PENDING PUBLIC HEALTH LEGISLATION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

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PENDING PUBLIC HEALTH LEGISLATION

WEDNESDAY, SEPTEMBER 15, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The Subcommittee met, pursuant to call, at 4:02 p.m., in Room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. [Chairman of the Subcommittee] presiding.

Members present: Representatives Pallone, Engel, Green, DeGette, Capps, Schakowsky, Baldwin, Barrow, Space, Matsui, Shimkus, Pitts, and Burgess.

Staff present: Ruth Katz, Chief Public Health Counsel; Sarah Despres, Counsel; Purvee Kempf, Counsel; Naomi Seiler, Counsel; Katie Campbell, Professional Staff Member; Stephen Cha, Professional Staff Member; Emily Gibbons, Professional Staff Member; Virgil Miller, Professional Staff Member; Anne Morris, Professional Staff Member; Alvin Banks, Special Assistant; Clay Alspach, Minority Counsel, Health; and Ryan Long, Minority Chief Counsel, Health.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. I call the meeting of the House subcommittee to order, and today we are having a hearing on a number of public health bills that are priorities of our committee members, so I will recognize myself for an opening statement.

Given that this is the second hearing of the day, I am going to keep my remarks very brief so we can hear from the witnesses from the Department of Health and Human Services. I do want to express my gratitude to HHS, not only for providing helpful feedback and comments on the bills we plan to consider this week, but also for their flexibility with this hearing. The hearing was originally scheduled for yesterday, but the witnesses for HHS agreed to testify today, late in the day, to accommodate members' schedules. We truly appreciate your true commitment to be accessible and available to the Energy and Commerce Committee, and look forward to your testimony.

The legislation that you—that Health and Human Services will be commenting on today encompasses a broad number of public health priorities that will strengthen and enhance research-related pediatrics, heart diseases, multiple sclerosis, scleroderma, bone marrow failure, and cancer. Research and treatment is informed by

strong data, and so HHS will also comment today on legislation to improve the collection of data for health disparities.

Finally, we will hear from the Department on the critical services that public health veterinarians provide in our communities to protect the public health. Congresswoman Tammy Baldwin and I have worked together on legislation to promote an adequate supply of public health veterinarians who work in subject areas that have an impact on human health by assuring access to grants and loans.

I am pleased that our staff and the minority are finalizing consensus language on this shared goal. I would like to ask unanimous consent to enter into the record a letter from the Association of American Veterinary Medical Colleges, and the American Veterinary Medical Association on the revised version of H.R. 2999.

Without objection, so ordered.

[The information was unavailable at the time of printing.]

[The Committee memorandum follows:]

Mr. PALLONE. And I will yield to our ranking member, Mr. Shimkus.

OPENING STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. SHIMKUS. Thank you, Mr. Chairman. As I promised this morning, we would also just put on the record that we appreciate the folks from Health and Human Services showing up. We are still anxiously awaiting the presence of the secretary to help us discern her intentions on the healthcare law. It has been a long time since it has now been passed into the law, and she is involved in the administration of that. Numerous letters—and we would like to at least start addressing some of those issues, especially those that we know need to be fixed. We know there are provisions that need to be fixed. There are bipartisan discussions on both sides, and we should be about that business.

But since that is not going to happen anytime soon, I want to thank you for also moving this to a time when members have no excuse for not being here. So if they are not here, they are absent. Fly-in days are a different position by most members, especially in this environment. At least now we can hold them accountable for not showing, because we all should be here. Again, I thank you for changing your schedule.

We have been working hard on this whole list of 20 or so bills, and we are making great headway in trying to move these expeditiously. I am just going to lay out some of the general concerns.

Spending in our national government is a primary concern of the population out there, I mean, at least in my district, and I think it is safe to say across the country. You can't spend money, theoretically, by the civics books if you don't authorize. Anytime you increase authorizations, you increase the ability to spend more money. So having said that, the compelling arguments increasing authorizations better be compelling. I hope to move, eventually, to a time when instead of having offsets, we move to auth-sets where we take an authorization and we remove one that doesn't really hold water or isn't applicable anymore. That would be a good signal to the public that we are not only trying to move government spending where it should go, but we are also recognizing the fact

that we probably authorize spending and spend money in inappropriate ways.

What some of the negotiations are is looking at authorization levels and inflationary adjustments, and I think—in those areas I think we can get to some agreement. Some bills talk about additional granting to states. That is going to be a problem in this environment, getting Republican support for additional spending.

I will end, there is also some that tread very close to abortion discussions and high amendment issues. We would think that that would not be helpful in moving bipartisan bills to the floor.

With that, Mr. Chairman, I will stop and I will yield back my time.

Mr. PALLONE. Thank you, Mr. Shimkus. We have some other members here. Mr.—the gentleman from Georgia, Mr. Barrow, was here first.

Mr. BARROW. I thank the chairman. As Mr. Shimkus says, I have no excuse not to be here, but I have nothing to add to what has been said to set the table for our discussion here today, so I will waive an opening. Thank you.

Mr. PALLONE. Thank you. And we have Mr. Green from Texas.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, and I have to admit, I wasn't listening to my colleague from Illinois. I was actually outside, and I am glad I am here and present.

I want to thank you for holding the hearing today on several pieces of healthcare legislation pending before the committee. I am a strong supporter and cosponsor of many of the bills, and I am glad we are moving these bills to the legislative process.

I don't want to take too much time, but I do want to point out one piece of legislation we will be discussing today. I have been working with Representative Hank Johnson on H.R. 5986, the Neglected Infections of Impoverished Americans Act of 2010 since we were marking up the health reform bill, and I included this legislation as an amendment. Recently Chairman Waxman and Representative Gingrey signed on the legislation as original cosponsors, and I would like to thank them for their efforts on the issue.

H.R. 5986 would require HHS to submit a report to Congress on the current state of parasitic diseases that have been overlooked among the poorest Americans. The 2008 study by George Washington University and the Saving Vaccine Institute identified high prevalence rates of parasitic infections in the poorest areas of the United States and along our border regions. Scientists estimate there may be as many as 100 million infections and neglected diseases identified in our legislation, including chigas, cystic cirrhosis, toxicaras—anyway, there are a whole bunch of them, and I would ask for the full statement to be placed into the record.

These diseases and other neglected diseases of poverty collectively infect over 1.7 billion people around the world, but they disproportionately affect minority and impoverished populations across the United States, producing effects ranging from asymptomatic infection to asthma-like symptoms, seizures, and death. This study is especially important, because these neglected dis-

eases receive less financial support than they deserve. A mere $231,730 of research funding was allocated by the NIH since 1995.

Discrepancy in funding is known as the 10/90 gap. A mere 10 percent of the global health research dollars is directed towards diseases affecting 90 percent of the global population. The Neglected Infections of Impoverished Americans Act of 2010 would provide an update evaluation of the current dearth of the knowledge regarding epidemiology in these diseases and the socioeconomic health and development impact they have on our society.

I want to thank our witnesses for appearing today, and I would like to submit two letters of support for H.R. 5986 for the record. One letter is from the University of Georgia and the other is from the University of South Alabama. Again, thank you, Mr. Chairman. I yield back my time.

Mr. PALLONE. Without objection, so ordered on the two letters.

[The information was unavailable at the time of printing.]

Mr. PALLONE. Next is our subcommittee vice chair, Ms. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman, for holding this hearing. I would like also to ask unanimous consent to enter two letters in the record, one in support of H.R. 1032, and the other in support of H.R. 2941.

Mr. PALLONE. Without objection, so ordered.

[The information was unavailable at the time of printing.]

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. CAPPS. So I am cosponsor of many of the bills before us today, and I urge us to act swiftly to pass them out of committee. I want to specifically thank you for including two bills that I have sponsored on the agenda.

The first is H.R. 1032, the HEART for Women Act, which I am proud to say has broad bipartisan support, including every single Republican and Democratic woman on this committee. It focuses on expanding CDC's WISE WOMAN program, which has been proven so effective in ensuring that FDA is evaluating all new drug and device applications for how they affect women and men differently.

Working closely with the majority and the minority committee staffs, I feel confident that we have solid changes to this legislation that should make it sort of a no-brainer for unanimous passage.

The other bill is H.R. 2408, the Scleroderma Research and Awareness Act, which also has strong bipartisan support and has been modified to address concerns of the minority and majority alike. H.R. 2408 would promote further NIH research into this debilitating disease and promote public awareness of scleroderma through the CDC.

Thank you again for considering these bills in today's hearing. I look forward to passing them out of committee, and ultimately the House. If you wouldn't mind an additional statement, because unfortunately Congresswoman Eshoo had a family emergency, and I would like to voice my support for her legislation, H.R. 211, with the strong support of United Way and 251 bipartisan cosponsors, the calling for 211 act builds on existing state and local efforts to connect people with services and volunteer opportunities. The legislation provides federal matching grants augmenting existing fund-

ing from state and local governments, nonprofits, and the business community. With this bill, 211 will finally become a truly national system.

I yield back.

Mr. PALLONE. Without objection, so ordered. And all members of the subcommittee's statements who desire to enter them into the record will be entered in the record without further—without any objection.

The gentlewoman from Wisconsin, Ms. Baldwin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman. I have two bills before the committee today, and both are deeply important to me and many others. I am delighted that the committee is considering them.

H.R. 2999, the Veterinary Public Health Workforce and Education Act, represents a comprehensive solution to ensuring that the veterinary public health workforce can meet vital public health challenges. We worked across the aisle to draft a manager's amendment that will serve as a good first step, and help attract and retain more veterinarians into public health careers. I thank you, Mr. Chairman, for your support in this effort, as well and my friend and colleague from Pennsylvania, Mr. Murphy, who is a key leader in this legislation.

Second, the Health Data Collection Improvement Act would authorize HHS to collect, where practical and appropriate, information on sexual orientation and gender identity for participants in health programs and health surveys. This is an issue that I have brought to this committee's attention a number of times over the past few years. Currently, no federal health survey or federal health program collects data on sexual orientation or gender identity. As a result, we are left with gaping holes in our knowledge base on LGBT health. The federal government must have basic information on the health of all Americans in order to help address these issues, especially for those who may face discrimination and stigma in the healthcare system and outside the healthcare system.

Again, thank you, Mr. Chairman, for considering these bills. I look forward to hearing from our witnesses today. I yield back.

Mr. PALLONE. Thank you. The gentleman from—the gentlelady from Illinois, Ms. Schakowsky, care to make an opening statement?

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Yes. Thank you, Mr. Chairman. I am in support of all of these bills, but I wanted to highlight H.R. 1210, the Arthritis Prevention, Control, and Cure Act, and thank its sponsor, Representative Eshoo, who couldn't be here today, for her leadership. She is attending a family funeral.

Forty-six point three million Americans, including 300,000 children, are living with this painful disease. Arthritis is the number one cause of disability in the United States, and costs our economy

$130 billion a year. I am cosponsor of H.R. 1210 because it helps address those problems, it includes competitive grants to support the prevention, control, and surveillance of arthritis, and gives NIH the authority to expand research activity surrounding juvenile arthritis.

I look forward to hearing from our witnesses today, and to consideration and passage, we hope, of the Arthritis Prevention, Control, and Cure Act tomorrow.

I yield back.

Mr. PALLONE. Thank you. Gentleman from Ohio, Mr. Space.

OPENING STATEMENT OF HON. ZACHARY T. SPACE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. SPACE. Thank you, Mr. Chairman. I appreciate your efforts in holding this hearing on a number of important bills.

Today, our subcommittee is taking into consideration a number of bills focused on improving public health efforts in our Nation, and addressing public health is no simple task right now. Childhood obesity rates are on the rise, diabetes is rapidly becoming epidemic. Long story short, there are a number of disturbing trends out there that give all of us significant concerns about the future of our healthcare system.

That is why I am extremely pleased that Chairman Pallone has offered us today's hearing as an opportunity to look at one of the bills that I have sponsored, along with my colleague from Nebraska, Mr. Terry, H.R. 6012. This legislation is designed to reduce the number of seniors in this country with undiagnosed diabetes, and it is easy to see why we are doing this. We are spending upwards of $200 billion a year now combating diabetes in all forms. That is more money than we spend in Iraq in any given year during our wars.

Figuring out a way to deal with this in a commonsense way that also mitigates the extensive human suffering that accompanies this epidemic disease is vital, and I appreciate the opportunity to address it today and take this up tomorrow in the markup.

I yield back. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. I think that is all of the members that we have, so we will go to our witnesses. Welcome to the subcommittee hearing. Let me introduce each of you.

Starting on my left is Dr. Lawrence Tabak, who is Principal Deputy Director of the National Institutes of Health with the U.S. Department of Health and Human Services.

Then we have Dr. Ileana Arias, who is principal Deputy Director of the Centers for Disease Control and Prevention, again with the U.S. Department of Health and Human Services.

Then we have Dr. Marcia Brand, who is Deputy Administrator for Health Resources and Services Administration with HHS.

And then I have—my note here says available for SAMHSA-related questions is H. Westley Clark, who is—oh my. You have so many degrees I don't even know where to begin. You are a doctor, M.D., a lawyer, M.P.H., CAS, FASAM, Director of the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration at the Department again.

So we try to keep it to 5 minutes. Your statements will become part of the record. If you want to submit additional written comments, you may.

I will start with Dr. Tabak.

STATEMENTS OF LAWRENCE TABAK, PRINCIPAL DEPUTY DIRECTOR, NATIONAL INSTITUTES OF HEALTH (NIH), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ILEANA ARIAS, PRINCIPAL DEPUTY DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND MARCIA BRAND, DEPUTY ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF LAWRENCE TABAK

Dr. TABAK. Mr. Chairman and members of the subcommittee, thank you. I am honored to attend this hearing with my colleagues to discuss issues relating to legislation pending before this committee today.

NIH and its research partners, patients and their families, scientists and their research institutions have collaborated to produce scientific understanding and medical innovation that has prolonged lives, reduced human suffering, and improved the quality of life for millions. Due to NIH research, mortality from heart disease and stroke has been cut by more than half in the United States. Today's new cancer therapies arrest the disease and prolong the life so cancer survivors number in the millions. Our blood supply is far safer because of tests for HIV and hepatitis B and C.

NIH funded science has also helped people make lifestyle changes that promote health, such as eating less fat, exercising more and quitting smoking. These are a few examples of NIH funded discovery that have transformed medical care.

NIH owes much of its success to the advocacy and strong support of millions of patients and their families. Historically, NIH has also been championed by Congress and has received strong bipartisan support. As a community, researchers on the NIH campus and around the country are very grateful for such support and are mindful of the responsibility we bear to be good stewards of the taxpayers' investment in medical science.

NIH has also been given the flexibility and indeed, the explicit responsibility to exercise the scientific communities' best collective judgment in determining research priorities. These decisions are made in a dynamic matrix of scientific opportunity, public health needs, burden of disease, and the input and perspective offered by patients, their families and advocates, scientists, and public health experts.

First and foremost, NIH must respond to public health needs, which are addressed through a complex balance among basic, transformative, and clinical sciences.

Second, NIH applies stringent review provided by outside scientists who are experts in a given field, evaluating the quality of all research proposals considered.

Third, scientific history has repeatedly demonstrated that significant research advances occur when new findings, often completely unexpected, open up new experimental possibilities and pathways.

Finally, we strive to ensure the diversity of NIH's research portfolio as we simply cannot predict the next scientific revelation or anticipate the next opportunity.

