

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES
APPROPRIATIONS FOR 2016

HEARINGS
BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED FOURTEENTH CONGRESS
FIRST SESSION

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

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**DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION, AND RE-
LATED AGENCIES APPROPRIATIONS FOR
2016**

TUESDAY, MARCH 24, 2015.

NATIONAL LABOR RELATIONS BOARD

WITNESSES

MARK PEARCE, CHAIRMAN, NATIONAL LABOR RELATIONS BOARD

**RICHARD F. GRIFFIN JR., GENERAL COUNSEL, NATIONAL LABOR RE-
LATIONS BOARD**

INTRODUCTION OF WITNESSES

Mr. COLE. If I could, we will now call the hearing to order.

And good morning. I want to welcome today's witnesses, Mr. Mark Gaston Pearce, the chairman of the National Labor Relations Board, and Mr. Richard Griffin Jr., the Board's general counsel. I want to thank both of you for your testimony today.

OPENING STATEMENT—CHAIRMAN COLE

I look forward to discussing the NLRB's fiscal year 2016 budget and some recent Board decisions and regulations that, frankly, I find troubling, but I certainly want to have the opportunity to have a good dialogue with you about them.

I see that the NLRB's budget request includes an additional 30 new FTE. I look forward to discussing the rationale for your request, and I also look forward to discussing a few policy items, again that I find somewhat concerning.

The National Labor Relations Act of 1935 recognized the right of employees to organize labor unions and private industry. All governments were excluded from the act's definition of an employer. No government is covered by the act.

For decades, the NLRB recognized Indian tribes' exemption from the NLRA's jurisdiction, as they are sovereign governments. Incomprehensible to me why the Board would attempt to assert jurisdiction over Indian tribes after so much history and precedent. These nations have a right to self-determination, and I would like to discuss your rationale for infringing upon their sovereignty this morning.

As I am sure you are aware, just last week, the House passed the Senate Joint Resolution 8, providing for disapproval of the NLRB's regulation on case representation procedures. For an agen-

cy that is supposed to be bipartisan, it is a very one-sided rule, in my view.

The rule reduces the amount of time allowed between when a union files a petition and the NLRB holds an election to just 2 weeks. I think that 2 weeks is certainly not long enough to organize something as important as an election of union representation. And it appears that the majority of my colleagues in Congress hold the same view.

The rule also requires employers to provide the email addresses and phone numbers of employees to prospective unions, but what if an employee doesn't use email, or important election correspondence gets caught in their spam filter? Under this rule, with such short time notice, an election could be petitioned and held before an employee even finds out about it.

I recognize and support the right of employees to elect union representation, and I support the NLRB's mission to ensure that those elections are fair. But this rule advances neither goal, in my view. It only makes it easier for unions to organize a workplace.

I also have questions about the NLRB's decision on specialty healthcare, which changes longstanding precedent of what constitutes a bargaining unit by dramatically changing the scope. I wonder if one employee could now be considered a bargaining unit.

Isn't the collective the point of collective bargaining? That is, all employees have the right to decide if they want to be represented by a union for purposes of negotiating terms of employment.

Finally, I am deeply disturbed by the NLRB's review of its current joint employer standard. Recent complaints issued against McDonald's for employment decisions, which are the sole responsibility of independent franchise owners, suggest what will come out of this review. The trial bar must be thrilled because I can't understand who else would benefit from this.

The franchise model has been the basis for many successful small businesses. Small businesses are the job creation engine of our economy, and in many cases, subcontractors are an integral part of a contractor's ability to successfully bid for projects.

A franchisor and the primary contractor have no control over the employment decisions of distinct entities with which they enter into contractual arrangements. Why then should they be liable for those decisions?

It seems to me that the unions and their lawyers want to be able to sue for more money, and the NLRB appears set to enable them. Hope you can convince me otherwise.

I will be asking questions about these issues shortly, and I want to yield now to the distinguished ranking member, Ms. DeLauro, for her opening statement.

OPENING STATEMENT—DELAURO

Ms. DELAURO. Thank you very much, Chairman.

Thank you, Chairman Pearce, and thank you, General Counsel Griffin, for joining us to testify here this morning.

2015 marks the 80th anniversary of the National Labor Relations Act, a landmark law that secured the freedom of workers to represent themselves in the workplace and designated the National Labor Relations Board to defend it.

The NLRB's role is to ensure that workers can form or join a union, be represented by that union in collective bargaining, and be free from retaliation for doing so. These are basic rights.

Today, the NLRB continues to do its job as outlined by the law. It considers unfair labor practice charges filed by individuals, by businesses, and by unions; works to find fair remedies in workplace disputes; and prosecutes violations wherever they occur.

Quite frankly, I find it a bit peculiar from a budgetary perspective that we are having this hearing at all. Only 4 years ago, this subcommittee held a hearing to analyze the NLRB's \$274,000,000 operating budget, which amounts to less than one-fifth of the percent of the total budget authority which is under our jurisdiction.

In the intervening 4 years, the subcommittee has not held budget hearings for many of the agencies under our purview with much larger, multibillion dollar budgets. Moreover, since our last hearing on the NLRB, this agency's budget has been actually cut by 12 percent in real terms.

But I doubt some of my colleagues are here this morning to express concern about budget cuts to the NLRB. Instead, I fear that this morning's hearing is simply an opportunity for yet another assault against workers' fundamental freedoms.

In recent years, we have seen Republican Governors roll back labor rights in Wisconsin and Michigan, among other States. Some groups are even pursuing this attack on the county level.

Just last week, the House majority voted to overturn a modest set of updates to the NLRB's union election procedures. Those procedures have not been revised for several decades, and many of the updates were needed because of the way the Internet has changed how we communicate and access information.

These revisions are designed to clear away unnecessary barriers, excessive delays, and frivolous litigation that make it more difficult for workers to exercise their basic right to a free and to a fair choice. Some would have the barriers remain.

I am pleased to say that none of my Democratic colleagues voted for what I view is a partisan attack, and I am encouraged that President Obama has announced that he will veto it. The truth is that many on the majority side are not just opposed to unions. They are opposed to the basic right of workers to bargain collectively for better wages and benefits.

Let me be clear. The freedom to form or join a labor organization and to bargain collectively, in my view, is sacrosanct. The NLRB's updated election rule favors neither employees, nor employers. It simply enables workers to decide for themselves whether or not to join a union without endless delays, litigation, and intimidation before they can cast a vote.

We know why we need these reforms. A study from the Center for Economic and Policy Research found that among workers who openly advocate for a union during an election campaign, one in five is fired. Other research suggests that as many as 25 to 30 percent of union organizers lose their jobs during these campaigns.

The longer an employer is able to delay the election process, the more likely it is to engage in illegal and unfair labor practices to block or influence the election. Even if an employer's actions are later found to be illegal, they can still be an effective intimidation

tactic. Many employers are more willing to pay fines and back wages if it means they can deter a fair union election.

I know that we will hear a lot at this morning's hearing about so-called "activism" by the NLRB. So I wanted to be clear about the actual content of the reforms that some find so objectionable. All they are designed to do is to modernize and streamline the union election process.

For example, parties may file election petitions and voter lists electronically rather than by mail or in person. Employee contact information, which previously included only names and home addresses, will now include phone numbers and email addresses if those are available to the employer. Employers will be required to provide more detailed and complete information to their employees on the petition.

Employers will be required to identify issues with the petition at least one business day before the pre-election hearing. Litigation that is not necessary to determine whether to hold an election will be deferred until the post election stage.

These, in my view, are commonsense reforms. In truth, there is nothing radical about the mission of the NLRB or the way it does its job.

Mr. Chairman, if I might, there is a fact sheet that I would like to get inserted into the record, the hearing record, if I can?

Mr. COLE. Without objection.

