building. We need an additional $10.9 million to help complete this building. Our vision for the south campus is to serve up to 5,000 students. We expect that funding for the project will come from Federal, State, tribal, and private sources. Without additional funding for titles III and III–A of the HEA, that provide construction funds for campuses such as ours, many students will be denied the opportunity for higher education.

Our Department of Education funds are essential to the operation of our campus. Our programs at UTTC continue to be critical and relevant to the welfare of Indian people throughout the Great Plains region and beyond. Thank you for your consideration of our request.