Having briefly discussed how NIH sets research priorities, I would like to review some of the research we are currently conducting in several of the disease areas that are addressed by the bills pending before the subcommittee.

Juvenile idiopathic arthritis has no definitive cause and strikes children before they turn 16. The National Institute of Arthritis and Musculoskeletal and Skin Diseases funds a broad range of research, from basic studies of underlying mechanisms of arthritis to clinical studies exploring new treatment options. Scleroderma is a group of diseases in which the connective tissue that supports the skin and internal organs grows in a highly abnormal manner. NIMS has supported the Scleroderma Family Registry and DNA Repository, which has enabled researchers to conduct genome-wide association studies of scleroderma, which will provide insight into which genes are responsible for susceptibility to scleroderma, and which biological pathways may cause organ damage in the disease.

Children deserve to be born healthy and to achieve their full potential for healthy and productive lives. NIH, led by the National Institute of Child Health and Human Development supports the bulk of research on normal and abnormal child health and development. The majority of NIH's institutes and centers include pediatric research in their portfolios.

Regarding the subcommittee's interest in type 2 diabetes research for minority populations, NIH primarily through the National Institute of Diabetes and Digestive and Kidney Diseases is investing significant resources in multi-faceted research on this disease in minority populations, as well as obesity research.

Let me conclude by offering the thanks of NIH, the biomedical research community, and the millions of American patients and their families for your unwavering dedication. I am personally grateful for your time and attention this afternoon, and look forward to your questions.

Thank you.

[The prepared statement of Dr. Tabak follows:]

TESTIMONY OF

LAWRENCE A. TABAK, D.D.S., PH.D.

PRINCIPAL DEPUTY DIRECTOR

NATIONAL INSTITUTES OF HEALTH

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 14, 2010

FOR RELEASE UPON DELIVERY

Introduction

Mr. Chairman, Members of the Subcommittee, I am Dr. Lawrence A. Tabak, the Principal Deputy Director of the National Institutes of Health (NIH). I am honored to attend this hearing with my HHS Operating Division colleagues to offer NIH's technical assistance on bills that are currently being considered by the Health Subcommittee.

I have been Principal Deputy Director of NIH for less than a month, but I have led the National Institute of Dental and Craniofacial Research for the past ten years and served as NIH Acting Deputy Director in 2008-09. Before joining NIH, I was the Senior Associate Dean for Research and Professor of Dentistry and Biochemistry & Biophysics in the School of Medicine and Dentistry at the University of Rochester in New York State. I have also been an NIH-funded investigator, working in the field of biochemistry to learn how some proteins become decorated with specific types of sugars and determine the roles played by these sugars. In my NIH lab, my team and I have continued to work on these questions.

It is a privilege to represent NIH before you this afternoon. Because of the support of members of this Subcommittee, NIH is a multidisciplinary powerhouse of discovery and innovation. Nearly 85% of NIH's $31 billion FY 2010 budget is dedicated to research grants that involve approximately 325,000 research personnel at some 3,000 institutions in each of the 50 states.

We appreciate the opportunity to discuss issues relating to legislation pending before this Committee today. We recognize that you have dedicated time and resources to incorporating our technical input, and we thank you for that.

About the National Institutes of Health

NIH and its research partners—patients and their families, scientists and their research institutions—have collaborated to produce scientific understanding and medical innovation that have prolonged lives, reduced human suffering and improved the quality of life for millions. Due in part to NIH research, mortality from heart disease and stroke has been cut by more than half in the U.S. Today's new cancer therapies arrest the disease and prolong human life so cancer survivors number in the millions. Our blood supply is far safer because of tests for HIV and hepatitis B and C that arose from NIH-funded research. NIH-funded science has also helped people make lifestyle changes that promote health, such as eating less fat, exercising more, and quitting smoking. These few examples of NIH-funded discovery and medical innovation have transformed medical care.

Whereas a generation or two ago, much of medicine was palliative care for acute and lethal diseases, today we are able to manage formerly fatal disorders as chronic illnesses. In the balance of my testimony, I would like to discuss how the support of Congress has allowed NIH the scientific flexibility to pursue these advances, how we will benefit from today's scientific opportunities, with that continued support and flexibility and how we

are pursuing research initiatives that address conditions mentioned in the bills pending before the Subcommittee.

Congressional Support, Allowing NIH Scientific Flexibility Equals NIH Success

Support for biomedical research—and the hope of new diagnostics, therapies, and cures—is among Americans' strongest shared values. NIH owes much of its success to the advocacy and strong support of millions of patients and their families.

Historically NIH has also been championed by Congress, and received strong, bipartisan support. As a community, researchers on the NIH campus and around the country are grateful for such support—and mindful of the responsibility we bear to be good stewards of the taxpayers' investment in medical science.

NIH has also been given the flexibility—and indeed the explicit responsibility—to exercise the scientific community's best collective judgment in determining research priorities. These decisions are made in a dynamic, continually shifting matrix of scientific opportunity, public health needs, burdens of disease, and the input, consultation, insight and perspective offered by patients and their families, scientists, and public health experts and patient advocates.

Scientific/Technological/Interdisciplinary/Trans-NIH Initiatives

The opportunities we see in today's multi- and interdisciplinary research and NIH's trans-institute research initiatives are a further affirmation of scientific flexibility in guiding our nation's biomedical research portfolio. Science today is a far more collaborative, multi-disciplinary and large-scale enterprise than when I was a newly appointed Assistant Professor.

With the investment of the American people and the support of Congress, we have amplified the power of the molecular approach to health and disease over the past couple of decades and sparked a revolution in medicine. Advances in research technologies, such as high-throughput screening and dramatic new imaging techniques, have further accelerated this transformation. As NIH Director Francis Collins has put it:

> The revolution now sweeping the field is the ability to be comprehensive—for example, to define all of the genes of the human or a model organism, all of the human proteins and their structures, all of the common variations in the genome, all of the major pathways for signal transduction in the cell, all of the patterns of gene expression in the brain, all of the steps involved in early development, or all of the components of the immune system. Further development of technologies in areas such as DNA sequencing, imaging, nanotechnology, proteomics, metabolomics, small-molecule screening, and RNA interference are ripe for aggressive investment.[1]

[1] "Opportunities for Research and NIH," *Science*, January 1, 2010.

This technological revolution and the continuing need for interdisciplinary approaches have blurred the scientific boundaries among traditional scientific disciplines. On June 15, Dr. Collins testified before you about the Human Genome Project, the Cancer Genome Atlas, and the Alzheimer's Disease Neuroimaging Initiative. These are the exciting new initiatives that are possible at this unique moment in our scientific and medical history, and promise new ways of understanding human biology and new hope for prevention, therapies, and cures. The scientific, medical and technological revolutions of today offer the possibility that we can now understand a disease comprehensively and raise the hope that we will be able to diagnose, prevent and ultimately treat many diseases—even tailoring a therapy for a patient based upon her unique genetic makeup. In our era, the era of molecular medicine, we are pursuing advances in myriad diseases as scientific opportunity and public health need dictate.

I would like to offer a few principles that govern NIH research priority setting.

How NIH Sets Priorities

First and foremost, NIH must respond to public health needs which are addressed through a complex balance between basic, transformative, and clinical sciences. The incidence, severity, cost and sheer human suffering associated with specific disorders are also factors in how we set research priorities.

Secondly, NIH applies stringent review, provided by outside scientists who are experts in a given field, in ranking the scientific opportunity and quality of all research proposals considered. The rigor of this process is so competitive, and the number of applications is so large, that today fewer than one in five research proposals receives NIH funding. Even in the past, no more than one in three applications received NIH support. This intense competition has always assured that NIH research is of the highest scientific quality.

Thirdly, scientific history has repeatedly demonstrated that significant scientific advances occur when new findings, often completely unexpected, open up new experimental possibilities and pathways. We are constantly assessing the research portfolio in light of what the latest science suggests. Frustratingly, not all disease or scientific problems are equally ripe for new advances, nor do such advances come at the same rate across the portfolio, no matter how pressing they might be for the public's health.

Finally, we strive to ensure the diversity of NIH's research portfolio. We simply cannot predict the next scientific revelation or anticipate the next opportunity. If you think of scientific priority-setting as an innumerable number of questions that we might try to answer, a series of doors that we might open—but we cannot know what is behind any one door—you can appreciate the challenge of setting priorities and the need for a broad research portfolio.

NIH Research Activities Relevant to Pending Legislation:

Having discussed how NIH sets research priorities, I would like to review some of the research we are currently conducting in several of the disease areas that are addressed by the bills pending before the Subcommittee.

Juvenile Idiopathic Arthritis

We know arthritis as a group of diseases that cause pain, swelling, stiffness, and loss of motion in the joints. Juvenile idiopathic arthritis (JIA) is a type of arthritis with no definitive cause and which strikes children before they turn 16.

There are multiple types of JIA that collectively are the most prevalent pediatric rheumatic illness, and among the most common causes of childhood disability in the United States. The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) funds a broad range of research, from basic studies of the underlying mechanisms of arthritis, to clinical studies exploring new treatment options.

For example, the NIAMS supports scientists in a network of pediatric clinical research centers, known as the Childhood Arthritis and Rheumatology Research Alliance (CARRA). One NIAMS-supported project is a clinical trial examining the effect of early, aggressive therapy on polyarticular juvenile idiopathic arthritis (poly-JIA), a condition in which five or more joints are affected. This research focuses on the identification and testing of new combinations of drugs not previously tested in pediatric patients.

In other research supported by the NIAMS, investigators have examined the challenges associated with diagnosing the various subtypes of JIA, in hopes of eventually allowing pediatric rheumatologists to tailor personalized treatments.

NIH also recently used funds provided by the American Recovery and Reinvestment Act (ARRA) to support a Grand Opportunities (GO) grant to expand the existing CARRA network and improve the outcomes and quality of life for all children with rheumatic diseases, including JIA.

These research endeavors are just a few examples of the many NIH programs that share the goals of H.R. 1210, the "Arthritis Prevention, Control, and Cure Act of 2010." The NIH is committed to supporting research that seeks to improve the outcomes and quality of life for children with rheumatic disease.

Scleroderma

Scleroderma is a group of diseases in which the connective tissue that supports the skin and internal organs grows in a highly abnormal manner. In milder forms of scleroderma, this abnormal growth causes hard and tight skin in the patient. In other forms of

scleroderma, however, the problems are much more serious, affecting blood vessels and internal organs, such as the heart, lungs, and kidneys.

To identify the genetic changes that make an individual susceptible to scleroderma and provide a source of genetic material for researchers who study scleroderma and other autoimmune diseases, NIAMS has supported the Scleroderma Family Registry and DNA Repository. The Family Registry has enrolled approximately 4,000 participants. The information collected allows researchers to conduct genome-wide association studies (GWAS) of scleroderma which will provide insights into what genes are responsible for susceptibility to scleroderma, and which biological pathways may cause organ damage in the disease.

The NIAMS also supports the Center for Research Translation in Scleroderma that is examining the molecular basis of scleroderma in order to understand its underlying causes. Investigators have already conducted detailed genetic analysis of blood samples from scleroderma patients, grouping them by ethnicity, gender, and autoantibodies—the immune system molecules that mistakenly attack the body they would normally protect from infection. In a promising step forward, this research has established the correlation of individual gene variants and disease subtype-specific autoantibodies. Such findings offer the hope of new and personalized treatment options for patients.

NIAMS funds a broad range of research, from basic studies to translational clinical efforts. We share the hope for improved outcomes for scleroderma patients that are conveyed in H.R. 2408, the "Scleroderma Research and Awareness Act."

Diabetes research in minority populations

There are three main types of diabetes: type 1, type 2, and gestational diabetes. Type 1 is an autoimmune disease where the immune system attacks and destroys the insulin-producing beta cells in the pancreas. The pancreas then produces little or no insulin. Type 2 is the most common form of diabetes and is most often associated with older age, obesity, family history of diabetes, previous history of gestational diabetes, physical inactivity, and certain ethnicities. Finally, some women develop gestational diabetes late in pregnancy. Although this form of diabetes usually disappears after the birth of the baby, women who have had gestational diabetes have a 40 to 60 percent chance of developing diabetes (mostly type 2) within 5 to 10 years.[2]

The NIH, primarily through the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), is investing significant resources in multifaceted research on type 2 diabetes in minority populations, as well as in obesity research. Obesity is a major risk factor for type 2 diabetes. Both disorders disproportionately affect minority populations. As part of the NIDDK-CDC National Diabetes Education Program, specific work groups address minority issues and include minority health professionals. The Work Groups include the African American/African Ancestry Work Group, the American Indian and

[2] Centers for Disease Control and Prevention (2007). National Diabetes Fact Sheet, 2007. Accessed from http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2007.pdf on August 31, 2010.

Alaska Native Work Group, the Asian American and Pacific Islander Work Group, and the Hispanic/Latino Work Group. The Diabetes Mellitus Interagency Coordinating Committee, led by the NIDDK, effectively coordinates diabetes activities across the Government, including diabetes issues in minority populations, through regular meetings, strategic planning, development and coordination of special programs, and through evaluation of ongoing diabetes efforts. The DMICC continues to improve the dissemination of information about diabetes and enhance coordination of federal efforts to advance diabetes research and improve the health of Americans with or at risk for diabetes.

Title I of H.R. 1995, the "Eliminating Disparities in Diabetes Prevention Access and Care Act," aims to increase research in diabetes disparities, as well as participation of health providers from minority communities in this research. While the NIH is making great strides in our efforts to understand and address diabetes health disparities, we continually monitor the state of the science for new and important research opportunities that merit pursuit.

Pediatric research

Children deserve to be born healthy and to achieve their full potential for healthy and productive lives, free from disease or disability. NIH, led by the National Institute of Child Health and Human Development (NICHD), supports the bulk of research on normal and abnormal child health and development. The majority of the NIH's 27 Institutes and Centers (ICs) include pediatric research in their portfolios.

In FY 2009, the NIH, through 22 Institutes and Centers (ICs), awarded about $3 billion in support of pediatric research activities across the country with another $500 million for pediatric research from funding under ARRA. This funding was distributed to the research community through the full range of available funding mechanisms, including investigator-initiated grants, contracts, and research networks, which allowed those with extensive scientific expertise at the NIH and across the extramural scientific research community to determine which mechanism(s) might be best suited for the specific research needed to answer questions about children's health and development, diseases and conditions. Less commonly, where the scientific challenge warrants and with mindfulness of the significant ongoing investment involved, NIH ICs (often in trans-institute collaboration) have created multidisciplinary centers of excellence or research networks for specific pediatric populations or conditions, such as autism, pediatric oncology, neonatology, and adolescents with HIV/AIDS, to name a few.

In addition, a number of the Clinical and Translational Science Awards (CTSAs) sites include a strong emphasis on creating infrastructure to conduct pediatric clinical trials, which will allow pediatric researchers who focus on a wide variety of conditions to utilize this new resource and to conduct clinical trials efficiently and effectively.

H.R. 758, the "Pediatric Research Consortia Establishment Act", would require NIH to establish new pediatric research consortia to supplement ongoing research in these areas.

We are constantly looking for new ways to push our pediatric research agenda to the next level, and appreciate the interest in exploring this area.

These are but a few of the examples in which NIH is exploring the scientific areas under consideration by the Subcommittee today. Let me conclude my testimony by offering the thanks of NIH, the biomedical research community and millions of American patients and their families for your unwavering dedication. I am personally grateful for your time and attention this afternoon and look forward to your questions.