[The information follows:]

NLRB Representation Case-Procedures Fact Sheet

The National Labor Relations Board's (NLRB) Final Rule governing representation-case procedures is designed to remove unnecessary barriers to the fair and expeditious resolution of representation questions. The Final Rule will streamline Board procedures, increase transparency and uniformity across regions, eliminate or reduce unnecessary litigation, duplication and delay, and update the Board's rules on documents and communications in light of modern communications technology. The amendments provide targeted solutions to discrete, specifically identified problems to enable the Board to better fulfill its duty to protect employees' rights by fairly, accurately and expeditiously resolving questions of representation.

Background on Representation-Case Procedures

Representation petitions are filed by employees, unions and employers seeking to have the NLRB conduct an election to determine if employees wish to be represented for purposes of collective bargaining with their employer. The Board will investigate these petitions to determine if an election should be conducted and will direct an election, if appropriate.

In most instances, parties agree on the voting unit and other issues. If parties do not agree, the NLRB's regional office holds a pre-election hearing to determine whether an election should be conducted. The NLRB's regional office conducts the election and, if necessary, holds a post-election hearing to resolve challenges to voters' eligibility and objections to the conduct of the election or conduct affecting the results of the election. Parties can seek Board review of regional determinations made before and after the election.

Modernizing Board Procedures

Electronic Filing/Communications – Parties may file documents, such as petitions, electronically, rather than by fax or mail. Parties and the NLRB's regional offices can transmit documents electronically, rather than using slower or more expensive forms of communications, such as mail or express delivery services.

Election Voter List – The employer must include available personal email addresses and phone numbers of voters on the voter list in order to permit non-employer parties to communicate with prospective voters about the upcoming election using modern forms of communication.

Streamlining Board Procedure and Reducing Unnecessary Litigation

Identifying Disputed Issues – The non-petitioning parties will be required to respond to the petition and state their positions generally the day before the pre-election hearing opens. The petitioner will be required to respond to the issues raised by the non-petitioning parties at the opening of the hearing. Litigation inconsistent with the positions taken by the parties will generally not be allowed.

Litigation of Eligibility and Inclusion Issues – Generally, only issues necessary to determine whether an election should be conducted will be litigated in a pre-election hearing. A regional director may defer litigation of eligibility and inclusion issues affecting a small percentage of the appropriate voting unit to the post-election stage if those issues do not have to be resolved in order to determine if an election should be held. In many cases, those issues will not need to be litigated because they have no impact on the results of the election.

Post Hearing Oral Argument and Briefs – All parties will be provided with an opportunity for oral argument before the close of the hearing. Written briefs will be allowed only if the regional director determines they are necessary.

Review of Regional Director Rulings – The parties may seek review of all regional representation-case rulings through a single post-election request, if the election results have not made those rulings moot. The election will no longer be stayed after the regional director issues a decision and direction of election, in the absence of an order from the Board.

Review Standard for Post-election Issues – The Board will have the discretion to deny review of regional director post-election rulings, under the same standard that has governed Board review of regional director pre-election rulings for many years.

Increasing Transparency and Standardizing Board Process

Earlier and more complete information to the parties – When the petitioner files its petition, it will be required to simultaneously serve a copy of the petition, along with a more detailed Agency description of representation case procedures and an Agency Statement of Position form, on all parties identified in its petition in order to provide them with the earliest possible notice of the filing of the petition and Board procedures for processing those petitions. NLRB regional offices will serve a Notice of Hearing and a Notice of Petition for Election (along with a copy of the petition, description of representation case procedures and the Statement of Position form) on all parties. The non-petitioning parties will be required to respond to the petition (generally the day before the hearing opens) by filing with the regional director and serving on the other parties a Statement of Position identifying the issues they have with the petition. As part of its Statement of Position, the employer will be required to provide all other parties with a list of prospective voters, their job classifications, shifts and work locations.

Earlier and more complete information to employees – The employer is required to post a Notice of Petition for Election containing more detailed information on the filing of the petition and employee rights within two business days of the region's service of the petition. The Notice of Election will provide prospective voters with more detailed information about the election and the voting process.

Scheduling of Hearings – Except in cases presenting unusually complex issues, pre-election hearings will generally be set to open 8 days after a hearing notice is served on the parties. Post-election hearings will generally open 14 days after objections are filed.

Ms. DeLAURO. Thank you.

As I said at this hearing 4 years ago, attacks on workers' rights are not serious attempts to restore jobs, to boost economic growth, or to address budget deficits. Instead, they are designed, purely and simply, to accelerate a race to the bottom. They can only do further harm to middle-class families who are already struggling with a tough economy.

Thank you, and I look forward to hearing your testimony.

Mr. COLE. Thank you very much.

And gentlemen, again, thank you for being with us.

Chairman Pearce, you are recognized for 5 minutes. Your full testimony will be entered into the record. So whatever comments you care to make.

OPENING STATEMENT—PEARCE

Mr. PEARCE. Thank you, Chairman Cole.

Chairman Cole, Ranking Member DeLauro, and members of the subcommittee, I am pleased to appear before you today.

I am privileged to serve as chairman of the National Labor Relations Board, which, as mentioned, will celebrate its 80th anniversary in July of this year. Since its creation in 1935, the National Labor Relations Board has been tasked with enforcing the National Labor Relations Act.

This agency has never functioned without controversy as we deal with the challenges workers and businesses face in our Nation's ever-changing economy. Indeed, labor law continues to stir spirited debate, as we have seen played here in Congress.

Regardless of political tides, this agency's job through 13 administrations has been to serve as independent enforcer of this Nation's most fundamental labor laws. My colleagues at the Board and I take this duty very seriously and strive to do so in a responsible and fair fashion.

General Counsel Griffin will speak more specifically about the agency's fiscal 2016 budget request, as his side of the agency oversees and employs the vast majority of its staff. On the Board side, my side, we have 149 full-time equivalents, and the Board's funding allocation presents about 10 percent of the overall agency budget.

Last year, the Board issued 248 decisions in contested cases, 205 unfair labor practice cases and 43 representation cases, which involves elections. During the first quarter of the current fiscal year, the Board has issued decisions in 119 cases. If we continue on this course, we will have one of the most productive years on record.

This is not to say that there are not issues affecting the agency's case process. Over the past 2 years, there has been continuous debates in the Senate over confirmation of Board nominees. This has resulted in numerous vacancies, impacting the Board's ability to process cases.

Faced with a loss of quorum, recess appointments were made by the Board and were later challenged in the case of *NLRB v. Noel Canning*, which the Supreme Court decided in June of 2014. Following that decision, 103 cases were returned to the Board for reconsideration.

I understand that for the parties involved in these cases, expeditious resolution is critical. To that end, my colleagues and I committed to resolve all these cases within 1 year of the issuance of the Supreme Court decision, and we are very well underway to getting that done. To date, just 18 cases are left to be decided.

My colleagues and I have also instituted an enhanced alternative dispute resolution process. This process will help minimize unnecessary and protracted litigation.

The Board has issued a final rule amending its rules and regulations governing representation case procedures. The final rule is intended to enable the Board to more effectively administer the NLRA. It includes several changes to existing procedures designed to reduce inefficiencies and streamline representation case procedures.

Mr. Chairman, the fiscal year 2016 budget request before you will enable our agency to provide workers and businesses with the efficient and effective case resolution that they deserve. We have an important role to play in the Nation's economy, and we need adequate resources to fulfill the responsibilities of enforcing the National Labor Relations Act as we have proudly done for 80 years.

Thank you for this opportunity to address this subcommittee, and I welcome your questions.