Mr. PALLONE. Thank you, Dr. Tabak.
Dr. Arias.

STATEMENT OF ILEANA ARIAS

Ms. ARIAS. Mr. Chairman, Ranking Member Shimkus, and members of the subcommittee, thank you for the opportunity to testify today along with my colleagues from the Department.

This is an exciting time to be engaged in prevention and public health. We are currently improving our immunization programs, taking steps to reduce healthcare associated infections, rebuilding our Nation's public health infrastructure, and supporting communities across America as they tackle critical problems like obesity and youth smoking.

In the years ahead, millions more Americans will have coverage for preventive services. We are anxious to take advantage of these opportunities, and to track the health gains that this focus on prevention can bring.

I am pleased to be here as you consider legislation to address certain health issues of concern. We appreciate the interaction that we have had with members of the subcommittee and staff on these bills, and we greatly appreciate the opportunity to share our public health expertise with you.

CDC's mission is to promote health and quality of life by preventing and controlling disease, injury, and disability. Working closely with our sister agencies, CDC is committed to reducing the health economic consequences of the leading causes of death and disability, thereby promoting a long, productive, and healthy life for all people in the country. Today I want to provide you with a broad perspective on CDC's current efforts to achieve these goals, and to discuss CDC's work that relates to many of the bills that you are considering.

First, I would like to review a few of CDC's current initiatives that demonstrate the range of public health challenges that we are facing. CDC has begun an effort to achieve measurable impact quickly in a few targeted areas, which we refer to as "Winnable Battles." These Winnable Battles were selected based on the scope of the burden posed by these health threats, and equally importantly, CDC's ability to make significant progress in improving relevant health outcomes. To date, CDC director Dr. Thomas Frieden and CDC leaders have identified six Winnable Battles, and have outlined a number of achievable priorities and opportunities for each of these.

The six Battles are, first, prevention of HIV; second, motor vehicle collisions; third, the prevention of healthcare associated infections; fourth, the control of tobacco; fifth, prevention of teen pregnancy; and then lastly but not least, the prevention of obesity, the improvement of nutrition, physical activity, and food safety, which includes diabetes, a critical and costly health problem that the subcommittee is working to address today in three legislative initiatives advanced by Representatives Engel, DeGette, and Space.

In many cases, we have known effective solutions; in others, such as gestational diabetes, work remains to identify the path to prevent the issue.

First, the CDC leadership has identified five strategic priorities to help achieve these Winnable Battles and to support other public health priorities. The first of these five priorities is applying effective policies. The science currently tells us that effective policies in areas such as tobacco control, motor vehicle safety, healthy eating, and physical activities in schools and communities can save lives and reduce healthcare costs. We are increasing our effectiveness in this area. The subcommittee today is considering a bill on methamphetamine education and treatment, which is very relevant to CDC's effort to identify policy interventions that can reduce the health toll from overuse of prescription medications.

Second, providing leadership in global health. Global public health investments have a direct benefit on U.S. public health and U.S. national security. Programs in AIDS, malaria, and pandemic preparedness have improved health systems throughout the world and strengthened our outbreak response. CDC has specifically created a new global health center to accelerate work in this area.

Third, with the support of Congress and the public health and prevention fund, CDC is making investments that will significantly address the third priority, improving and strengthening surveillance, epidemiology, and laboratory capacity. This is essential and critical to our ability to identify health problems and to develop—and importantly to track the progress of solutions. Many of the bills being considered by the subcommittee today explicitly call for improvements in the availability of data on public health issues, such as Representative Burgess' work with Mr. Van Hollen on surveillance of neurological diseases, Representative Baldwin's initiative to expand data collection on sexual orientation and gender identity, Representative Eshoo's proposal to advance arthritis surveillance, and Representative Johnson's focus on neglected diseases, and Representative DeLauro's initiative on birth defects. We are confident that any of these specific mandates would benefit from CDC's current focus on improving national surveillance capacity.

State, local, tribal, and territorial health agencies collect surveillance data, they conduct laboratory testing, and they investigate outbreaks and take public health action. They essentially are our boots on the ground. Because these CDC partners are critical to implementing public health programs across the country, many of the measures before the subcommittee today rely on grants to these agencies to achieve the bills purposes. These measures include Representative Space's work to increase research and data collection on the widespread occurrence but unclear origins of gestational diabetes, and Representative Eshoo's initiative to implement a State-based call-in system providing individuals with information about human services. We are confident that CDC's focus on working with our partners to improve the performance of public health agencies would improve the capacity relative to these specific initiatives.

Our final priority is to use the above strategies and the focus on Winnable Battles to have a significant impact on the leading causes of death, illness, injury, and disability. CDC would be interested in working with the subcommittee to ensure that any initiatives being considered today could build on successful efforts to ad-

dress high-burden health problems. For example, this week CDC launched a campaign addressing prevention of gynecological cancers, and we will also be addressing heart disease through the WISEWOMAN program. These programs address cancer and heart disease, which are among the leading causes of death in our country.

With the support of Congress we have made progress in addressing the Nation's most pressing health needs, and the focus I have outlined above, supported by investments in the Recovery Act and the Affordable Care Act, we feel we are poised to accelerate these gains.

I appreciate the opportunity to discuss CDC's work with you, and look forward to working with the subcommittee as you consider the legislative initiatives before you. Thank you.

[The prepared statement of Ms. Arias follows:]

Testimony before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

Pending Public Health Legislation

Ileana Arias, PhD
Principal Deputy Director
Centers for Disease Control and Prevention and
Agency for Toxic Substances and Disease Registry
U.S. Department of Health and Human Services

CDC
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ATSDR
AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

For Release upon Delivery
Expected at 3:00 p.m.
September 14, 2010

Mr. Chairman, Ranking Member Shimkus, and members of the Subcommittee, thank you for the opportunity to testify today along with my colleagues from the Department of Health and Human Services (HHS). I am Dr. Ileana Arias, Principal Deputy Director for the Centers for Disease Control and Prevention (CDC). In this role, I am responsible for advising the Director, Dr. Thomas Frieden, on all scientific and programmatic activities of CDC. I have been at CDC since 2000. Prior to coming to my current position, I served as the Director of the National Center for Injury Prevention and Control at CDC.

This is an exciting time to be engaged in prevention and public health. With investments from the American Recovery and Reinvestment Act we are improving our immunization programs, taking steps to reduce healthcare associated infections, and supporting communities across America as they tackle critical problems like obesity and youth smoking. With the Affordable Care Act's Prevention and Public Health Fund, we are expanding these efforts and making investments to improve our nation's public health infrastructure. Also through the Affordable Care Act, millions more Americans will soon have coverage for preventive services such as immunization, preventive screenings, and smoking cessation – and we are anxious to track the health gains that this focus on prevention can bring.

I am pleased to be here as you consider legislation to address certain health issues of concern, and the extent to which CDC can contribute to addressing these issues. We appreciate the interaction we have had with members of the Subcommittee and staff on these bills, and recognize that many of the bills you are addressing today reflect our technical input. As on other legislation that has been addressed by the Subcommittee this year and in the past, we greatly appreciate the opportunity to share our public health expertise with you.

Today, I want to provide you with a broad perspective on CDC's current work, and to discuss CDC's work that relates to many of the bills you are considering. CDC's mission is to promote health and quality of life by preventing and controlling disease, injury, and disability. Working closely with our sister agencies in the Department of Health and Human Services (HHS), CDC is committed to reducing the health and economic consequences of the leading causes of death and disability, thereby promoting a long, productive, healthy life for all people.

Current CDC Priorities and Initiatives

First, I'd like to review a few of CDC's current initiatives that demonstrate the range of public health challenges we, as an agency and a country, are facing. CDC has begun an effort to achieve measurable impact quickly in a few targeted areas, which we refer to as "Winnable Battles." These Winnable Battles were selected based on the scope of the burden posed by these public health threats and CDC's ability to make significant progress in improving relevant health outcomes. The charge for these Winnable Battles is to identify optimal strategies that are feasible and cost-effective, and to rally resources and partnerships to make a meaningful impact on health nationwide. By identifying these clear targets and by working closely with our public health partners, we can make significant progress in these areas. To date, CDC Director Dr. Thomas R. Frieden and CDC leaders have identified six Winnable Battles. For each of these areas, we have also outlined a number of achievable priorities and opportunities:

- **HIV**: An estimated 1.1 million Americans are infected with HIV, and about 1 out of 5 of those who are infected is unaware of his or her status. Moreover, people are engaging in riskier sexual behaviors than they have over the previous decade, thereby increasing the rate of syphilis and HIV spread. To combat this trend, CDC has implemented programs designed to increase HIV status

awareness and improve linkages to care. CDC is also working with our Federal Partners to implement the National HIV/AIDS Strategy.

- **Motor vehicle collisions** are the leading preventable cause of death among people between the ages of 1 and 34, killing almost 45,000 people annually and resulting in 4 million visits to emergency rooms. CDC has recently determined that motor vehicle collisions cost the United States $99 billion annually. To prevent these tragedies, CDC has worked diligently with its state and local partners to increase seat belt use, reduce impaired driving, and implement graduated drivers license policies.

- **Healthcare-associated infections (HAIs):** Each year HAIs affect 1 in 20 hospitalized patients and cost our health care system billions of dollars. Yet, the three most common types of healthcare-associated infections– those in the blood stream, the urinary tract, and surgical sites – are preventable. CDC has been working to prevent HAIs by increasing surveillance, implementing prevention guidelines in hospitals, and encouraging prevention reimbursement policies. CDC is working in concert with our colleagues across HHS through the HHS Action Plan To Prevent Healthcare-Associated Infections. H.R. 3104, which this Subcommittee is currently considering, also relates to this issue.

- **Tobacco** use is the single most preventable cause of disease, injury and death in the United States and leads to tens of billions of dollars worth of medical expenses and lost productivity annually. Unfortunately, even those who choose not to use tobacco are negatively impacted by smoking; 22 million children under the age of 11 are being exposed to second hand smoke. To win the battle against tobacco use, CDC focuses on influencing individual behavior and changing the environment surrounding tobacco users. We are making significant investments in tobacco control programs

through the American Recovery and Reinvestment Act, as well as through the Prevention and Public Health Fund.

- **Obesity, Nutrition, Physical Activity and Food Safety:** Between 1980 and 2000, United States obesity rates in adults doubled and rates tripled in children. In recent years, we have slowed, but not reversed, the rapid rate of increase in the number of Americans who are obese. We know of interventions that can significantly reduce obesity rates and save lives. These interventions can take many forms, from changing community environments to better support healthy lifestyles, to health promotion campaigns such as the First Lady's "Let's Move" campaign. CDC's efforts to prevent obesity and promote physical exercise and good nutrition will also have a significant impact on diabetes, a critical and costly health problem that the Subcommittee is working to address today in three legislative initiatives (H.R. 1995, H.R. 5354, H.R. 6012).

  At the same time, the recent *salmonella* enteritidis outbreak and recall of shell eggs reinforces the importance of preventing foodborne illness. CDC participates in the President's Food Safety Working Group with other agencies within and outside of HHS, with the goals of having safe food that does not cause us harm and enhancing our food safety systems. In particular, we are working to improve CDC's ability to detect, respond to, and prevent foodborne illness. CDC's work on food safety also focuses on the intersection of animal and human health.

- **Teen pregnancy** rates in the United States are the highest of any industrialized nation and 82% of these pregnancies are unintended. Moreover, although teen birth rates declined from 1991 to 2005, they rose for the next two years before declining again in 2008. Teen pregnancy is a significant public health concern not only because it perpetuates the cycle of poverty – a significant socioeconomic determinant of health – but also because babies born to teen mothers are more

likely to die, to have low birth weights, or to be born prematurely. The CDC is working with its partners to deter teen pregnancy through science based approaches

To help achieve these Winnable Battles and to support other public health priorities, CDC has identified five strategic priorities to further strengthen the nation's public health. I want to briefly address these five priorities, and also identify how they relate to many of the legislative initiatives being considered by the Subcommittee today:

- **Applying effective health policies**: CDC is increasing its efforts to identify and advance policies that promote prevention and foster healthier environments throughout the country. Effective policies in areas such as tobacco control, motor vehicle safety, healthy eating, and physical activity in schools and communities can save lives and reduce health care costs. The Subcommittee is today considering H.R. 2818 (relating to methamphetamine education and treatment), which is relevant to CDC's efforts to identify policy interventions that can reduce the health toll from overuse of prescription medications.

- **Providing leadership in global health**: Global public health investments have a direct benefit on U.S. public health and national security. Programs such as the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), and the international pandemic influenza preparedness plans have improved health systems throughout the world and strengthened our outbreak response. CDC has created a new Global Health Center to enhance our efforts to build capacity at ministries of health; strengthen disease detection, surveillance, response, and laboratory capacity; and improve sustainability of public health programs.

- **Strengthening surveillance, epidemiology, and laboratory services:** The ongoing systematic collection, analysis and interpretation of data on health and disease are essential to planning, implementing and evaluating public health practices. With the support of the Congress and the Public Health and Prevention Fund, CDC is making investments that will significantly improve our ability to monitor important public health indicators. Many of the measures being considered by the Subcommittee today directly address improving surveillance, or rely on improved data to guide interventions. These include H.R. 1362 (to enhance surveillance of neurological diseases), H.R. 1210 (arthritis), H.R. 5986 (neglected diseases), and H.R. 5462 (birth defects). Additionally, the Subcommittee is considering legislation to expand data on sexual orientation and gender identity, and H.R. 6012 addresses the need for expanded data on disparities in diabetes. We are confident that any of these specific mandates, including additional mandates for data to address health disparities will benefit from CDC's current focus on improving the overall surveillance infrastructure.

- **Strengthen the capacity of state, local, tribal, and territorial health agencies:** State, local, tribal, and territorial health agencies collect surveillance data, conduct laboratory testing, investigate outbreaks, and take public health action. CDC has been working diligently to improve its technical, financial and direct assistance to these vital state and local partners. Because these CDC partners are critical to implementing public health programs across the United States, many of the measures before the Subcommittee today rely on grants to these agencies for performance of functions important to achieving the bills' purposes. These measures include H.R. 1347 (to reduce concussions among school-aged children), H.R. 3212 (to study and prevent sudden unexplained infant death syndrome), and H.R. 211 (to implement a state based call-in system providing individuals with information about human services). We are confident that CDC's focus on working

with our partners to improve the performance of public health agencies would improve capacity relative to these specific initiatives.

- **Addressing the leading causes of illness, injury and disability.** The above priorities, as well as the Winnable Battles, taken together, can help achieve the goal of having a significant impact on the leading causes of illness, injury, and disability. As a nation, we have made significant investments in health care and public health, and we need to continually test our investments to ensure they are achieving the largest possible health gains. One of our priorities – in evaluating current programs, in implementing the Affordable Care Act, and in contemplating new investments – is to ensure that we can maintain our focus on tackling these significant issues. CDC would be interested in working with the Subcommittee to ensure that any initiatives being considered today could build on successful efforts to address high-burden health problems, and also contribute to the achievement of demonstrable health gains for the American people. For example, the Subcommittee is considering H.R. 2941 (Johanna's Law focusing on the prevention of gynecological cancers, a campaign that CDC has recently launched in response to previous Congressional action), and H.R. 1032 (the HEART Act, addressing women's heart health including through CDC's WISEWOMAN program), both of which relate to existing CDC programs designed to address cancer and heart disease – among the leading causes of death in our country.

Conclusion

With the support of the Congress, we have made progress in addressing the nation's most pressing health needs, and with the focus I have outlined above – supported by investments in the Recovery Act and the Affordable Care Act – we feel we are poised to accelerate these gains. I appreciate the opportunity to discuss CDC's work with you, and look forward to working with the Subcommittee as you consider the legislative initiatives before you.

Mr. PALLONE. Thank you, Dr. Arias.
Dr. Brand.

STATEMENT OF MARCIA BRAND

Ms. BRAND. Yes, good afternoon, Mr. Chairman——
Mr. PALLONE. I think it is either not on or not close enough to you.
Ms. BRAND. Good afternoon——
Mr. PALLONE. A little closer.
Ms. BRAND. Mr. Chairman——
Mr. PALLONE. Is it on?
Ms. BRAND. Yes.
Mr. PALLONE. Green light, OK.
Ms. BRAND. Mr. Chairman, members of the subcommittee, thank you for the opportunity today to testify on behalf on the Secretary for Health and Human Services, Kathleen Sebelius, and Dr. Mary Wakefield, the Administrator of the Health Resources and Service Administration. I am Marcia Brand. I am the Deputy Administrator at HRSA and I am pleased to join my other Department colleagues appearing before you today.

The Health Resources and Services Administration helps the most vulnerable Americans receive quality primary healthcare without regard to their ability to pay. HRSA works to expand access to healthcare for millions of Americans, the uninsured, the underserved, and the vulnerable. The individuals we serve include mothers and their children, those living with HIV and AIDS, and residents of rural areas. HRSA recognizes that people need to have access to primary healthcare, and through its programs and activities, the agency seeks to meet these needs.

HRSA delivers on its obligation to address primary care access through six bureaus and 13 offices that comprise the agency. HRSA helps to train future nurses, doctors, and other health providers, placing them in areas of the country where health resources are scarce. The agency collaborates with government at the federal, state, and local levels, and also with community-based organizations to seek solutions to primary healthcare challenges. HRSA provides leadership and financial support to healthcare providers in every state and every U.S. territory.

HRSA's vision for the Nation is health communities and healthy people. Our mission is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs. The agency seeks to further our vision and carry out our mission through our four major goals: improve access to quality care and services, strengthen the health workforce, build healthy communities, and improve health equity.

At HRSA, we believe that primary case is more than having a place to go when you are sick. We view primary case as the Institute of Medicine does, providing integrated, accessible care services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community.

In addition to supporting the provision of direct patient care, HRSA focuses on implementing programs that increase the number

of primary care providers, including the National Health Service Corps. HRSA programs train primary care providers, long-term care workers, and individuals skilled in providing care for the elderly. HRSA programs also support loans and scholarships that encourage disadvantaged individuals and those from diverse backgrounds to enter into the health profession.

HRSA is committed to making sure that the U.S. has the right clinicians and the right skills working where they are needed most. HRSA-funded centers are often the practice sites for clinicians trained and supported through our programs. HRSA-funded health centers are community-based and patient-directed organizations that serve populations with limited access to healthcare.

HRSA's programs, however, are as diverse as the individuals, families, and communities that we serve. Among the innovative programs that we oversee are organ, bone marrow, and cord blood donation. The agency also coordinates activities related to rural health within the Department of Health and Human Services, and for 20 years, HRSA's Ron White HIV/AIDS program has provided a legacy of care to persons living with HIV and AIDS. Our programs play a critical part in the Nation's healthcare safety net.

It seems fitting to close my overview of HRSA's programs by noting that our Title V Maternal and Child Health Services Block Grant program, which is the Nation's oldest federal state healthcare partnership, will be celebrating its 75th anniversary this year. Title V has provided a foundation and structure for ensuring the health of the Nation's mothers and children.

In closing, Mr. Chairman and members of the subcommittee, tens of millions of Americans get affordable healthcare and other assistance through HRSA's programs and its 3,000 grantees. We are extremely proud of our programs and look forward to continuing to work with you to provide quality primary care for all. I appreciate the opportunity to testify today, and hope this testimony will inform the subcommittee's future deliberations on the many important legislative proposals before you.

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

[The prepared statement of Ms. Brand follows:]

Statement of

Marcia K. Brand, Ph.D.

Deputy Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services

Before the
Committee on Energy and Commerce/Subcommittee on Health
U.S. House of Representatives

Washington, D.C.
September 14, 2010

Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to testify today on behalf of the Secretary for Health and Human Services and the Administrator of the Health Resources and Services Administration (HRSA). I am Dr. Marcia Brand, Deputy Administrator of HRSA. I am pleased to join my other Department colleagues in appearing before you today. In my testimony today, I will provide an overview of HRSA, the programs we deliver and the people we serve. I will also touch upon the relationship between HRSA programs and certain bills under consideration by the Subcommittee. We appreciate your interest in HRSA and welcome the opportunity to work with you, Mr. Chairman, and the Subcommittee.

Introduction

HRSA Overview: The Health Resources and Services Administration helps the most vulnerable Americans receive quality primary health care without regard to their ability to pay. HRSA works to expand the health care of millions of Americans— the uninsured, the underserved and the vulnerable. The individuals served include mothers and their children, those living with HIV/AIDS, and residents of rural areas. HRSA recognizes that people need to have access to primary health care and, through its programs and activities, the Agency seeks to meet these needs. HRSA takes seriously its obligation to diligently and skillfully implement laws that address primary care access. HRSA helps to train future nurses, doctors, and other clinicians, placing them in areas of the country where health resources are scarce. The Agency collaborates with government at the Federal, State, and local levels, and also with community-based organizations, to seek solutions to primary health care problems.

HRSA also oversees organ, bone marrow and cord blood donation. It supports programs that compensate individuals harmed by vaccination and that provide low cost drugs to safety net providers.

HRSA's Strategic Plan: HRSA's mission is to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. The Agency's strategic plan includes four major goals:

1. Improve Access to Quality Care and Services
2. Strengthen the Health Workforce
3. Build Healthy Communities; and
4. Improve Health Equity

We at HRSA believe that primary care is more than having a place to go when you are sick. We view primary care as the Institute of Medicine (IOM) does: providing integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.

I will now describe some of the key programs administered by HRSA.

National Health Service Corps

In addition to supporting the provision of direct patient care, HRSA seeks to strengthen primary care by placing health care providers in communities where they are needed most. For example, the National Health Service Corps (NHSC), through scholarship and loan repayment programs, helps Health Professional Shortage Areas (HPSAs) in the U.S. obtain medical, dental, and mental health providers in order to meet the area's need for health care.

Since its inception in 1970, more than 30,000 primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and mental health professionals have served in the NHSC, expanding access to health services and improving the health of people who live in urban and rural

areas where health care is scarce. The NHSC recruitment tools of scholarships and loan repayments enable individuals motivated to provide high quality care for underserved people who in many instances have nowhere else to go for primary care services, to enter and complete health professions training that might otherwise be unaffordable to them, or to relieve them of some of the staggering debt burden they face. The Affordable Care Act will invest $1.5 billion dollars to expand the National Health Service Corps over the next five years.

About half of all NHSC clinicians work in HRSA-supported health centers, which deliver preventive and primary care services to patients regardless of their ability to pay. About 40 percent of health center patients have no health insurance.

Health Professions

In addition to directly assisting in the placement of primary care providers, HRSA supports the health profession programs that provide the infrastructure for their education and training. HRSA's health professions programs provide policy leadership and grant support for health professions workforce development—making sure the U.S. has the right clinicians, with the right skills, working where they are needed.

HRSA's health professions programs are designed to address shortages throughout the country. These programs, which include a wide range of training programs, scholarships, loans, and loan repayments for health professions students and practitioners, are essential to producing health professionals who provide high quality, culturally competent health care.

Through the Affordable Care Act, the U.S. Department of Health and Human Services has made a series of new investments worth $250 million to increase the number of health care providers and strengthen the primary care workforce. The investments in the primary care workforce announced in June of this year will be used to boost the supply of primary care providers in this country. The new investments will support the training and development of many new primary care providers over the next five years. Specific activities include:

- $168 million in funding to create additional primary care residency slots to train more than 500 new primary care physicians by 2015;
- $32 million in funding to support physician assistant training in primary care with the goal of developing more than 600 new physician assistants, who can practice medicine as members of a team with their supervising physician. Physician assistants are trained in a shorter period of time compared to physicians;
- $30 million to train an additional 600 nurse practitioners, including providing incentives for part-time students to become full-time and complete their education sooner;
- $5 million in funding to encourage States to plan and implement innovative strategies to expand their primary care workforce by 10 to 25 percent over ten years to meet increased demand for primary care services; and
- $15 million in funding for the operation of 10 nurse-managed health clinics that both provide comprehensive primary health care services to populations living in medically underserved communities, and assist in the training of nurse practitioners and other health care providers.

Building on the earlier investments made by the American Recovery and Reinvestment Act and the Affordable Care Act, particularly for the National Health Service Corps, these investments will support the training and development of more than 16,000 new primary care providers over the next five years.

Legislation introduced by members of this Subcommittee pertains to a wide range of public health training. One such measure, HR. 1210, the "Arthritis Prevention, Control, and Cure Act of 2009," which is sponsored by Representative Eshoo, creates a system of loan repayments for pediatric rheumatologists who agree to provide

health care in an area where there is a shortage of pediatric rheumatologists. Another measure, H.R. 2999, "The Veterinary Public Health Workforce and Education Act," sponsored by Representative Baldwin, aims to increase and strengthen the veterinary public health workforce and training capacity in the United States.

HRSA also supports public-private partnerships to encourage health professional training. For example, HRSA funds Area Health Education Centers (AHECs), which are academic and community partnerships that provide health career recruitment programs for high school students and also increase access to health care in medically underserved areas. AHECs address health care workforce issues by exposing students to health care career opportunities that they otherwise would not have encountered, establishing community-based training sites for students in service-learning and clinical capacities, providing continuing education programs for health care professionals, and evaluating the needs of underserved communities.

HRSA health professions programs also identify health professional shortage areas and work to address those shortages. There are programs that reach down into middle schools and high schools to expose promising students to health care careers and others that reach out to experienced clinicians to give them the skills needed to work where health care is scarce. The programs are as diverse as the health workforce.

Maternal and Child Health

HRSA also administers the Title V Maternal and Child Health (MCH) Services Block Grant program, which is the Nation's oldest Federal-State health care partnership. For 75 years, Title V has provided a foundation for ensuring the health of the Nation's mothers and children. Title V supported programs provide prenatal health services to more than 2 million women, and primary and preventive health care to more than 17 million children, including almost 1 million children with special health care needs. Today, State MCH agencies, which are located within State health departments, apply for and receive a Title V formula grant each year.

Every $4 of Federal Title V money received must be matched by at least $3 of State and/or local money. This "match" results in there being more than $5 billion annually available for MCH programs at the State and local level. At least 30 percent of Title V Federal funds are earmarked for preventive and primary care services for children and at least 30 percent are earmarked for services for children with special health care needs.

The purpose of the Title V MCH Block Grant is to improve the health of all mothers and children consistent with the applicable health status goals and national objectives, and to provide and assure mothers and children (in particular those with low income or with limited availability of health services) access to quality maternal and child health services.

The Affordable Care Act provided $100 million in FY 2010 for grants to States and tribes to provide evidence-based home visitation services to improve outcomes for children and families who reside in at-risk communities. Through the Maternal, Infant, and Early Childhood Home Visiting Program, nurses, social workers, or other professionals meet with at-risk families in their homes, evaluate the families' circumstances, and connect families to the kinds of help that can make a real difference in a child's health, development, and ability to learn—such as health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance. Home visiting is a strategy that has been used by public health and human services programs to foster child development and address such problems as infant mortality. HRSA and ACF are working collaboratively on this program.

Secretary Sebelius also announced this summer $4.9 million in grants to continue support for 51 Family-to-Family Health Information Centers in each State and the District of Columbia. Created in 2005, the centers are state-wide, family-run organizations that provide information, education, training, outreach, and peer support to families of children and youth with special health care needs and the professionals who serve them. Funding

for the centers was extended through 2012 by the Affordable Care Act. The Family-to-Family Health Information Centers are staffed by family leaders with children having special health care needs, and who have expertise in Federal and State public and private health care systems, as well as by health professionals. Overall, these centers help families make more informed health care choices for their children leading to better treatment decisions and improved outcomes.

I would like to recognize a few bills introduced by members of the Subcommittee that support enhanced access and quality of care for our Nation's mothers and children, and that also have synergies with programs at HRSA. H.R. 3212, which you introduced, Mr. Chairman, aims to improve the health of children and reduce the occurrence of sudden infant death syndrome, an issue that is a high priority at HRSA, and H.R. 1347, Representative Pascrell's "Concussion Treatment and Cares Tool Act", which addresses what we call more globally at HRSA traumatic brain injury.

Division of Transplantation

HRSA's Division of Transplantation provides federal oversight of national systems that support organ, bone marrow, and cord blood donation and allocation systems that ensure these life-saving gifts are given fairly and efficiently to the people who need them most. HRSA's efforts to increase donation and transplantation mean the difference of life and death for thousands of Americans and their families each year. HRSA's programs work to not only increase donation, but also improve the health outcomes of those who have transplants.

The Organ Transplantation Program seeks to extend and enhance the lives of individuals with end-stage organ failure for whom an organ transplant is the most appropriate therapeutic treatment. The Program works towards achieving this goal by providing for a national system, the Organ Procurement and Transplantation Network (OPTN), to allocate and distribute donor organs to individuals waiting for an organ transplant. Today, there are 108,000 individuals waiting for an organ transplant. Although a substantial number of transplants were performed in 2009, the demand for organ transplantation continues to far exceed the number of donor organs.

Additionally, each year nearly 18,000 people in the U.S. are diagnosed with life-threatening illnesses where blood stem cell transplantation from a matched donor is their best treatment option. Often, the first choice donor is a sibling, but only 30 percent of people have a fully tissue-matched brother or sister. For the other 70 percent, or approximately 12,600 people, a search for a matched unrelated adult donor or a matched umbilical cord blood unit must be performed.

HRSA funds two major programs that facilitate the provision of blood stem cell units to individuals in need of a transplant. The C.W. Bill Young Cell Transplantation Program supports activities to increase the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and cord blood. The National Cord Blood Inventory (NCBI) program supports the collection, processing and storage of a genetically and ethnically diverse inventory of high-quality umbilical cord blood for transplantation. These cord blood units, as well as other units in the inventories of participating cord blood banks, are made available to physicians and patients for blood stem cell transplants through the C.W. Bill Young Cell Transplantation Program.

At any given time, 6,000 people are searching for a matched bone marrow donor or cord blood unit. HRSA acknowledges Representative Matsui's work on this critical issue through H.R. 6081, the "Stem Cell Therapeutic Research Reauthorization Act" and through H.R. 1230, the "Bone Marrow Failure Disease Research and Treatment Act of 2009."

ORHP/Telehealth

The Office of Rural Health Policy within HRSA supports programs to increase access to health care for Americans living in rural areas. Recently, the Secretary announced $32 million to support rural health priorities, including funding for telehealth. These activities also dovetail with the President's Improving Rural Health Care Initiative in the Fiscal Year (FY) 2010 and 2011 budgets, which include a focus on telehealth services.