[The information follows:]

STATEMENT OF
CHAIRMAN MARK GASTON PEARCE
NATIONAL LABOR RELATIONS BOARD
BEFORE THE SUBCOMMITTEE ON LABOR, HEALTH, AND HUMAN SERVICES
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 24, 2015

Chairman Cole, Ranking Member DeLauro, and Members of the Subcommittee, I am pleased to appear before you today. Thank you for the invitation. I am privileged to serve as the Chairman of the National Labor Relations Board, which will celebrate its 80th Anniversary in July of this year.

Since its inception in 1935, the National Labor Relations Board has been tasked with enforcing the National Labor Relations Act. The Act, borne out of the Great Depression, has long been a vehicle for employees and employers to resolve workplace disputes. The Agency has never been a place without controversy as we deal with the challenges workers and businesses face in our Nation's ever-changing economy.

Indeed, labor law continues to stir spirited debate, as we have seen play out here in Congress. There has also been vigorous debate of these issues in state houses in recent months. Regardless of political tides, this Agency's job, under 13 Presidents has been to serve as the independent enforcer of one this Nation's most fundamental labor laws.

My Colleagues at the Board and I take this duty very seriously and strive to do so in an efficient, responsible fashion. General Counsel Griffin will speak more specifically about the Agency's Fiscal Year 2016 budget request, and his side of the agency, which oversees and employs the

vast majority of staff. On the Board side, we have 149 FTEs and the Board's funding allocation represents about 10 percent of the overall Agency budget.

The Board issued 248 decisions in contested cases last fiscal year. Decisions were issued in 205 unfair labor practice cases and 43 representation cases. During the first quarter of the current fiscal year, the Board has issued decisions in 119 cases. If we continue on this course, we will have one of our most productive years on record.

That is not to say that there are not issues affecting the Agency's case processing. We have experienced many challenges over the prior two fiscal years. Contentious debates in the Senate over confirmation of Board nominees have resulted in numerous vacancies, impacting the Board's ability to process cases. Faced with a loss of quorum, recess appointments were made to the Board on January 4, 2012. These appointments were challenged in the Supreme Court in the case of *NLRB v. Noel Canning*. On June 26, 2014, the Supreme Court issued its decision in that case. Following that decision, 103 cases were returned to the Board for decision.

To date, the Board has issued new decisions in 73 of those cases with another 27 cases still pending and four that were otherwise resolved. I understand that for parties involved in these cases, expeditious resolution is critical. To that end, my colleagues and I share a commitment to resolving all of these cases within one year of the issuance of the Supreme Court Decision.

In addition to resolving the *Noel Canning* impacted cases, my colleagues and I have also instituted an enhanced alternative dispute resolution process. This process, led by the Office of the Executive Secretary, will help to minimize unnecessary and protracted litigation. I am optimistic that this initiative will help improve our Agency's efficient case processing.

In addition to its casework, the Board has continued to expand its outreach efforts. We have worked to provide user-friendly information to employees and employers via social media outreach and the creation of a free mobile application. These resources help make workers aware of their rights and help employers better understand the protections available under the law.

The Board has also issued a final rule amending its rules and regulations governing representation-case procedures. The final rule is intended to enable the Board to more effectively administer the National Labor Relations Act. It includes several changes to existing procedures, all designed to reduce inefficiencies, modernize processes, and streamline representation case procedures.

Mr. Chairman, the fiscal year 2016 budget request before you will enable our Agency to provide workers and businesses with the efficient and effective case resolution they deserve. We have an important role to play in the nation's economy, and we need adequate resources to fulfill the responsibility of enforcing the National Labor Relations Act, as we have proudly done for nearly 80 years. Thank you for the opportunity to appear before you today and I look forward to your questions.

OPENING STATEMENT—GRIFFIN

Mr. COLE. Thank you very much, Mr. Chairman.

Mr. Griffin, we will go to you next. Again, your full statement will be entered into the record, but you have 5 minutes to comment on whatever you care to.

Mr. GRIFFIN. Thank you very much.

Chairman Cole, Ranking Member DeLauro, and members of the subcommittee, thank you for asking me to appear before you to discuss the agency's fiscal year 2016 budget request.

The National Labor Relations Board is responsible for administering the National Labor Relations Act. The act ensures the right of private sector workers to organize and bargain collectively with their employers and to participate in concerted activities to improve their pay and working conditions with or without a union.

The Office of General Counsel serves as the agency's investigative and prosecutorial branch. I also serve as the agency's chief administrative officer. I have general supervisory authority over the agency's 26 regional and 24 satellite offices and directly oversee 7 headquarters divisions responsible for case handling, administrative, financial, and personnel functions.

I am privileged to work with extremely talented professionals and administrators who ensure that the agency is properly serving the public. They do this through investigating and prosecuting unfair labor practice cases, handling representation elections, and providing support for mission critical functions.

Our fiscal year 2014 statistics illustrate our fulfillment of our statutory responsibilities. In excess of 23,000 cases were filed last fiscal year; 20,415 were unfair labor practice cases, 72.3 percent of which were resolved within 120 days of filing, and the rest were representation cases.

Unfair labor practice charges are filed by individuals, businesses, and unions. After investigation by our regional offices, 64.7 percent of unfair labor practice charges, almost two-thirds, were found to be without merit and dismissed or withdrawn. For those deemed meritorious, 93.4 percent, more than 9 in 10 were settled.

When litigation had to be pursued, 85 percent of our unfair labor practice and compliance cases were won in whole or in part before the NLRB and an administrative law judge, and 84.6 percent of our cases in the Courts of Appeals were enforced or affirmed in whole or in part. We recovered over \$44,000,000, predominantly in back pay on behalf of employees, and secured more than 3,000 offers of reinstatement.

The agency also has authority to seek temporary injunctions from the Federal District Court to ensure that traditional remedies do not come too late to repair the damage done by unfair labor practices. Last fiscal year, the Board authorized my office to see injunctive relief in 38 such cases, and in all the cases that ended up having to be litigated, those were won in whole or in part.

The agency's successful resolution of disputes between employers, unions, and employees implements our congressional mandate to promote industrial peace. In this regard, the efficient resolution of workplace disputes saves all parties from expending significant time and resources in debilitating industrial conflict.

Success resolving industrial disputes is completely dependent upon maintaining adequate staffing levels, training that staff, engaging in appropriate succession planning in light of the expected loss of many retirement-eligible employees, investing in long-term information technology solutions, and addressing all other operating costs, including case-related travel.

About 80 percent of our proposed budget is dedicated to personnel compensation. About 10 percent is for rent and security. More than half of the remaining amount is committed to crucial technological improvements to the agency's public Web site and case handling software.

The National Labor Relations Board plays a critical national role in ensuring that workplace disputes are resolved efficiently and effectively. There is no private right of action under the National Labor Relations Act, and thus workers, employers, and labor unions depend entirely on the agency to resolve their disputes.

Without sufficient funding, both workers and employers stand to lose. Employees unlawfully fired for joining together to get better wages and working conditions will lose. Employers subjected to jurisdictional disputes or unlawful picketing will lose.

I assure you that in fiscal year 2016, the agency will continue to execute our congressional mandate in a fair and timely manner. The agency's budget request will help us to carry out our important statutory mission.

Mr. Chairman, thank you again for inviting me today. I look forward to working with you and am happy to respond to any questions that you or any other members of the committee may have.

[The information follows:]

**STATEMENT OF
RICHARD F. GRIFFIN, JR.
GENERAL COUNSEL
NATIONAL LABOR RELATIONS BOARD
BEFORE THE SUBCOMMITTEE ON LABOR, HEALTH, AND HUMAN SERVICES
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 24, 2015**

Chairman Cole, Ranking Member DeLauro, and Members of the Subcommittee, thank you for the invitation to testify today. I appreciate the opportunity to appear before you to discuss the Agency's Fiscal Year 2016 budget request.