In many rural communities, patients can only receive certain specialty services locally through the HRSA-funded telehealth program. That is, there are no local providers or traveling clinicians or non-HRSA funded telehealth programs to provide certain specialty services and patients must travel to obtain such services. Telehealth allows patients in underserved and remote areas to receive health care without traveling great distances; it is also frequently used for distance education and health care administration. The services provided via telemedicine range from primary care to highly specialized care found in leading academic medical centers.

Of the $32 million in funds recently announced, more than $2 million was allocated for the Telehealth Network Grant Program, which helps communities build capacity to develop sustainable telehealth programs and networks.

Additionally, more than $1 million was allocated for the Telehealth Resources Center Grant Program, which provides technical assistance to help health care organizations, networks and providers implement cost-effective telehealth programs serving rural and medically underserved areas and populations. The program is designed for entities with a successful track record in helping to develop sustainable telehealth programs.

We understand that Representative Butterfield, a strong supporter of telehealth, intends to introduce a bill to reauthorize certain telehealth programs.

Health Center Program

Health centers are community-based and patient-directed organizations that serve populations with limited access to health care. These include low-income populations, the uninsured, those with limited English proficiency, individuals and families experiencing homelessness, and those living in public housing. These centers are designed to provide accessible, dignified health services to low-income people and their families. Community and consumer participation in the organization and a patient majority governing board were and continue to be the hallmark of the health center model.

Here are some additional points about health centers:

- More than half of the nearly 19 million patients seen by health centers in 2009 were members of racial and ethnic minority groups. Nearly forty percent had no health insurance; a third were children.
- One out of every 17 people living in the U.S. now relies on a HRSA-funded clinic for primary care.
- Community health centers are an integral source of local employment and economic growth in many underserved and low-income communities. In 2009, community health centers across the nation injected more than $11 billion in operating expenditures directly into their local economies.
- Community health centers employ more than 9,100 physicians and more than 5,700 nurse practitioners, physician assistants, and certified nurse midwives in a multi-disciplinary clinical

workforce designed to treat the whole patient through culturally-competent, accessible, and integrated care.

We appreciate this Subcommittee's support for the health center program and recognition of the value of health centers as providers of affordable, quality health care.

The Affordable Care Act will invest $11 billion dollars over the next five years for the operation, expansion and construction of health centers throughout the Nation. On August 9th, Secretary Sebelius announced the availability of up to $250 million in grants for health center New Access Points, made available by the Affordable Care Act. These funds will support approximately 350 new service delivery sites in fiscal year 2011. A new access point is a new full-time service delivery site that provides comprehensive primary and preventive health care services. New access points improve the health status and decrease health disparities of the medically underserved populations to be served. Organizations eligible to compete include public or nonprofit private entities, including tribal, faith-based and community-based organizations that meet health center funding requirements.

Health Disparities

Eliminating health disparities is one of HRSA's top priorities. When it comes to efforts to eliminate disparities in access to care and health outcomes, our largest programs do the heavy lifting: health centers, Ryan White, health professions training, and maternal and child health. The largest portion of the individuals whose health care we support—more than 19 million people—are served through our network of 1,100 health center grantees operating more than 7,900 service delivery sites in every State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

Whether it is clinicians who provide culturally competent care or understanding the unique needs and health concerns of the Lesbian, Gay, Bisexual and Transgender (LGBT) community, HRSA recognizes the importance of these efforts in addressing health disparities. Representative Baldwin's proposal aimed at LGBT data collection offers a remedy for addressing health disparities impacting the LGBT community.

Another way to address disparities is to improve health outcomes, which is especially important to vulnerable communities, including individuals with chronic illnesses, children and the elderly. HRSA funded six patient navigator projects for a two-year demonstration, beginning in September 2008, to support non-medical health workers, especially in communities with significant health disparities and barriers to health services. The workers, also known as patient navigators, help people learn about chronic disease, such as cancer, diabetes, cardiovascular disease, obesity and asthma, then steer them into screening and treatment as needed. In addition, navigators assist people in finding and using community services that will help them manage chronic disease for longer, healthier lives.

Like patient navigators, medical legal partnerships (MLPs) can help patients improve health outcomes by addressing unmet health-related legal needs. For example, MLPs could be valuable to health centers and their patients who need assistance navigating Federal and State rules and regulations. One study indicated that 90% of health center patients have unmet legal needs.

HRSA has some experience with MLPs, as HRSA's Maternal and Child Health Bureau undertook an initiative in FY2010 to support a small MLP demonstration project. This project provides tools, resources and technical assistance to three Healthy Start Sites to determine if MLP services can positively impact health indicators at these sites.

HRSA believes that the medical-legal partnership (MLP) model could potentially address challenges and issues that affect the health needs of vulnerable populations. And we note that H.R. 5961, Representative Maffei's and Representative Murphy's "Medical Legal Partnerships" legislation, aims to address this issue.

HIV/AIDS

As it relates to HIV/AIDS, HRSA's Ryan White HIV/AIDS Program, which recently entered its twentieth year of providing a legacy of care to persons living with HIV and AIDS, is a critical part of the health care safety net. I would like to acknowledge the essential efforts of this Subcommittee in the Program's reauthorization. Ryan White provides critical medical care and support services to uninsured, underinsured, and low-income people living with HIV/AIDS who have no other source of care. Through HRSA's HIV/AIDS Bureau, grants are awarded to cities, States, and local community-based organizations for the purpose of providing primary medical care and support services to individuals living with HIV/AIDS. The program serves over a half million individuals living with HIV/AIDS who rely on us for life-saving, life extending care and treatment.

Additionally, I would like to acknowledge the Administration's National HIV/AIDS Strategy. The Plan, which is a coordinated national response to the HIV epidemic, aims to accomplish three primary goals: 1) to reduce the number of people who become infected with HIV, 2) to increase access to care and optimizing health outcomes for people living with HIV, and 3) to reduce HIV-related health disparities. HRSA will remain involved in the Plan's implementation.

Conclusion

We are extremely proud of our programs and look forward to continuing to work with you, Mr. Chairman and Members of the Subcommittee, to provide quality primary health care for all.

I appreciate the opportunity to testify today, and I hope this testimony will inform the Subcommittee's future deliberations on the many important legislative proposals before you. I would be pleased to answer any questions at this time.

Mr. PALLONE. Thank you, Dr. Brand.

Dr. Clark, you were just here to answer questions, right? OK. So we will go to the questions and I will start with myself and recognize myself for 5 minutes.

I wanted to ask about the veterinary bill, H.R. 299, because that is one of the ones that I am particularly concerned about. I will ask Dr. Brand—I will start with you.

Your testimony describes HRSA's work to support the training and education of health professionals. I would like to ask you about HRSA's support for public health professionals. My understanding is that HRSA administers programs to promote the training and education in various ways, but how does this relate to this bill in particular? And if you could tell us how certain veterinarians with expertise in public health contribute to the public health workforce.

Ms. BRAND. HRSA already provides support for veterinary schools through our health profession student loan program. Scholarships for disadvantaged students, our HCOP program, which is our Health Careers Opportunities Program, geriatric education centers, loans for disadvantaged students, and our Centers for Excellence Program. So we already have a relationship with a number of veterinary schools.

We have also a new provision that would allow us to provide loan support for veterinarians and support their training, should those resources be made available.

Mr. PALLONE. And then Dr. Arias and Dr. Tabak, is there anything you would like to add about the role of these veterinary public health professionals from either CDC or NIH perspectives, if you would?

Dr. Arias.

Ms. ARIAS. Sure. CDC clearly recognizes the relationship between veterinary issues, emerging issues among animals and then humans. In fact, H1N1 is the most recent example of how it is that what happens with animals is something that eventually can influence humans, which is what we are primarily charged with making sure we address.

In addition to that, we continue to face the challenge of vector-borne illness, the most obvious of those currently is the spread of Dengue Fever, which first was a significant issue in Puerto Rico but now has crossed borders into Florida, making sure that we engage in whatever it is that we have to do in order to make sure that that spread does not continue. One of the things that we are committed to is making sure that we identify and rely on the professional expertise of all those who need to be brought to the table so that we can then address those health issues among humans in an effective way, and veterinary professionals are part of that.

Mr. PALLONE. Thank you.

Dr. Tabak.

Dr. TABAK. Yes. I can tell you that the NIH, through the National Center for Research Resources, administers programs that are similar to the bills' goals with regard to training in infectious disease and environmental research. These include training programs and career development programs specifically oriented to veterinarians receiving training in biomedical and translational research of public health significance, as well as providing funding

for the construction acquisition of equipment, and other capital costs related to the expansion of entities related to veterinary medicine, biomedicine, and public health.

Mr. PALLONE. OK, thanks.

Can I ask Dr. Clark—I have to ask you something, since that is why you are here, right?

On the methamphetamine bill, H.R. 2818, it reauthorizes and enhances residential treatment programs for pregnant women and mothers. What need does this program meet that makes it different from other drug treatment programs, and does the bill only address meth?

Dr. CLARK. The—we take no official position on the bill, per se, but we do recognize that the important issues associated with substance use and pregnant women, and the intergenerational transmission of substance abuse-related problems. We know that methamphetamine affects not only children, families, law enforcement, but the environment, so we have specific programs targeted to pregnant, postpartum, and parenting women, and this bill assists us in addressing that.

Since 2002, we—through our existing pregnant, postpartum women program we have treated almost 4,700 women; 51.6 percent were pregnant. So this bill allows us to move what we have been doing in the field, to change the authorization to include outpatient care, and women who are parenting but who are not pregnant. And that is an important thing.

I should note that our program has included care for 4,000 children, 58 percent of whom were in their mother's custody, so that becomes an important issue, because as we are aware, reuniting families is an important issue where possible. So this bill would allow those issues to be addressed, and we are very much concerned about that, making sure that families can be reunited. We deal with the substance abuse issue, both in residential an outpatient settings, and the authorization associated with this bill broadens the scope of our current activity.

Mr. PALLONE. OK, thank you.

Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I would like for you, Dr. Brand and Dr. Arias, to send my warm regards to the Secretary and let her know I look forward to her coming sometime. She will eventually get here and we will eventually have an interesting day of addressing questions and concerns about implementation. It is important, because a lot of these—a lot of our consternation here is that the dust hasn't settled on the law. The new law does give the Secretary a lot of authority and money to do a lot of things that a lot of these bills could do without authorization. So that is of concern. That is the point of some of these questions.

Let me go to Dr. Arias first. I understand that CDC has been involved with arthritis research, education, and surveillance, including the implementation of a National Arthritis Action Plan. Would you describe these activities for us?

Ms. ARIAS. I can get you more specific information that I think is going to be more helpful to you for the written record, but just broadly, it is to primarily provide education about arthritis, and then encourage the linkage of individuals afflicted with arthritis to

services that may be important for them in order to improve the quality of life.

One of the significant concerns among individuals with arthritis, especially with increasing age, is the high risk for falls, and then unfortunately the negative health consequences associated with that. So not only because of the arthritic issues per se, but then the consequences for general health that unfortunately are true for those individuals. Our program then expands and looks at those issues as well.

Mr. SHIMKUS. So we already have a plan to some extent, is that correct?

Ms. ARIAS. I can get—to the extent that we have a plan, I will send that to you as follow-up. I know that we have the broad strategy as to be able to then identify individuals who are afflicted and make services either for prevention or——

Mr. SHIMKUS. Can you—when you also do this, can you send us how much money CDC is currently spending on this plan? We think you do have a plan, so——

Ms. ARIAS. Certainly, we can do that.

Mr. SHIMKUS. Issue two on this is part of the arthritis bill talks about a $19 million funding for rheumatologists—pediatric rheumatologists, and it is our understanding—in fact, I have a pull-out here as to the big law—and here is the page—but in Section 5203 of the new healthcare law, there is—it looks like $30 million loan repayment program for pediatric specialists, loan repayment program. Would—this also could be available for—I mean, it is a pediatric specialist—pediatric rheumatologist would be a pediatric specialist, would it not?

Ms. ARIAS. Yes, although I couldn't speak to a repayment program, and I don't know if her——

Mr. SHIMKUS. Well, that is why we need the Secretary here, because that is the part of the new law.

Dr. Brand.

Ms. BRAND. Well——

Mr. SHIMKUS. It is 5203.

Ms. BRAND. Yes, sir. It creates the pediatric specialties loan repayment program, and HRSA does manage the loan repayment programs. I don't believe any resources remain available for it, so it is——

Mr. SHIMKUS. Well, there is $20 million for each of the fiscal year 2010 through 2013, which is part of the law——

Ms. SCHAKOWSKY. Excuse me, would the gentleman yield just for factual——

Mr. SHIMKUS. Sure, yes.

Ms. SCHAKOWSKY. Let me just say that the $30 million that was originally in 2010—H.R. 2010 has been taken out. It is out of the bill, the bill that is before us now.

Mr. SHIMKUS. You are talking about the $19 million. This is the healthcare law that we signed——

Ms. SCHAKOWSKY. No, I understand that, but there is no redundancy. I just wanted to make that point.

Mr. SHIMKUS. Well, we have—unless you pulled it out from what we were provided right before the hearing, it is in here now.

Hopefully then as we move forward—that is our question. That is why we have hearings, to try to address redundancies, and if that is the case, we appreciate it.

I also need to move to Dr. Arias again. In fiscal year 2011, the CDC budget justification request includes an increase of $79.4 million above the fiscal year 2010 omnibus for the World Trade Center program for a total of $150 million. Your budget justification states with this increase, CDC will continue to provide monitoring and treatment services for mental and physical health conditions related to World Trade Center exposures for both responders and eligible non-responders. The World Trade Center program is critical in meeting the ongoing and long-term special needs of individuals that were exposed to smoke, dust, debris, and psychological trauma from the World Trade Center attacks. This increase will enable CDC to continue providing these much needed services.

The question some members are apparently unaware that CDC currently provides monitoring and treatment services for first responders of the World Trade Center related attacks, so you can—can you confirm that CDC does, in fact, currently provide monitoring and treatment services?

Ms. ARIAS. We don't provide services. We do provide technical assistance to develop a registry, and then the surveillance of individuals who were exposed and whatever health conditions they may present, but we don't provide the services.

Mr. SHIMKUS. And the services are provided where?

Ms. ARIAS. The services are provided in New York City by community-based organizations, hospitals in that area.

Mr. SHIMKUS. Great, thank you. My time is expired, but I will just put on the record, the First Lady's Let's Move program is a program that is not authorized but is funded by the—by HHS, through, I guess, by some discretionary funding and the like. So the point, again, for us is a lot of these things HHS has the authority to do, can do, and I will just put that on the record.

I yield back my time.

Mr. PALLONE. Our vice chair, Ms. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman. As some people know, I have been a very proud sponsor of the Heart for Women Act since 2006, and a big component of this legislation is expanding the CDC's WISEWOMAN program, which you referenced, Dr. Arias, in your testimony, which screens low income, uninsured, and underinsured women between the ages of 40 and 64 for cardiovascular disease. The program also provides outreach, referral, education, and counseling to the participants.

Dr. Arias, would you please speak a bit about the success of the WISEWOMAN program? Is this considered a valuable and effective program, and does the CDC favor expanding it?

Ms. ARIAS. We are very excited about the opportunity for more women to have access to basic screening and other preventive measures starting in 2014. We look forward to WISEWOMAN continuing as a vital complement to those services. WISEWOMAN currently provides for a specific health screening, but it is actually a broader effort to improve heart health among women. So in addition to those clinical preventive services, women in the program can also take advantage of lifestyle programs that target poor nu-

trition, physical inactivity, smoking. It includes programs such as cooking classes in order to improve nutrition, not just in those women but their families, fitness classes and competitions, and quit smoking classes.

These are elements that are not part of clinical preventive services, and therefore we are committed to continuing making sure that these are provided and supported, since there is a significant need for them. It is important to recognize that having insurance coverage doesn't necessarily mean that individuals receive recommended preventive services.

So from our experience with WISEWOMAN, especially in the breast and cervical cancer screening program and our immunization program, we understand that it takes much more. And so we are looking forward to being able to provide even greater comprehensive response to a leading cause of death for women in the U.S.

Mrs. CAPPS. Thank you. Actually, I will follow-up with a question but you kind of answered it. There are some who are saying—you know, question whether we need an expanded role for WISEWOMAN program into the future, because both immediate and long-term after 2014, when most of the new health reform law goes into effect.

It talks a little bit more about ways that you see this being complimentary and not duplicative of the primary care that we expect everyone to be accessing.

Ms. ARIAS. Yes, you are correct, and that is our intention. It has been our—we are very interested in making sure that we coordinate with clinical services, as we should in order to have a good response to health conditions. However, from a public health perspective, that is not our primary focus. It is really looking at the context in which those clinical services are made available and are accessed by individuals that can be supported in ways that the services themselves will not do.

Mrs. CAPPS. So you—this is one of the areas—and I imagine that there are very many other ones as well, where programs in the community, that are based in the community that serve particular populations will only be enhanced by having more of your target group now also receiving primary care, and that this will be a symbiotic relationship rather than one competing or in any way duplicating what the other is doing. Rather, it will help to reinforce and actually extend the value of primary care that hopefully more women will be getting for themselves and for their families.

Ms. ARIAS. Yes, that is exactly correct, and a major reason for why I said that this is a very exciting time for public health, as we look forward to how it is that we can bring down costs, improve the quality of life for every man, woman, and child in this country.

Mrs. CAPPS. Thank you very much. I yield back, Mr. Chairman.

Mr. PALLONE. The gentleman from Pennsylvania, Mr. Pitts. We went and visited your district to see the University of Pennsylvania—what do we call it—veterinary campus when we were looking at the—at Tammy's bill. We went to the farm—all the farms and it was very interesting. Large animal farm, yes. It was great.

Mr. PITTS. Thank you. You are welcome to come anytime.

Thank you, Mr. Chairman. Dr. Arias, you mentioned the 211 in passing and described it as a bill to implement a state-based call-in system providing individuals with information about human services.

Implement infers these programs do not exist. Are you aware of the programs that do exist? Forty-seven states already have these programs?

Ms. ARIAS. We know that states have been moving in the direction of providing similar types of programs. Our staff have been primarily involved with committee staff on figuring out what is the best way of implementing the bill, if it should move forward in order to capitalize on what already has been done, and build upon what has been done.

Mr. PITTS. Does the Administration support H.R. 211?

Ms. ARIAS. I do not—there is no official policy on this bill or any of the bills, actually, that we are discussing today. It is a complex sort of decision-making process in terms of what are the kinds of things that will get supported and done, and we—and it usually involves coordinating among all of the agencies within the Department and then within the Administration, and that process has not been complete.

Mr. PITTS. All right. Would the services provided by the 211 bill be considered an HHS health services program?

Ms. ARIAS. Does HRSA want to comment on that?

Mr. PITTS. Dr. Brand?

Ms. BRAND. In terms of health services program, Health Resources and Services Administration? It is not, as I understand it, it is directed toward the CDC from the management up. It is not something that HRSA would do. There is, certainly, an interest in ensuring that folks have access to information about Health and Human Services for the underserved, and this is one vehicle for accomplishing that. But the Department hasn't taken a position on this.

Mr. PITTS. 211 programs are currently funded by states, and some states have chosen to allow these services to make referrals to abortion service providers. Many believe that the federal taxpayer funds should not be utilized to subsidize or refer for abortions.

Would H.R. 211 allow states to receive federal funds for 211 services, and those services refer patients to abortion service providers?

Ms. ARIAS. Most likely we will be consulting with other HHS agencies and other administrative agencies before making that determination. And again, the issue is whatever then is allowed by law, one, and the other by administrative regulations is what we would look to in terms of deciding what is it—what kinds of services actually do get covered and what wouldn't get covered.

Mr. PITTS. OK. H.R. 1347 requires HHS to establish concussion management guidelines that address the prevention, identification, treatment, and management of concussions in school-age children, including standards for student athletes to return to play after a concussion.

How would these guidelines differ from CDC's Heads Up program that Dr. Kapil testified about last week at the subcommittee's field hearing in New Jersey?

Ms. ARIAS. The Heads Up program is a specific campaign to educate professionals and educate parents and athletic personnel on how to, number one, how to recognize concussion, how to manage them. The bill, in my understanding, is that it would be an extension of that. Currently we have provided those materials, we have generated those materials. They are available for use and that is as far as we have been able to take that program.

Mr. PITTS. In developing the Heads Up educational materials, did CDC consult with outside experts?

Ms. ARIAS. We did consult with both professional and then with education and with sports professionals in the context of the educational sector as well.

Mr. PITTS. Does CDC have a grant program to states to conduct injury surveillance and develop strategic plans and engage in coalition building work to address injuries?

Ms. ARIAS. We have a broad program to address—to essentially support state and local health departments. A lot of—well, a significant number of activities that they engage in are surveillance activities for the number of issues with both unintentional injury and intentional or violence.

Mr. PITTS. And does—go ahead. Were you finished?

Ms. ARIAS. I was going to add, it is a very small program. It is not a very comprehensive program. Currently there are only 30 states that are being supported for a small amount, and again, they usually then often have enough to just support—to just focus on the surveillance activities.

Mr. PITTS. OK, my time is up. Thank you, Mr. Chairman.

Mr. PALLONE. The gentlewoman from Wisconsin, Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman. Before I begin my questions, I would like to submit four items for the record. The first is a letter of support for H.R. 2999 and the manager's amendment that we will be offering during tomorrow's markup. The second is a small section out of the 1999 World Health Organization report titled "Future Trends in Veterinary Public Health," and specifically, I just want to put into the record the scope of VPH in the 21st century, because it contains a definition of veterinary public health that I think will be helpful to have in the committee record. And then two additional items in support of H.R. 6109. The first is testimony of the Human Rights Campaign submitted by Joe Solomon, he is president, and also an article entitled "How to Enclose the LGBT Health Disparities Gap" from the Center for American Progress.

Mr. PALLONE. Without objection, so ordered.

[The information was unavailable at the time of printing.]

Ms. BALDWIN. Thank you, Mr. Chairman.

First, I would like to—I would be interested in answers from all of our witnesses on this question, but perhaps we could start with Dr. Arias to respond more generally, and then move to Dr. Tabak for an update on the Institute of Medicine's work.

But is it your belief that the Department's current understanding of LGBT health is sufficient to inform federal initiatives to reduce health disparities? Would legislation to ensure the voluntary collection of data on sexual orientation and gender identity as appropriate and practicable in programs and surveys that are supported

by the Department of Health and Human Services help to improve and expand the Department's understanding?

Start with you, Dr. Arias.

Ms. ARIAS. Thank you. One of the things that, if you hang around with epidemiologists for any amount of time, you very quickly learn that measurement is key, key issue. Whatever gets measured is addressed. What doesn't get measured doesn't exist and doesn't get addressed.

One of the challenges that we face is not knowing and not having a sufficient understanding of LGBT health. CDC is committed not only to promoting and protecting health, but making sure that we address whatever health disparities or inequities may exist, and unfortunately, currently we don't have enough information to be able to identify what those disparities are.

Ms. BALDWIN. Thank you. Dr. Tabak, could you give us general comments and any update you have on the Institute of Medicine's inquiry into this matter?

Dr. TABAK. Yes, thank you. As you know, NIH determined that more information about research needs and gaps in this area were needed, and so commissioned a study by the Institute of Medicine, who is conducting a study and will be submitting a report on the state of knowledge regarding LGBT health, health risks, and protective factors and health disparities, and we expect that report in the spring of 2011.

There are many challenges, obviously, that were made to conducting research and address health disparities in LGBT populations, and so we are looking forward to the IOM report, and continuing to work with the research community to address the research gaps and opportunities in this area.

Ms. BALDWIN. Thank you.

Dr. Brand?

Ms. BRAND. Yes. HRSA agrees with CDC and NIH, and we don't think we have sufficient understanding of LGBT issues, and we look forward to working with our colleagues at CDC and NIH to better understand those issues.

Ms. BALDWIN. Thank you. We are also talking a little bit about veterinary public health and H.R. 2999. Dr. Brand, you were asked a little bit about current existing loan repayment programs in HRSA.

I am specifically interested in how effective those have been in recruiting and retaining public health veterinarians? How many public health veterinarians have been able to access these funds, and is it your belief that you are reaching the full universe of public health veterinarians who could be working to meet our Nation's public health needs?

Ms. BRAND. It is clear that there are shortages of public health providers in all of the disciplines, and certainly, this is one of them. I would have to go back and ask my colleagues at HRSA to find out how effective we have been at reaching folks through these programs.

These programs do a variety of activities. They recruit individuals and encourage them to go into health careers or stay in health careers or help offset their student expenses. It is not the direct loan that perhaps is suggested in the bill.

Ms. BALDWIN. I would just add briefly, we had a hearing on the full bill last session and it was so illuminating for me to realize how critical public health veterinarians were in responding to human health threats. I mean, you wouldn't think of it intuitively, and then we found out so much about that.

It is my understanding that a very small fraction of the currently available funds are actually directed to public health veterinarians, and we will follow-up after—in making the record full, but I am delighted, Mr. Chairman, that you have chosen to put this bill on the hearing docket, as well as the markup docket for tomorrow.

Mr. PALLONE. Thank you.

Mr. Burgess.

You are recognized for whatever you like.

Mr. BURGESS. Mr. Chairman, I would like to ask unanimous consent for the letters that we have received in support for the National Neurologic Disease Surveillance System Act of 2010, from the Alliance for Aging Research, the American Academy of Neurology, Distonia Medical Research Foundation, National Multiple Sclerosis Society, Parkinson's Action Network, Research America, and the MS Coalition, the American Brain Coalition to be entered into the record.

Mr. PALLONE. Without objection, so ordered.

[The information was unavailable at the time of printing.]

Mr. BURGESS. In addition, I ask unanimous consent for the letters we have received in support of the Gestational Diabetes Act of 2010 from the American Association of Colleges of Pharmacy, the American Diabetes Association, the American Association of Diabetes Educators, the American Congress of Obstetricians and Gynecologists, the American Medical Women's Association, the Association of Women's Health, Obstetric and Neonatal Nurses, and the Society for Women's Health Research be entered.

Mr. PALLONE. Without objection, so ordered.

[The information was unavailable at the time of printing.]

Mr. BURGESS. And finally, I ask unanimous consent that the letters we received in support for the Birth Defects Prevention Risk Reduction Awareness Act of 2010 from the American College of OB/GYN, Allergy and Asthma Network, Mothers of Asthmatics, American Academy of Allergy, Asthma and Immunology, the American Academy of Pediatrics, the March of Dimes Foundation, Spina Bifida Association, and the Organization of Tetrology Information Specialists be also entered.

Mr. PALLONE. Without objection, so ordered.

[The information was unavailable at the time of printing.]

Mr. PALLONE. Oh, I see. You were trying not to have that count towards your time. Was that the idea?

Mr. BURGESS. I have learned under your guidance, Mr. Chairman.

Mr. PALLONE. I see, OK.

Mr. BURGESS. I would also ask unanimous consent that my opening statement be entered into the record.

Mr. PALLONE. So ordered.

[The information was unavailable at the time of printing.]

Mr. BURGESS. I apologize for not being here at the start of the hearing.

Let me just ask you a question, Dr. Arias. You just said what gets measured gets addressed, in response to a previous question. Would you also agree that if we measure to address, registries will help tell us how we are doing?

Ms. ARIAS. Part of our interest in surveillance activities is not only to identify what the problems are and who needs to be served in order to address those issues, but then also over time to be able to measure the effectiveness of whatever solutions are implemented or tried.

Mr. BURGESS. So in other words, to make better decisions on how to spend the research dollars?

Ms. ARIAS. Yes, sir.

Mr. BURGESS. So the cost of providing these tools for surveillance would be a wise investment, so that we have the useful data and make the Federal Government better stewards of the billions of dollars of taxpayer's money they are spending on medical research?

Ms. ARIAS. Yes, sir. Certainly at CDC we do try to be good stewards of how it is that those federal dollars are invested. Again, the major issues that we look at when we make those decisions is, number one, what is the burden and so is it a significant problem that is going to address the greatest number of people, then the other is do we currently have strategies—evidence based strategies that will allow us to intervene.

And so usually those two are critical issues, and then making sure that that investment is an optimal one.

Mr. BURGESS. And Dr. Tabak, from the NIH perspective would you agree with that, that a surveillance system does help us measure—not just measure, but tell us how we are doing with those things that we are measuring?

Dr. TABAK. Well, as you know the CDC is responsible for surveillance, but certainly that helps inform the situation, yes, sir.

Mr. BURGESS. But referencing here specifically 1362, the National MS and Parkinson's Disease Registries Act—and I trust, have you all had made available to you the amendment in the nature of a substitute that will be submitted during the markup later when we do that? Is that information that you have available?

Dr. TABAK. I do not, sir.

Mr. BURGESS. Well again, the concept would be to allow scientists to better leverage efforts to find better treatments and cures for this compendium of neurologic diseases. Again, Dr. Arias, I would assume that you would be in agreement with the general notion of that?

Ms. ARIAS. Yes, we are. Generally we are very supportive of—and look for opportunities to cover as many things as we need to in order to be able to, again, make those sound investments with either current surveillance systems, or the development of those surveillance systems over time.

Mr. BURGESS. And then Dr. Tabak, as we get further into development and understanding of the human genome we will be able then to cross reference to these surveillance systems of registries in order to help more patients and perhaps identify additional risk factors that were not previously anticipated.

Dr. TABAK. Yes, of course. As you identify genetic linkages through genome-wide association studies, the idea then is to circle

back to patients to see how generalizable things are, and in fact, there is research currently being supported by NIH in this arena.

Mr. BURGESS. Let me—Dr. Arias, let me just ask you, moving on to the Gestational Diabetes Act of 2009, H.R. 5354. Are there currently any demonstration grants going toward gestational diabetes education?

Ms. ARIAS. We are currently working to strengthen state capacity for diabetes prevention programs. Prevention of type 2 diabetes is an outcome of addressing CDC's Winnable Battle of obesity, nutrition, and physical activity. We do not have a specific gestational diabetes component to that, but are committed to addressing whatever the needs are within the broad framework of diabetes prevention.

Mr. BURGESS. So you would agree that having a specific effort to look at gestational diabetes is an important part of our overall diabetes management?

Ms. ARIAS. Again, what we would do is based on whatever science is available at that point in—at any particular point in time, giving us a good picture of where the issue is and what can be done about it to determine where is the best place to try to intervene.

Mr. BURGESS. Let me just ask you, Dr. Arias, one last question in regards to H.R. 5462, the Birth Defects Prevention and Risk Reduction and Awareness Act.

Are you familiar with the pregnancy risk information services as they exist in a handful of states, such as my home State of Texas?

Ms. ARIAS. Yes, and we do support just a handful of states to actually collect information and do some educational work on pregnancy-related issues and birth issues.