The National Labor Relations Board (NLRB/Agency) is responsible for administering the National Labor Relations Act (NLRA/Act), which ensures the right of private-sector workers to organize and bargain collectively with their employers and to participate in concerted activities to improve their pay and working conditions with or without union representation.

As General Counsel, my Office serves as the investigative and prosecutorial branch of the Agency. I also serve as the Agency's chief administrative officer. In that capacity, I have general supervisory authority over the Agency's 26 Regional and 24 satellite offices located throughout the country (Field offices). In addition, my Office directly oversees seven Headquarters divisions, which are responsible for various case handling, administrative, financial and personnel functions.

As General Counsel, I am privileged to work with and to rely upon a talented group of professional and administrative staff members, who help to ensure that the Agency is serving the

public in the most effective and efficient manner. They do this through ably investigating and prosecuting unfair labor practice cases, handling representation elections, and providing administrative, financial and personnel support of mission-critical functions.

The Agency continues to proactively analyze its workload, budgetary constraints, technology requirements and human capital, and to take appropriate steps to restructure, consolidate and otherwise streamline operations. For example, with regard to Field offices, within the past two and a half years, we consolidated six Regional offices and closed one Resident office, and continue to regularly assess these operations. Similarly, in Headquarters, within the same time frame, we developed a Compliance Unit to better assist Regions with obtaining remedies for statutory violations and created a Division of Legal Counsel, which enhanced our handling of legal and government ethics issues and of Freedom of Information Act (FOIA) matters. Specifically, as to the latter, we have begun centralizing the handling all FOIA requests and appeals through the FOIA Branch; this centralization is designed to enable over 1050 Field office staff members to focus primarily on case handling matters.

Our below-referenced Fiscal Year 2014 statistics illustrate our dedicated efforts to meet our statutory responsibilities.

The Agency's case intake was in excess of 23,000 cases. 20,415 cases were unfair labor practice cases, 72.3 percent of which were resolved within 120 days of filing, and the rest were representation cases.

Unfair labor practice charges are filed by individuals, businesses, and unions. After investigation by the Regions, 64.7 percent of unfair labor practice charges filed were found to be without merit. For those deemed meritorious, 93.4 percent were settled without litigation. When litigation had to be pursued, 85 percent of our unfair labor practice and compliance cases were won, in whole or in part, before the NLRB or an Administrative Law Judge, and 84.6 percent of our cases in the Court of Appeals were enforced or affirmed, in whole or in part.

As for remedies, last fiscal year the Agency recovered over \$44 million, predominantly in back pay, on behalf of employees, and secured offers of reinstatement for more than 3,000 workers. One such case involved a San Francisco facility where the Agency was able to secure an agreement with a successor employer to offer jobs and pay \$1 million to more than 100 current and former employees, who were not hired because of the successor employer's unwillingness to accept a duty to bargain with its employees' chosen bargaining representative.

The Agency must also ensure that appropriate remedies are expeditiously sought in cases where traditional NLRB remedies come too late to repair the damage done by unfair labor practices. In this regard, Section 10(j) of the Act authorizes the NLRB to seek temporary injunctions against employers and unions in federal district courts to stop unfair labor practices while the case is being litigated before administrative law judges and the NLRB. These temporary injunctions are needed to protect the process of collective bargaining and employee rights under the Act. In Fiscal Year 2014, the NLRB authorized my Office to seek injunctive relief in 38 cases and all such cases that were litigated in district court were won, in whole or in part.

The NLRB's ability to successfully help to resolve disputes between employers, unions, and employees in private sector workplaces directly correlates with our Congressional mandate to promote industrial peace. In this regard, the efficient resolution of workplace disputes saves employers, unions, and workers – American taxpayers – from expending significant time, resources, and funds in debilitating industrial conflict.

Of course, success in this area is completely dependent upon our ability to maintain adequate staffing levels, to sufficiently train our staff, to engage in appropriate succession planning in light of the expected loss of a significant number of our retirement-eligible employees, to invest in long-term Information Technology (IT) solutions, and to address all other operating costs, including case-related travel.

Most of our proposed budget – about 80 percent - is dedicated to personnel compensation. Further, about 10 percent is required for rent and security. As a result, only a small percentage, about 10 percent, of the Agency's overall budget is available to cover the rest of the Agency's necessary activities. More than half of that remaining amount is committed to support necessary technological improvements to the Agency's public website and case handling programs. These expenditures are particularly crucial now that the Agency has moved to a system where the electronic case file —maintained in an internal computer system called NxGen— is the official case file. Additional funds sustain educational and outreach efforts aimed at providing guidance to business owners and human resource professionals, as well as workers, about our statute. These outreach efforts include the issuance of public memoranda discussing appropriate

handbook rules and policies in response to the business community's desire for guidance in this area, including a comprehensive guidance memorandum that is in its final draft stages.

In addition, the Agency works to leverage resources. We have executed letters of agreement with foreign ministries designed to strengthen collaborative efforts to provide foreign business owners doing business in the United States, as well as workers from those countries, with education, guidance and access to information regarding their rights and responsibilities under our statute. I believe that the costs associated with this outreach will pay dividends as employers will be able to avoid unintentionally violating our statute and workers will be educated about their statutory rights to engage with one another to improve their conditions of employment, both of which benefits taxpayers, and the country as a whole, through increased economic growth.

The National Labor Relations Board plays a critical role in ensuring that workplace disputes are resolved efficiently and effectively. As there is no private right of action under the National Labor Relations Act, workers, employers, and labor unions depend on the Agency to resolve their issues effectively and efficiently. Without sufficient funding, both workers and employers stand to lose. I assure you that, in Fiscal Year 2016, the Agency will continue to ensure that our Congressional mandate is executed, and in a fair, timely and quality manner. The Agency's budget request will help us to carry out this important statutory mission.

Mr. Chairman, thank you again for inviting me today. I look forward to working with you and am happy to respond to any questions that you may have.

TRIBAL SOVEREIGNTY

Mr. COLE. Well, again, thank both of you gentlemen for being here. And I know we do have some differences on some issues, but I appreciate the commitment to public service and the desire to do the right thing.

Let me go on something, and I am going to add a disclaimer upfront because I want all my biases to be perfectly appropriate on the record. I am a pretty fierce defender of tribal sovereignty. My own tribe is the Chickasaw Nation. We are actually in litigation with the NLRB now.

And you know, so it is obviously an issue of a great deal of personal concern, but it is also professional concern as well, as somebody that believes very strongly in tribal governance. And frankly, this administration has a very good record, by and large, on Native American affairs. It really does.

I have worked with the President on everything from VAWA to increased funding for Native Americans. We are working together on an education initiative now. So this is an area that, frankly, in my view, it predates the administration because the agency many years accepted that tribal governments were governments.

It had no jurisdiction there any more than it does over a State government or over the Federal Government or over a possession in the United States. It just has—we have pretty carefully drawn a line between this agency's responsibilities and public versus private employment.

And again, before either of you were there, the decision was made at the agency that tribes would now come under their jurisdiction. If I recall right, it was early in the 2000s. So, again, for over 65 years, tribal governments were outside, and then the agency unilaterally made the decision to take jurisdiction over some areas of their economic activity.

Can you give me the intellectual justification for that decision by the NLRB?

Mr. PEARCE. Well, thank you, Mr. Chairman, and I appreciate your concern. Of course, I won't speak on the Chickasaw Nation case because that is before us and pending, and it would be inappropriate to do so.

But our determinations relative to Indian tribes and our jurisprudence that followed that stems from San Manuel Indian Casino, which was affirmed by the D.C. Circuit in 2007. It follows the Supreme Court's case that is Tuscarora and Coeur d'Alene in the 9th Circuit, and it follows that framework.

The NLRB generally—and I am not going to get into the weeds on that because I will probably confuse myself. The NLRB will decline jurisdiction if one of these exceptions apply. And that is if there is a treaty that specifically deals with the issue at hand, there will be no abrogation of that treaty.