Mr. BURGESS. Well, I mean I was a practicing OB/GYN for 25 years before I came to Congress. I will just tell you there are precious few places to go for the practitioner, and this really came home to me last August. We were all gearing up for H1N1 and what the impact of that was going to be, and in fact, on the phone with researchers at NIH one day, and really felt for the practitioner out there in the communities who was going to be seeing a great number of school teachers who possibly could become pregnant during the school year who were going to be teaching young children who might be reservoirs of H1N1. It really was a conundrum about how to advise this large subset of the population. Do you seek a vaccination or is this something that would become demanded by the pregnancy? It really put a big burden on providers. I can sympathize with the questions that they were going to get in a week or two when the school year started, and people came in—women came in and were questioning whether or not they should have the vaccine, and if they, in fact, knew they were pregnant, if the vaccine would be harmful.

So it is so important to have this type of information that is literally just a phone call away when people are faced with making tough decisions. I do hope you will look on this legislation favorably. I think it is an important part of our—of what we provide—the services that we provide, not just to our patients but our providers out there as well.

Thank you, Mr. Chairman, for your indulgence. I will yield back the balance of my time.

Mr. PALLONE. Thank you. No, you went 2 minutes over, but that is OK. We have a lot of time today.

The gentlewoman from Colorado, Ms. DeGette.

Ms. DEGETTE. Mr. Chairman, I just want to thank you for having this hearing today, in particular on the two bills which I am the primary sponsor, the Pediatric Research Consortia Establishment Act, H.R. 758, and H.R. 1995, the Eliminating Disparities in Diabetes Prevention, Access, and Care Act. And I also want to thank you for bringing up Mr. Space's H.R. 6012 Diabetes Screening Utilization bill. These are all important bills that we have been working hard all year to try to pass.

I also want to ask unanimous consent to introduce two letters—for the record two letters, one on H.R. 1995 from the American Diabetes Association, and the other one on H.R. 758 from the Federation of Pediatric Organizations.

Mr. PALLONE. Without objection, so ordered.

[The information was unavailable at the time of printing.]

Ms. DEGETTE. Thank you. And I guess I can retroactively yield 2 minutes of my time to Mr. Burgess, and with that, I will yield back.

Mr. PALLONE. Thank you. No, she wasn't serious.

Next is—what about Doris? The gentleman from New York, Mr. Engel.

Mr. ENGEL. Thank you very much, Mr. Chairman, and I stand behind everything that Dr. Burgess said. He and I have a bill which we are talking about today and will be voting on tomorrow, the Gestational Diabetes Act, known as the GEDI Act, which we sponsored together. I just want to, since I didn't make an opening statement, make a mini opening statement now and just say that 135,000 women in the U.S. are diagnosed with gestational diabetes each year, and it can occur in pregnant women who have never had diabetes before but who have had high blood sugar levels in pregnancy. And while gestational diabetes generally goes away after pregnancy, it can have significant health impacts upon both the mother and baby.

In particular, women are at much higher risk of developing type 2 diabetes in the future, and their children are at higher risk of obesity and/or the onset of type 2 diabetes as adults. That is why we introduced this act, and the bill aims to lower the incidents of gestational diabetes and prevent women afflicted with this condition and their children from developing type 2 diabetes.

We need to have a greater understanding on how to prevent and treat this condition. There is currently an insufficient system for monitoring cases of gestational diabetes to uncover trends and target at-risk populations. In addition, new therapies and interventions to detect, treat, and slow the incident of gestational diabetes need to be identified and our bill will help us accomplish these goals. I know Dr. Burgess mentioned that all the groups that support this legislation, I am going to mention them again, the American Diabetes Association, the American Association of Colleges of Pharmacy, American Association of Diabetes Educators, the American Medical Women's Association, the Association of Women's

Health, Obstetric and Neonatal Nurses, and the Society for Women's Health Research.

Mr. Chairman, if Dr. Burgess hadn't done it—I think he did as I was coming in the room—I would like to request unanimous consent that the letters of endorsement be entered into the record.

Mr. PALLONE. I believe they all have.

Mr. ENGEL. Thank you. Let me ask Dr. Arias, based on what I have said, can you tell me what support and outreach programs are currently available to those with gestational diabetes, and also, is there currently a system in place to monitor cases of gestational diabetes?

Ms. ARIAS. Monitoring gestational diabetes specifically would be a new activity for us. As I mentioned earlier, we do comprehensive diabetes prevention work, and in the context of that, if the issue gets raised then we devote whatever resources we may have in order to address the issue.

Mr. ENGEL. What more can be done in these areas, in your opinion?

Ms. ARIAS. At the risk of being repetitive, it is surveillance, and making sure that we are very clear about not only the extent of the problem, but where the problem seems to be most and where it is that we need to focus in order to be most effective in addressing the issue from a population-based perspective.

Mr. ENGEL. Thank you. Let me ask you one final question. Can you speak to the unique differences between gestational diabetes and other forms of diabetes like type 2, and is there a way to determine if a woman is at high risk to get gestational diabetes?

Ms. ARIAS. I am afraid I am not a subject matter expert, and that is information that then we can follow up and send you.

Mr. ENGEL. OK. Can anybody else attempt to answer that at all? No? OK.

Well, I hope—Mr. Chairman, I will yield back the balance of my time. I hope that the committee can tomorrow pass this. This is obviously not a partisan bill, it is a very bipartisan bill, and gestational diabetes doesn't happen with people belonging to one political party or another. It happens to Americans, and I think this is something whose time has come. We need to address this very serious issue.

I yield back.

Mr. PALLONE. Thank you, Mr. Engel.

The gentlewoman from California, Ms. Matsui.

Ms. MATSUI. Thank you, Mr. Chairman, for holding today's hearing. Before I begin, I would like to ask unanimous consent to submit these letters of support from the National Marrow Donor Program and the Aplasic Anemia and MDS International Foundation for the record.

Mr. PALLONE. Without objection, so ordered.

[The information was unavailable at the time of printing.]

Ms. MATSUI. I am so pleased that two of the bills that are most important to me are included in this hearing. Together, H.R. 1230, the Bone Marrow Failure Disease Research and Treatment Act, and H.R. 6081, the Stem Cell Therapeutic and Research Reauthorization, represent holistic approach to combat bone marrow failure diseases. If enacted, they will address new critical areas for re-

search, further awareness of the diseases in high incidences communities, and provide for a one-stop shop for adult stem cell treatment options.

Dr. Tabak, one of the aspects that H.R. 1230, the Bone Marrow Failure Disease Research and Treatment Act, would provide for coordinated outreach and informational programs targeted to minority populations affected by these diseases, including information on treatment options and clinical trials research.

Can you speak broadly about the challenges associated with ensuring minority participation in clinical trials?

Dr. TABAK. Yes, thank you. We issue a 5-year strategic plan on health disparities which describes the agency's priorities for addressing minority health and health disparities. As part of this, the new institute, the National Institute of Minority Health and Health Disparities, has committed to ensuring greater representation and participation of racial and ethnic minority populations, as well as other health disparity populations in research activities. They have done this through the establishment of a bioethics research infrastructure initiative, which is a network of bioethics centers around the United States. Both academic and other non-profit entities with a history of research and training engagement with health disparity communities provides a perfect platform for this initiative. And through this initiative, the NIMHD has dedicated about $15 million in Recovery Act funds over the past 2 years, '09 and '10.

Ms. MATSUI. Dr. Tabak, is it true that you—it is difficult getting minority participants in all sorts of clinical trials, and it is important to have research relevant to all groups.

Dr. TABAK. It is very important to have research relevant to all groups.

Ms. MATSUI. OK. Dr. Brand, I appreciate your mentioning these bills in your testimony. You mentioned that there are 6,000 people searching for a match bone marrow donor or cord blood unit at any time. Can you explain the relationship between the increased research and public education campaigns included in H.R. 1230, and on the potential future successes for the C.W. Beal Young Cell Transplant Program?

Ms. BRAND. H.R. 1230, the Acquired Bone Marrow Failure and Treatment Act, provides for research on acquired bone marrow diseases, encourages outreach, and directs the Agency for Healthcare Research and Quality to examine best practices regarding diagnosing and providing care to individuals with acquired bone marrow disease.

To do this, the Secretary may rely partly on the Stem Cell Therapeutic Database, which is authorized by H.R. 6081, the Stem Cell Reauthorization. The C.W. Beal Young Cell Transplantation Program and the National Cord Blood Injury—Inventory increase the number of transplants suitably matched to biologically unrelated donors, and supports the collection and storage of a genetically and ethically diverse inventory of high quality umbilical cord blood for transplantation.

Additionally, the education outreach called for in H.R. 1230 would help assist patients understand all their treatment options, including transplant, and help patients and physicians assist transplant as a treatment option early in the course of their disease. Op-

timal transplant outcomes are more likely to occur if the transplant is done before the patient's health has deteriorated significantly.

Ms. MATSUI. And Dr. Brand, one way to measure the success of the C.W. Beal Young Cell Transplantation Program is through the number of transplants performed. Can you tell us how the program has performed in this manner during the last 5 years in terms of the actual number of transplants, as well as the actual performance when compared to the part goals?

Ms. BRAND. Cord blood stem cell transplants exceeded goals of 4,500 in 2010, and we have reached over 5,000. Transplants for minority patients are up sharply. We exceeded our goal of 636 in fiscal year 2010, and we will facilitate 840 by the end of the fiscal year. I can provide you a 5-year summary for the record, but we have exceeded our targets every year.

Ms. MATSUI. Thank you. One more question. Another important indicator describing how the program operates is survival rates over time. How are the survival rates over time changed for the transplants that the program facilitates? How do they compare to transplants for related donors?

Ms. BRAND. Survival for standard risk patients now is at 70 percent at one year after transplant, compared to 50 percent in 2000 and 42 percent in 1988. Standard risk patient survival after unrelated donor transplants now matches that for sibling donor transplants.

Ms. MATSUI. OK, thank you.

I yield back the balance of my time.

Mr. PALLONE. Thank you. Gentlewoman from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I just have a couple of questions.

Ms. Arias, I wanted to ask you, there are—as you know, there are 46 million people who suffer from arthritis, but in 2008, only 12 states received funding for programs to prevent and control arthritis. How were these 12 states determined? I understand that 40 states applied, but only 12 were funded.

Ms. ARIAS. Yes, that is correct. We only had enough funding for 12 states, and those were chosen on the base of a competitive process, so it was an evaluation of the applications and then the highest—strongest applications until we ran out of money essentially were supported.

Ms. SCHAKOWSKY. But not all—would you say that the others were not worthy, necessarily, or——

Ms. ARIAS. No, no, not necessarily. Essentially we had a limited pot of funds and could not fund anymore than the 12 if we had wanted to. There were other applications that were worthy of funding and were recommended for funding, however there weren't any funds available for them.

Ms. SCHAKOWSKY. Well, along the same lines, Dr. Tabak—did I say that right? OK. In your testimony, you described the process that NIH uses to set priorities, and you say that "The rigor of this process is so competitive and the number of applications is so large that to date, fewer than one in five research proposals receives NIH funding." So again, I want to ask you, does this mean that only one in five is worth pursuing, or again, is it funding limits

prevent the approval of research proposals that really do have the potential to be worthwhile?

Dr. TABAK. The latter. We certainly, if we had the resources, would be very proud to support additional applications that we receive.

Ms. SCHAKOWSKY. OK, thank you. That is why I look forward to the markup on H.R. 2010 that deals with arthritis, which affects so many Americans, and see if we can't get some of these other worthy projects, and more particularly, we are short of pediatric rheumatologists, to try to get more of those to address this problem.

Thank you, and I yield back.

Mr. PALLONE. Thank you. I think all members have had a chance to ask questions, unless anyone else—well, let me thank you, first of all, for being here. We appreciate your input on this and as you know, we plan to move to the markup tomorrow so it was very useful to have you here today. Thank you very much.

We—I don't know if anybody said they have any written questions they were going to send you, but they still could—you still could get some written questions from members, so we would ask you to get back to us quickly.

Anyone else? If not, without objection, the meeting of the subcommittee is adjourned.

[Whereupon, at 5:27 p.m., the Subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Statement of
the Honorable John D. Dingell
Subcommittee on Health Hearing on "Pending Public Health Legislation"
September 15, 2010

Mr. Chairman, I thank you for holding this hearing today. There are a number of good bills before us, but I would like to focus on two that are important to me and my district.

The first is H.R. 2941, Johanna's Law Reauthorization. Johanna's Law, first enacted in 2007, is an education program that educates women and healthcare providers about gynecologic cancers. This law was named in memory of Johanna Silver Gordon, a Michigan public school teacher. Prior to being diagnosed with an advanced stage of ovarian cancer, Ms. Silver experienced symptoms that are common with this cancer. However, she learned these symptoms were warning signs too late – after her cancer diagnosis.

Reauthorization of this law is vitally important. Each year, more than 71,000 women are diagnosed with a gynecologic cancer, and approximately 26,500 women die from the disease. As with all cancers, early detection of gynecologic cancer is crucial for successful treatment.

I applaud the Centers for Disease Control for carrying out the mission of Johanna's law. We must reauthorize this bill, so that their work can continue to help women across this country.

The other bill of particular interest for me and my district is H.R. 2408, Scleroderma Research and Awareness Act. I have heard from constituents about their difficulties of living with this chronic and disabling condition. Its symptoms range from thickening of skin to shortness of breath, difficulty swallowing, stiff joints and even pain and damage to internal organs.

This is a very complex disease making misdiagnosis very common. Therefore, more research is needed. I am pleased that my district is home to some of the leading experts on scleroderma. The University of Michigan's Scleroderma Program was established in 2004 and brings together specialists in rheumatology, internal medicine, pulmonary medicine, pediatrics and occupational therapy. Since it's inception they have been at the forefront of research and clinical care for this disease.

H.R. 2408 will accelerate this type of work all across the country. I want to thank my colleague, Congresswoman Lois Capps, for her work on this bill and urge my colleagues to support this bill.

Thank you, Mr. Chairman. I yield back the balance of my time.

STATEMENT OF THE HONORABLE JOE BARTON

RANKING MEMBER COMMITTEE ON ENERGY AND COMMERCE

HEALTH SUBCOMMITTEE HEARING:
"PUBLIC HEALTH LEGISLATION"

September 15, 2010

Thank you, Mr. Chairman. Today we will hear about a host of public health bills that will be marked up tomorrow. I thank the witnesses for coming today and look forward to their testimony.

Many of these proposals have underlying merit. The question is, why are we in Congress deciding how to direct disease research instead of allowing scientists to do their jobs? The collective cost also makes one wonder whether the Majority understands the gravity of country's current

fiscal situation. These are not good times for many people, millions of whom have lost their jobs and their income during the last 18 months. And it won't be good times for their children and grandchildren, either, if we can't slow down the president's spending extravaganza and reduce his record deficits.

One of the reasons that I and many others fought so hard to reform the National Institutes of Health was to stop politicizing the research funding process. I want funding to go where the promise of cures and treatments is brightest, with the priorities set by researchers instead of politicians.

That's why I am unhappy to see the return of disease-specific funding proposals. I understand why it happens, and I'm sure everyone else in the room does, too. It is very

difficult for a Member of Congress to tell sick people and their worried families that someone else will make a better decision on research than they can, or we can. As much as we want to say "yes" to those heart-wrenching requests, doing so returns us to the bad days when the special interests, not scientific merit, dictated where research funds went. I think that would sound the retreat from an effective policy that saves the maximum number of lives.

Unfortunately, these many bills suggest that the Majority's still does not understand of our country's dire fiscal situation. This country currently faces a budget deficit of $1.3 trillion and national debt totaling over $13.5 trillion. And although the Majority pushed through Obamacare, with its trillion dollars of spending, it seems that runaway spending is not enough.

The American people have to balance their checkbooks and prioritize their purchases. It is time for Congress to follow the example of the people we represent. We need to start making tough decisions just like the people back home do every day.

If we are afraid to cut an old, outdated program when we create a new one, we will never get the nation's budget in order. If we create duplicative, unnecessary programs just because they seem like good politics, we will have failed. We work for everybody, but sometimes it seems like the ones most likely to be forgotten are the people who pay taxes and trust us to spend their money responsibly. With that responsibility comes choice. We should be prepared to make these choices because our nation's

economic future, our nation's ability to be a leader in the world,, and the futures of our children and grandchildren, depend on it.

Now, it is true that some of the bills we will hear about today represent substantial progress in reducing costs. I wish that were true of all of them.

I look forward to hearing from the witnesses today and look forward to hearing from what their agencies are doing in these various areas of interest. Thank you, Mr. Chairman. I yield back the balance of my time.

HENRY A. WAXMAN, CALIFORNIA
CHAIRMAN

JOE BARTON, TEXAS
RANKING MEMBER

ONE HUNDRED ELEVENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225–2927
Minority (202) 225–3641

MEMORANDUM

September 11, 2010

To: Members of the Subcommittee on Health

Fr: Democratic Health Subcommittee Staff

Re: Hearing on pending public health legislation

On Tuesday, September 14, 2010 at 3:00 p.m. in room 2322 of the Rayburn House Office Building, the Subcommittee on Health will hold a legislative hearing on the following pending public health bills:

- H.R. 211, Calling for 2-1-1 Act of 2009
- H.R. 758, Pediatric Research Consortia Establishment Act
- H.R. 1032, Heart Disease Education, Analysis Research, and Treatment for Women Act
- H.R. 1210, Arthritis Prevention, Control, and Cure Act of 2009
- H.R. 1230, Bone Marrow Failure Disease Research and Treatment Act of 2009
- H.R. 1362, National MS and Parkinson's Disease Registries Act
- H.R. 1995, Eliminating Disparities in Diabetes Prevention Access and Care Act of 2009
- H.R. 2408, Scleroderma Research and Awareness Act
- H.R. 2818, Methamphetamine Education, Treatment, and Hope Act of 2009
- H.R. 2941, Johanna's Law Reauthorization
- H.R. 2999, Veterinary Public Health Workforce and Education Act
- H.R. 5354, Gestational Diabetes Act of 2009
- H.R. 5462, Birth Defects Prevention, Risk Reduction, and Awareness Act of 2010
- H.R. 5986, Neglected Infections of Impoverished Americans Act of 2010
- H.R. 6012, Diabetes Screening Utilization
- H.R. 6081, Stem Cell Therapeutic and Research Reauthorization Act of 2010

- H.R. ___, Telehealth Improvement and Expansion Act of 2010
- H.R. ___, Health Data Collection Improvement Act

I. H.R. 211, Calling for 2-1-1 Act of 2009

This bill requires the Secretary of Health and Human Services (HHS) to award a grant to each state (based on a formula to-be-developed by the Secretary) to make the 2-1-1 health and human services referral service available throughout the state. The bill specifies that the 2-1-1 service will be operated through a lead entity that either has previously had responsibility to carry out this service or meets certain criteria. It authorizes $150 million for each of fiscal years 2009 and 2010 and $100 million for each of fiscal years 2011-2014 to carry out the bill's activities.

II. H.R. 758, Pediatric Research Consortia Establishment Act

This bill requires the National Institutes of Health (NIH) to establish up to 20 pediatric research consortia throughout the nation. Each consortium will be a collaborative effort involving a leading "hub" pediatric medical center and numerous supporting "spoke" institutions. The consortia will focus on both basic and translational research, as well as training for new researchers. Funding will be based on the likelihood of bringing together investigators from multiple disciplines to comprehensively address child health and lifelong genetically-based chronic illness.

III. H.R. 1032, Heart Disease Education, Analysis Research, and Treatment for Women Act

This bill codifies Food and Drug Administration (FDA) regulations that require the inclusion of women in clinical trials submitted to FDA to support an application for a drug, device, or biologics approval. It requires that patient safety data reported to and among the network of patient safety databases be stratified by gender. In addition, the bill requires that the Department of Health and Human Services (HHS) carry out an education campaign about heart disease and women and reauthorizes the WISEWOMAN program at the Centers for Disease Control and Prevention (CDC). The bill authorizes the WISEWOMAN program at: $70 million for fiscal year 2010, $73.5 million for fiscal year 2011, $77 million for fiscal year 2012, $81 million for fiscal year 2013, and $85 million for fiscal year 2014.

IV. H.R. 1210, Arthritis Prevention, Control, and Cure Act of 2009

This bill authorizes the Secretary of Health and Human Services (HHS) to develop and implement a National Arthritis Action Program, at a level of $32 million in fiscal year 2010, rising to $40 million in fiscal year 2014. The program would support control, prevention, surveillance, research, education, and outreach activities, through grants and direct support to public or private nonprofit entities and states. The bill further authorizes the Secretary to expand and intensify programs of the National Institutes of

Health (NIH) with respect to research and related activities concerning various forms of juvenile arthritis and related conditions. It also provides for the Centers for Disease Control and Prevention (CDC) to award grants or enter into cooperative agreements for the collection, analysis, and reporting of data on juvenile arthritis, and supports the development of a national juvenile arthritis population-based database. It authorizes $25 million for each of the fiscal years 2010-2014 for these CDC surveillance activities. In addition, the bill requires the Secretary to provide grants to support pediatric rheumatology training at a level of $3.75 million for each of fiscal years 2010- 2014. It also directs the Secretary to establish and carry out a pediatric rheumatology loan repayment program, as needed. For the purposes of this subsection, the Secretary may reserve funding from amounts already appropriated to the Health Resources and Services Administration for the fiscal year involved.

V. H.R. 1230, Bone Marrow Failure Disease Research and Treatment Act of 2009

This bill requires the Secretary of Health and Human Services (HHS), acting through the Director of the Centers for Disease Control and Prevention (CDC), to develop a system to collect data on acquired bone marrow failure diseases and to establish the National Acquired Bone Marrow Failure Disease Registry and allows the Secretary to award grants to, and enter to contracts and cooperative agreements with public or private nonprofit entities for the management of the Registry. It also requires the Secretary to conduct pilot studies to determine which environmental factors may cause acquired bone marrow failure diseases. It authorizes $3 million for each of fiscal years 2010-2014 to carry out these activities. The bill further requires the Secretary to establish outreach and information programs targeted to minority populations affected by such diseases and to award grants to, or enter into cooperative agreements with, entities to perform research on such diseases It authorizes $2 million for each of fiscal years 2010-2014 to carry out these activities. Finally, the bill requires the Secretary, acting through the Director of the Agency for Healthcare Research and Quality (AHRQ), to award grants to entities to improve diagnostic practices and quality of care with respect to patients with acquired bone marrow failure diseases.

VI. H.R. 1362, National MS and Parkinson's Disease Registries Act

This bill requires the Secretary of Health and Human Services (HHS) to develop surveillance systems, in the form of registries, for both Multiple Sclerosis and Parkinson's disease. It also requires the Secretary to establish an advisory committee on Neurological Disease Registries to review and make recommendations to the Secretary on the surveillance activities authorized in this bill, including the development and maintenance of the systems. The bill authorizes $5 million for each of fiscal years 2010-2014 to carry out the bill's activities.

VII. H.R. 1995, Eliminating Disparities in Diabetes Prevention Access and Care Act of 2009

This bill requires the National Institutes of Health (NIH) to expand, intensify, and support ongoing research and other activities with respect to pre-diabetes and diabetes in minority populations and carry out health care professional mentorship and education activities specific to diabetes. It also requires the Centers for Disease Control and Prevention (CDC) to conduct and support research and other activities with respect to diabetes in minority populations, conduct and support public education efforts, and carry out culturally-appropriate diabetes health promotion programs. In addition, the bill requires the Health Resources and Services Administration (HRSA) to conduct and support programs to educate health professionals on diabetes in minority populations. It authorizes such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year to carry out the bill's activities.

VIII. H.R. 2408, Scleroderma Research and Awareness Act

This bill directs the Director of the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMSD) of the National Institutes of Health (NIH) to expand, intensify and coordinate activities relating to scleroderma. It requires NIAMSD to research the causes and treatment of scleroderma and to establish a scleroderma patient registry at authorization levels of $25 million for fiscal year 2010, $30 million for fiscal year 2011 and $35 million for fiscal year 2012. It also requires the Director of the Centers for Disease Control and Prevention (CDC) to carry out an education campaign to increase awareness of scleroderma and authorizes $2.5 million for fiscal years 2010-2012 for this activity.

IX. H.R. 2818, Methamphetamine Education, Treatment, and Hope Act of 2009

This bill expands and strengthens the Substance Abuse and Mental Health Services Administration (SAMHSA) activities to address the prevention and treatment of addiction to methamphetamine and other drugs. It refines an existing family-centered residential drug treatment program for pregnant and postpartum women and authorizes $20 million for fiscal year 2010, $21 million for fiscal year 2011, $22 million for fiscal year 2012, $23 million for fiscal year 2013, and $24million for fiscal year 2014. The bill also requires support for a workplace-based drug information clearinghouse, and student involvement in prevention programs for methamphetamine and other drugs.

X. H.R. 2941, Johanna's Law Reauthorization

This bill reauthorizes and expands the Center for Disease Control and Prevention (CDC) programs to educate women and healthcare providers about gynecologic cancers. It authorizes $16.5 million for the period of fiscal years 2010-2012 and such sums as are necessary for each subsequent fiscal year for these efforts. It further creates demonstration projects to evaluate research and outreach strategies for educating women and healthcare providers about gynecological cancers. For fiscal years 2010-2012, $15 million is authorized for these activities; such sums as are necessary are authorized for each subsequent fiscal year.

XI. H.R. 2999, Veterinary Public Health Workforce and Education Act

This bill authorizes a competitive grant program for schools of veterinary medicine. Schools can use these grants for faculty recruitment, physical capacity expansion, or the development of curricula to retrain midcareer professionals. It authorizes $100 million for fiscal year 2010, $100 million for fiscal year 2011 and $50 million for each of fiscal years 2012-2014 for these activities. The bill also establishes a loan repayment program whereby the federal government repays loans for veterinarians that make a four-year teaching commitment at a school of veterinary medicine. It authorizes $20 million for each of fiscal years 2010-2014 for this program. In addition, the bill creates two fellowship programs for public health veterinarians that would be administered by the Department of Health and Human Services (HHS) but would be available to all federal agencies that utilize public health veterinarians. It authorizes $2.5 million for each of fiscal years 2010-2014 to support these fellowships. Finally, the- bill establishes a Division of Veterinary Medicine and Public Health at the Health Resources and Services Administration (HRSA).

XII. H.R. 5354, the Gestational Diabetes Act of 2009

This bill requires the Centers for Disease Control and Prevention (CDC) to conduct a multi-site gestational diabetes research project to expand and enhance surveillance data and public health research on gestational diabetes. It would award competitive grants to eligible entities for demonstration projects to build capacity with key stakeholders, establish new surveillance systems, and implement and evaluate evidence-based interventions to reduce the incidence of gestational diabetes and its recurrence and to prevent type 2 diabetes after pregnancy. It authorizes $5 million for each of fiscal years 2010- 2014 for these activities. In addition, the bill requires the CDC Director to conduct research on the epidemiology of gestational diabetes, and on screening methods at an authorization level of $5 million for each of fiscal years 2010-2014. Finally, the bill requires the CDC Director to encourage postpartum screenings after a diagnosis of gestational diabetes within CDC-funded state-based diabetes prevention and control programs.

XIII. H.R. 5462, Birth Defects Prevention, Risk Reduction, and Awareness Act of 2010.

This bill requires the Secretary of Health and Human Services (HHS,) acting through the Director of the Centers for Disease Control and Prevention (CDC,) to establish and implement a birth defects prevention and public awareness program about pregnancy and breastfeeding information services. It requires CDC to award grants for the provision of, or campaigns to increase awareness about, pregnancy and breastfeeding information services. The bill also requires CDC to award grants for research on maternal exposures and maternal health conditions that may influence the risk of adverse pregnancy outcomes. It authorizes $5 million for fiscal year 2011, $6 million for fiscal year 2012, $7 million for fiscal year 2013, $8 million for fiscal year 2014 and $9 million for fiscal year 2015 to carry out the bill's activities.

XIV. H.R. 5986, Neglected Infections of Impoverished Americans Act of 2010

This bill requires the Secretary of Health and Human Services (HHS) to develop a report on the epidemiology and impact of, and appropriate funding required to address neglected infectious diseases of poverty in the United States.

XV. H.R. 6012, Diabetes Screening Utilization Act

This bill directs the Secretary of Health and Human Services (HHS) to review the utilization of diabetes screening benefits and identify existing efforts by HHS agencies, and private and non-profit sectors to increase awareness of diabetes screening benefits. An annual report to Congress on these activities is required.

XVI. H.R. 6081, Stem Cell Therapeutic and Research Reauthorization Act of 2010

This bill reauthorizes the C.W. Bill Young Cell Transplantation Program, which includes the National Registry for adult donors of bone marrow, peripheral blood adult stem cells, and umbilical cord blood units; the Office of Patient Advocacy; and the Stem Cell Therapeutic Outcomes Database. It authorizes $30 million for each of fiscal years 2011- 2014 and $33 million for fiscal year 2015 for the program. The bill also reauthorizes the National Cord Blood Inventory (NCBI), a program that provides grants to public cord blood banks to assist them in collecting donated cord blood units that are then listed on the National Registry. $23 million for each of fiscal years 2011- 2014 and $20 million for fiscal year 2015 is authorized for the NCBI.

XVII. H.R. ___, Telehealth Improvement and Expansion Act of 2010

This bill reauthorizes three telehealth programs currently administered by the Health Resources and Services Administration (HRSA), including (1) the telehealth network program, (2) the telehealth resource center program, and (3) incentive grants to coordinate telemedicine activities among the states. The bill also revises the requirements for funding priorities within both the telehealth network and telehealth resource center programs. It authorizes each of the three programs at $10 million for each of fiscal years 2012- 2016.

XVIII. H.R. ___, Health Data Collection Improvement Act

This bill provides for the voluntary collection of data on sexual orientation and gender identity, as appropriate and practicable, in programs and surveys supported by the Department of Health and Human Services (HHS). It requires the Secretary to develop standards for the development of questions and the appropriate and confidential collection of such information. It also directs that this information be analyzed to assess disparities in health status and access to healthcare.

XVIIII. Witnesses

The following witnesses have been invited to testify:

Lawrence Tabak, D.D.S., Ph.D.
Principal Deputy Director
National Institutes of Health (NIH)

Ileana Arias, Ph.D.
Principal Deputy Director
Centers for Disease Control (CDC)

Marcia Brand Ph.D.
Deputy Administrator
Health Resources and Services Administration (HRSA)

Available for SAMHSA related questions:

H. Westley Clark, M.D., J.D. M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration (SAMHSA)