But in circumstances where a tribe is not fulfilling a traditional tribal or governmental function, such as engaging in a commercial enterprise like a gaming facility, a casino that is targeted to non-Native Americans, employing substantially non-Native Americans, and not involved in tribal governmental functions, the NLRB has exacted jurisdiction. Where the circumstances are tribal govern-

ment related, we have and will continue not to establish jurisdiction. So there is a balancing test that we utilize.

Mr. COLE. Well, a couple of points in response, and then another question. And I am sure we will revisit this several times in the course of the hearing.

And without getting specifically into cases, the San Clementes, that is a tribally operated corporation, chartered corporation. There is a big difference with the Chickasaws, who operated directly through their Department of Commerce. So they would regard it as a governmental function.

And since the income is what funds their government, because these are governments that we don't allow to tax. We don't give them the full governmental authority, they would argue—and most tribes would.

And by the way, just for the record, you mentioned the case you prevailed. If I recall, the Chickasaws actually won the opening round of this case in Federal court in Oklahoma City. It now goes to you, and then my guess is this is going to go through the court system because most tribes feel very strongly about this.

But again, we see a big distinction between entities that are operated by a government and that fund the activities of those government that evidently you don't see.

TRIBAL SOVEREIGNTY CONSULTATIVE PROCESS

Let me ask you this, and again, I am running out of my time. So I will come back to this. But, and this may, again, may predate you. So if you need to take this for the record, that is fine.

I am very curious about what sort of consultative process went on with tribes when this decision was made because, again, for many decades, the NLRB did not assume jurisdiction here, did not see that it had it. So can you sort of familiarize me with whatever process it was as you made your decision to expand your jurisdiction into the area?

Mr. GRIFFIN. If I could just address that briefly?

Mr. COLE. Certainly.

Mr. GRIFFIN. Because the chairman is the chairman of the Board that sits as sort of an appellate adjudicative body of unfair labor practice cases. And so, the record that is before them is a formal record that is established through an administrative law judge's hearing, and then there are briefs filed. And any kind of ex parte communications outside the scope of that would be problematic.

On the other hand, my office constitutes the sort of investigative and prosecutorial office, and we engage in fairly extensive discussions with the parties before proceeding. And so, I can't speak to the time at which the San Manuel case was initiated. As you mentioned, it was before our time.

And I would note that your point, which is that there are cases in the circuit that encompasses Oklahoma, which includes the 10th Circuit. The 10th Circuit law may end up being different from the D.C. Circuit, and this may end up in the Supreme Court.

But returning to your question, we have a consultative process, and as an example, there was recently an issue with the Little River Band in Michigan where there was an unfair labor practice case. It wasn't a representation election.

And it took us some time because of the weather in Michigan in the winter, and we were going to have an in-person consultation with the tribal council. And we set it up two or three times, and ultimately, we ended up having a videoconference for an extended period of time where they advised me and the people in my office of the tribal procedure for processing cases that they contended were similar to ours and that we ought to defer to. And we had an extended back and forth.

Now, ultimately, we didn't agree with them. But we did engage in a full consultative process, and I certainly would commit that that is the kind of discourse and respect for the tribal government that we would want to—

Mr. COLE. Again, let me—and I will make this quickly because I have abused my time, and the gentlelady's time is next, and she has been very kind.

And I will come back to this, but the thing I am trying to get at—and number one, I am not questioning your process or your effort to arrive at a fair decision. And again, this predates your time. So this might be a discussion for another time.

But I am very interested in how and when the decision was made—again, before either of you were in your current positions—that the NLRB decided it had jurisdiction in an area which for decades it had never asserted jurisdiction in. So that is just a personal, you know, where did the idea come from? Why was the decision made?

Because it does cause a great deal of consternation among a lot of Indian tribes. They see themselves as subjected to a jurisdiction that they never visualized they would be and that, indeed, for the majority of the history of the agency, the agency chose not to exercise.

So any information you can give me on how that decision was arrived at these many years ago would be gratefully received.

And again, I thank the gentlelady for indulging me, and she is recognized for whatever questions she cares to put to our witnesses.

NLRB INVESTIGATIVE PROCESS

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

Many of you know I am not a supporter of the current push for trade promotion authority. It is not that I am against trade, but I am in favor of fair trade.

The trouble is that what we have seen in the labor standards rise to our expectations in countries after we realize we have not seen the labor standards rise to our expectations after we finalize a trade agreement with them. In fact, the GAO has found that the U.S. Trade Representative's monitoring and enforcement of labor clauses in these agreements is limited and slow.

So I know how difficult it is to enforce labor standards in foreign countries, but I would like to better understand how the NLRB fulfills its fundamental mission to enforce our labor laws here at home.

Mr. Griffin, I recognize the NLRB doesn't have independent enforcement authority over other agencies. I believe you are limited to responding to claims filed by individuals, businesses, or unions.

Could you describe briefly the process of an investigation through one of your field offices? What are the challenges that you face in enforcing our labor laws? And then I would like to move to another question.

Mr. GRIFFIN. Thank you, Member DeLauro.

You are correct. We do not—we are different from, say, Wage and Hour in the Labor Department or where they have independent investigative authority, we don't have that. We have to wait until either an employee or a union or a business files a charge.

Once the charge is filed, the regional office in which it is filed assigns an investigator to the case, seeks the evidence from the charging party in support of the charge, which generally includes the taking of affidavits by the field investigator, and then contacts the charged party, whether it be an employer or a union, and seeks to obtain evidence from them in terms of what their position is with respect to the charge.

As a general matter, that evidence is also sought in the form of affidavits, and generally speaking, cooperation is not forthcoming with respect to an affidavit. We will get a statement of position from the charged party or something like that.

Upon review of that evidence, if there is sufficient information that has been put together to reach a conclusion as to whether or not the charge has merit, that determination will be made by the region. In the absence of sufficient evidence, we do issue investigative subpoenas in a relatively limited number of cases, seeking either documentary or testimony type evidence.

Once the regional office makes the merit determination, then absent settlement, a complaint will issue. And at that point, counsel for the general counsel will proceed to litigate that complaint in front of an administrative law judge. And then, once the administrative law judge makes the determination, there is an appeal to the Board.

If the Board finds a violation, the Board's order is not self-enforcing so that if the respondent, the charged party chooses not to comply, then the Board has to go into the Federal Courts of Appeals to enforce the Board's order. And if the order is enforced, then failure to comply obviously becomes a matter for contempt of the Federal court.

But it is a process, and that process has its challenges.

NLRB CASE DISPOSITION

Ms. DELAURO. Okay. In your testimony, Mr. Griffin, you note that regional offices determined nearly two-thirds of the charges for unfair labor practices are without merit. Of the remaining cases, over 90 percent are settled without litigation.

That suggests to me that the NLRB either dismisses or settles about 98 percent of all charges of unfair labor practices. It doesn't sound to me like an activist agency. If anything, I am concerned that the number of cases the NLRB pursues is too low.

Of the remaining 2 percent of unfair labor practice charges that result in litigation, you note that the NLRB in whole or in part, about 85 percent of the time, wins about 85 percent of the time. And the NLRB decisions are upheld in the Court of Appeals about

85 percent of the time. That sounds like a high success rate as well.

First, can you explain why such a high percentage of charges are dismissed or settled? Second, what usually prompts a case to proceed to litigation? Do you pursue settlements in all cases and only pursue litigation if an employer refuses to settle? Or is there a small percentage of cases that are so egregious that you feel that strongly about pursuing the litigations?

Again, it is also my understanding NLRB does not have the authority to issue fines or punitive remedies, as you pointed out. You are to force corrections to make someone whole by paying back wages. I would just say, and we can come back around to that argument, are there any enforcement tools that would help you to reach better outcomes, and are there tools that would serve as a deterrent to businesses that are bad actors?

Mr. GRIFFIN. Well, let me—thank you for the opportunity to discuss this.

Let me first say that we are open to settlement at any point in the process, and but we do have fairly strict guidelines about what will constitute a settlement. And our guidelines, for example, for back pay, there has got to be at least 80 percent of the back pay owed in order for it to be a settlement. And we, generally speaking, are successful in getting close to 100 percent of back pay owed.

So it is true that we settle a lot of cases.

Ms. DELAURO. Ninety-eight percent, is that accurate? About 98 percent of the claims—

Mr. GRIFFIN. Well, I haven't done—I haven't done the math—

Ms. DELAURO. Okay.

Mr. GRIFFIN [continuing]. Between dismissal, and they are either dismissed or settled. I think that is pretty close to correct.

Of the last year, there were a little over 1,200 complaints issued. There were more than 20,000 charges that were filed. So I haven't gone right down to what percentage that turns out to be, but I think approximately 1/20 is 5 percent.

So, with respect to the remedies, you are correct that we are limited by statute to remedial relief. We cannot do penalties. We cannot do treble damages. We cannot do any of those kind of things that are available under other statutes.

We are limited to remedial relief, and in that regard, our usual relief is back pay, reinstatement, and posting a notice indicating what conduct has been done that is against the law and a commitment not to do it again.

Ms. DELAURO. Thank you. I am sorry, Mr. Chairman.

Mr. COLE. Believe me, I set the example. So I was the problem, not you.

Ms. DELAURO. Do it on the next round.

REPRESENTATION-CASE PROCEDURES

Mr. COLE. Okay. Me, too.

So, with that, just by order of arrival, we will move next to my good friend from Tennessee, Mr. Fleischmann.

Mr. FLEISCHMANN. Thank you, Mr. Chairman.

Chairman Pearce, good to see you this morning. Counsel Griffin, good to see you as well, sir.

Mr. Chairman, I have a question for you, sir. In response to the Senate's introduction of a Congressional Review Act resolution of disapproval on the NLRB's representation case procedures rule, you issued a statement, sir, on February 9th noting that, "Both businesses and workers deserve a process that is effective, fair, and free of unnecessary delays, which is exactly what this rule strives to accomplish."

Even though protracted delays of elections are exceedingly rare, it is undeniable that at least some of these delays can be attributed to union blocking charges or protracted decision-making by the Board itself.

My question, sir, is if the final regulation is truly about eliminating unnecessary delays, why does it do nothing to address delays caused by labor unions or the Board itself?

Mr. PEARCE. Thank you, Congressman, for the opportunity to talk about that.

It should be noted that the rulemaking that we have engaged in was designed to streamline, modernize, and make uniform and transparent the regulations that are currently in operation. The idea is to present a set of circumstances where those people filing petitions, those people having to respond to those petitions have clarity, and the operation can run smoothly and more effectively. That is the responsibility we have to the American public.

Our responsibility clearly doesn't end there. That is one part of the process. We are addressing and pursuing all aspects, including—including how fast elections are dealt with when they are appealed to the Board in Washington.

It should be noted that the rule also addresses blocking charges. There are aspects of the rule that require a higher standard for blocking charges where those bringing those charges would be required to bringing their proof in an expeditious manner so that it can be dealt with efficiently and quickly.

RULEMAKING EXPENSES

Mr. FLEISCHMANN. Okay. I have another question, sir. How much has the Board spent to date—and I don't know which one would like to answer this, either one of you all. How much has the Board spent to date in researching, drafting, making preliminary preparations for implementing its new election rule, including the holding of hearings on the new election rule, reviewing thousands of comments regarding the new rule, and training Board staff regarding the new rule?

Mr. PEARCE. Well, and thanks again. I believe that it is my responsibility to ensure that the agency operates efficiently and effectively, as I mentioned previously. This rule is part of that effort, and the ultimate goal of the rule is to promote efficiency. It includes reforms designed to save the parties from litigating unnecessary issues and ultimately saving the agency and the taxpayer resources.

And an immediate answer to your question, I don't have a dollar figure that I can give you. But the rule is designed to modernize elements of the representation case process, permitting electronic filing, which helps the agency reduce paperwork and associated

cost. Any efforts to improve the efficiency has costs associated with it.

I felt it was important that the Board engage in the Administrative Procedure Act and have a notice and comment period so that people could have input into the development so that we have a full range of concerns being addressed to us. And of course, there costs were associated with that.

We have made every effort to minimize the costs. There will be costs of implementing the rule, but those are transitional costs because the agency's transition to a more efficient and streamlined process is the goal.

Mr. FLEISCHMANN. Thank you.

Mr. Chairman, I know there are a lot of folks who want to ask questions. So I am going to yield back at this time.

Gentlemen, I thank you very much.

Mr. COLE. Thank you very much.

ALTERNATIVE DISPUTE RESOLUTION

We will next go again in order of arrival to the distinguished gentleman from Pennsylvania. Mr. Fattah?

Mr. FATTAH. Thank you, Mr. Chairman.

Chairman, you mentioned in your testimony about this expedited resolution process that you have instituted to help move cases along. Could you talk a little bit about how that is working?

Mr. PEARCE. Well, the alternative dispute resolution process and—

Mr. FATTAH. Yes, I used my own phraseology.

Mr. PEARCE. No, that is fine. I knew exactly what you meant. It is one—it is one where once we have possession of the case, once it is within the jurisdiction of the Board itself, the executive secretary will contact the parties, and this is after a judge's decision has issued and there has been a recommendation by the judge, finding either a violation in some or all of the allegations. And they get the parties together and to discuss how these cases can be resolved.

And he is a trained mediator, and there are trained mediators accessible to the Board that are involved in trying to mediate the dispute so that we can reach—

Mr. FATTAH. Is there appetite for utilizing this alternative process? Is it, I mean, are people taking you up on your offer?

Mr. PEARCE. Well, not as much as we would like. But we do have people, parties responding to that. Of course, it is a voluntary thing.

Oftentimes, parties are more amenable to responding to that once the administrative law judge's decision has issued, and the recommendation is not in the favor of the party holding out.

SUCCESSION PLANNING

Mr. FATTAH. And to the general counsel, you indicated, as is the case for all of the American economy, but particularly the Federal Government, that there is a crisis of baby boomers retiring over time, and there is going to be critical skill shortages. And you said that you are spending some time on succession planning for the agency.

Could you talk a little bit about that?

Mr. GRIFFIN. Yes, we have a very significant percentage of the employees of the agency who are retirement eligible. And they tend to be—because of their seniority and accumulated knowledge, they tend to be in supervisory and leadership positions. And as you know, the hardest thing to do in these contexts is to get the stuff that is in their brains out in a way that is accessible to people.

So, for example, we have a very senior person or a very senior set of leadership in our Injunction Litigation Branch. They work with the regions on trying to make sure that the filings in the Federal courts, seeking either 10(j) injunctions or 10(l) injunctions—which are injunctions that are sought against certain types of unions, secondary picketing, and other unfair labor practices—that they have the best thinking with respect to filing those briefs, samples documents and things like that.

So we have recently engaged in an effort to get the senior people to take their information that is in their heads and get it onto an internal Web site that is easily searchable. That is one example.

The other example is we are trying to bring on staff to make sure that there are people who are trained and ready to take over when those senior leaders retire. And that is really a challenge because people are very busy, and it is difficult to take the time to do that.

But we are encouraging it because it is going to be necessary. These folks have worked a long time, and they are entitled to their retirement when they decide to go.

R-CASE TRAINING

Mr. FATTAH. And one last question, and I have still got a green light, which is great. So you are going to be present in Philadelphia for an R-case rule dissemination process in April at the ABA. It is limited for 100 lawyers. Is that because is that the normal size? Is that because of space limitations?

Mr. GRIFFIN. Well, what we are trying to do, I am not personally—

Mr. FATTAH. I hate to ask you a local question, but—

Mr. GRIFFIN. No, no. That is perfectly—

Mr. FATTAH [continuing]. In our business, local is important.

Mr. GRIFFIN. I got you. What we are trying to do is set up training in as many locations as we can and with as much of the practitioner community, working with our regional offices, as we can. And we have sort of an evolving schedule of that.

And I don't know the personal—I personally don't know the particulars with respect to the Philadelphia training, but I can look into it and provide your office with whatever information you need.

Mr. FATTAH. Thank you.

And I thank the chairman. I yield back.

Mr. COLE. Thank the gentleman very much.

R-CASE PROCEDURES RULEMAKING

I think next up, our Senator Harris from Maryland is recognized.

Mr. HARRIS. Thank you very much.

And thank you, both of you, for being here today.

Let me follow up with the questions from the gentleman from Tennessee about the, you know, what is affectionately referred to

“ambush elections.” Because I tried to figure out why you would call them “ambush elections.” So you are going to have to educate me a little bit on this, on this rule.

So the way, my understanding, kind of compresses the time frame for elections so that which is triggered on I guess when a petition for representation somehow transmitted to the employer. Is that from the NLRB, that petition for representation?

How is the employer notified that this time frame is triggered?

Mr. PEARCE. Well, the petition is filed with the NLRB, and a copy of that petition is supplied to the employer.

Mr. HARRIS. The same day that it is filed with the NLRB?

Mr. PEARCE. Pretty close.

Mr. HARRIS. And my understanding now is that within 8 days, there has to be that first hearing. Is that right? Eight calendar days?

Mr. PEARCE. Yes, but there is leave for extensions with appropriate cause.

Mr. HARRIS. Right. But that is an NLRB decision. I mean, the rule says it is 8 days.

Mr. PEARCE. Yes.

Mr. HARRIS. Okay. And by noon of the day before that eighth day, basically, the employer has to have kind of I guess submits something to the NLRB that sets out its statement of position—is that what it is called—with regards to whether or not the representation unit is appropriate, things like that?

Mr. PEARCE. Well——

Mr. HARRIS. There is a deadline the day before——

Mr. PEARCE [continuing]. There is a deadline to provide a statement of position.

Mr. HARRIS. Right.

Mr. PEARCE. The day before the hearing.

Mr. HARRIS. Noon of the day before?

Mr. PEARCE. The hearing is to be——

Mr. HARRIS. At noon? Not close of business, noon. Is that right?

Mr. PEARCE. That is right.

Mr. HARRIS. Okay. So, and I am just thinking about it as a physician. I would imagine, and maybe I will ask Mr. Griffin, I would think labor law is pretty specialized. You don't go to just a general practitioner who does wills and estates when you are doing a labor law negotiation, I would imagine. Is that right?

Mr. GRIFFIN. Well, certainly, the labor bar would make that contention.

Mr. HARRIS. Sure, sure. And you, I imagine, was a member of the labor bar.

Mr. GRIFFIN. I am a member.

Mr. HARRIS. So do you make that contention?

Mr. GRIFFIN. I agree with that, yes.

R-CASE PROCEDURES

Mr. HARRIS. You do? Do you think NLRB law is kind of a subspecialty? You know, having——

Mr. GRIFFIN. Well, having practiced labor law at one point in time, and I have done it now for about 34 years, at one time, the

Board law was basically the central body of law that you had to go on.

Mr. HARRIS. Right. So it is pretty subspecialized.

Mr. GRIFFIN. It is, but you have a risk. So you have a number of—

Mr. HARRIS. You wouldn't go to a family practitioner to do hip joint replacement, and you wouldn't go to a general practice lawyer—

Mr. GRIFFIN. I have had a hip replaced—

Mr. HARRIS. And you didn't go to a general practitioner.

Mr. GRIFFIN. And I did not go to a family—

Mr. HARRIS. And just like that—

Mr. GRIFFIN. You are correct about that.

Mr. HARRIS [continuing]. You wouldn't go—you wouldn't go to a general practitioner to deal with a labor, NLRB representation. I would image. Just again, this is outside of my field.

Mr. GRIFFIN. I am not arguing with you. I am agreeing with you.

Mr. HARRIS. Good. Okay. Now I represent a pretty rural area with small employers. Is it true that the median number of employees who in a petition for representation in 2014, because this was testimony before one of the other committees earlier this year, is 28 employees. That is a median number?

Mr. GRIFFIN. The elections conducted by the Board over the last 10 years, the median number in elections that have been conducted has been between, I think, 23 or 24 and 28. It has kind of gone back and forth.

Mr. HARRIS. Right. So that is kind of small. So, and I am in a rural area. A lot of my employers are in that ballpark, maybe even less.

I imagine very few of them have in-house counsel, and I imagine none of them have in-house counsel that is actually specialized in NLRB law. So what they would have to do, and let us just pretend that the union, because it actually understands that this deadline sped up, files the petition Thursday before Labor Day.

By your laws, that hearing has to be next Friday, right, 8 calendar days?

Mr. GRIFFIN. It is business days.

Mr. HARRIS. I think it is calendar. I don't know. The testimony in front of the—are you sure? It says calendar days for that hearing.

Mr. GRIFFIN. I am sorry. My bad. Calendar days.

Mr. HARRIS. Wow. Let me get it straight. The general counsel of the NLRB got that critical question wrong? You needed to turn around and get—Mr. Chairman, I am amazed. But let us go on.

So it is filed for next Friday. So my small employer has to find a subspecialist lawyer the day—and my understanding, this could be filed by close of business on Thursday. It doesn't have to be noon. It doesn't say filed by noon, does it, the petition?

So, at close of business Thursday, the employer finds out and has to find a specialized lawyer to prepare a pretty in-depth statement of position and have it ready by Thursday after Labor Day. And if they don't include something in that statement of position, it can't be entered at the hearing. They can't bring it up at the hearing.

Is that—is my understanding? Look, I am just a doctor. I am not lawyer. Mr. Griffin, is that my understanding that if they don't have it included in that statement of position, they can't introduce it at the hearing next Friday after Labor Day?

Mr. GRIFFIN. My understanding is that if you don't have the issue raised in the petition or you don't have it in the statement of position, that you cannot raise it in the hearing.

Mr. HARRIS. Mr. Chairman, I am going to yield back. But I got to tell you, I now understand why it is called an ambush election. Thank you.

Mr. COLE. I thank the gentleman.

SUCCESSOR EMPLOYER

And next go to my good friend from California, the gentlelady, Ms. Lee.

Ms. LEE. Thank you very much.

Good to see both of you. And let me, first of all, commend you for all of the work that you do in protecting all employees. Your work for those who need labor and employment protections is extremely crucial, especially, unfortunately, given the still exploitation of workers, especially low-wage workers and immigrant workers. So thank you very much.

Now I understand that the NLRB played a very crucial role, and this is a case at the San Francisco facility, where the agency was able to secure an agreement with the successor employer to offer jobs. And they had to pay \$1,000,000 to more than 100 current and former employees.

Now these included people who were not hired because of the successor employee—employer's unwillingness to accept a duty to bargain with its employees' chosen bargaining representative. I am glad that you were able to step in and to get just compensation for these employees, but I am concerned that a successor company would refuse to bargain with a chosen representative.

So is this prevalent? Was this an unusual case? What have you done in the past to rectify this, and how well is this approach working now?

And I am glad that you were able to solve the San Francisco case, but I just hope it doesn't happen again.

Mr. GRIFFIN. Thank you very much, Congresswoman Lee.

The successor refusal, the higher issue, is one that has been of great concern to our office. And so, what we have done is we have included it in our priorities for seeking 10(j) injunctive relief.

My predecessors had established certain other priorities with respect to injunctions. Ron Meisburg, who was appointed by President Bush to be the general counsel, had established a bad faith first collective bargaining agreement initiative where if people involved in an initial collective bargaining agreement bargained in bad faith, that was going to be a priority for seeking injunctive relief.

His successor established the "nip in the bud" organizing campaign initiative where if someone was discharged at the very beginning of an organizing effort, that was the type of unfair labor practice charge that would be a priority for seeking injunctive relief. And my office, shortly after I got in, reissued a memorandum on

our 10(j) program—that is the program that governs seeking injunctive relief—and included successorship refusal to hire cases.

Because the problem with these cases is if the successor employer chooses not to hire deliberately in order to avoid the bargaining obligation, they then start to act unilaterally in changing terms and conditions of employment without negotiating with the union that should be in place.

And once these cases get a little too far down the road, it is very difficult to put them back together again. The employees who should have been hired are scattered to the four winds. They have to work. They have to go someplace to work. So it is very difficult to get them back to their jobs.

And so, we think that those are cases where temporary injunctions should be sought quickly to address the kind of situation that arose in San Francisco.

Ms. LEE. Are these cases prevalent, or is this—

Mr. GRIFFIN. They are—I can't say they are prevalent, but when they occur, they are very serious matters, and that is why we have made them a priority.

OUTREACH

Ms. LEE. Good. And let me ask you about your outreach efforts. I know you all have mounted now an effort to make sure that workers understand their rights for fair pay and adequate working conditions, and if these rights are violated, they have the right to file a claim.

I am concerned about ensuring that immigrant workers and people who have limited English language skills understand what these—what your outreach efforts are indicating what to do. Are these materials' language linguistically appropriate? And are they being reached, immigrant populations?

Mr. GRIFFIN. Well, this is a real challenge for us, and so what we have done is tried to make our materials available in other languages. We have also engaged in discussions and reached agreements with the embassies of Mexico, Ecuador, and the Philippines to provide information through the embassies and the consular offices to workers from those countries who are working here in the United States and also to business owners from those countries who are operating in the United States.

Ms. LEE. Are you doing it with any nonprofits who are working with immigrant groups? Do you work with them also?

Mr. GRIFFIN. We try to do that through our outreach efforts. We have very successful in certain regions that we are trying to use as kind of pilots. In the Chicago area, for example, we have been very successful in reaching out to community groups, to faith-based organizations, and to other organizations to try and work with them to advise people, workers of their rights.

Ms. LEE. Okay. Thank you very much, Mr. Chairman.

Thank you.

Mr. COLE. Thank you.

R-CASE PROCEDURES

Again, going by the order, my good friend from Virginia, Mr. Rigell, is next.

Mr. RIGELL. Thank you, Mr. Chairman.

And Chairman Pearce, Mr. Griffin, thank you very much for being here today.

Chairman Pearce, I would like to address this first question to you. Let us say, for example, I am employee at a company that has been targeted for unionization that is subject to the rule that you recently issued there at the Board. What rights do I have as an employee to have my personal information not disclosed to those seeking to unionize the business?

Mr. PEARCE. Well, you have the same rights that employees have always had for the last 50 years.

Mr. RIGELL. So I can opt out? Can I opt out of having my information disclosed, my home email or my personal email address and my shift schedule or anything like that?

Mr. PEARCE. Well, what the rule does is provide information to the union similar to the information that the employer has because the purpose of the rule is to give parties to the——

Mr. RIGELL. But I can't opt out if I want to?

Mr. PEARCE. No.

Mr. RIGELL. I can't?

Mr. PEARCE. Just like—just like an employee cannot opt out from an employer deciding——

Mr. RIGELL. I see that as profoundly different, but if I proactively want to opt out, I can't? My privacy is not protected. I can't—my information must be disclosed. Correct?

Mr. PEARCE. Well, currently, under the current law, before we even get into the rule, under the current law, an employer is obligated during that point in the process to provide the names and the addresses of employees——

Mr. RIGELL. Is there any—is there any provision under which the group trying to unionize has to no longer use that personal information? Let us say that the effort was unsuccessful to unionize. Is there any obligation by those seeking to unionize to not use that personal information going forward?

Mr. PEARCE. The rule specifies that the information should only be used for the representation proceeding.

Mr. RIGELL. Well, I mean, just during that certain period, or can they keep it and use it in a year from then or 2 years from then perhaps?

Mr. PEARCE. They perhaps could, yes.

Mr. RIGELL. All right. Let me ask I think going back to what Dr. Harris was asking about, the shortening of the time. If you just look at the statistics on it, 95 percent of the elections take place within 60 days. The average is less than 40 days. Two-thirds of the outcomes are in favor of unionization.

It does seem like it is a solution in search of a problem. What was the—what was the genesis of this? What was the concern that would cause you to accelerate this with the problems I think that Dr. Harris pointed out that were valid?

Mr. PEARCE. Well, I guess I don't agree with the premise, that what we did was we streamlined the operation. We didn't accelerate anything. Nothing in the final rule mandates that elections be held in a particular time period.

The statute gives the Board responsibility to hold elections as soon—

Mr. RIGELL. It is not a rule without substance, though, is it? I mean, it really had an impact. And the impact of this, the substance of it was that it compressed, at least potentially, the time between the initial attempt to organize and the actual election.

I don't want to—I take no pleasure in being argumentative with you, but it is my understanding that the time was compressed or at least it allowed it to be compressed. Is that true or not?

Mr. PEARCE. Well, what I am trying to explain to you, and I am glad to talk as long you want about it, is that the Board's responsibility is to make election—hold an election as soon as practicable. That is what the statute says.

Mr. RIGELL. Well, I would—

Mr. PEARCE. That is what we are following.

Mr. RIGELL. I would just say that perhaps it is hypothetical, but this scenario that was laid out by Dr. Harris, that is very plausible to me. And it seems unfair to the employer.

I think that the essential mission of the NLRB is a valid one, and I believe the rights of workers need to be protected. And there are examples, certainly if we go through American history, where employers took advantage of workers. So it is not—I don't start out with an inherent bias here. But as I look at this as objectively as I can, I think you missed—you missed the mark.

NLRB MISSION

I want to point out something, and I am going to give Mr. Griffin just a moment, if I even have it left, to respond to something. But I noticed in his opening testimony, he talks about what the NLRB is responsible for, and he mentions employees but nothing about employers.

And perhaps that was unintentional, but when you are the prosecutorial aspect and side of this operation, to not mention the other party that you are trying to, you know, administer justice to, I think it is an omission that should not have been made.

Mr. GRIFFIN. If I could respectfully disagree? In my opening remarks, and I will quote them accurately. "Without sufficient funding, both workers and employers stand to lose. Employees unlawfully fired for joining together to get better wages and working conditions will lose. Employers subjected to jurisdictional disputes or unlawful picketing will lose."

And employers have—you are 100 percent correct. There are provisions under the National Labor Relations Act that are unfair labor practices by unions. They are found in Section 8(b) of the act.

They include unlawful picketing by unions. They include certain aspects of jurisdictional disputes. They include unlawful aspects of unions taking action against their members or employees.

And we pursue those matters just as seriously and have an obligation to pursue them just as seriously as we have—

Mr. RIGELL. I appreciate you—I appreciate your clarification on that, and I thank the chairman for letting us go over just a minute. And I would still reference paragraph two of your testimony.

Thank you very much. I yield back.

Mr. COLE. Certainly. We next go to the gentlelady from Alabama. Mrs. Roby.

JOINT EMPLOYER

Mrs. ROBY. Sorry. I thought there was somebody on the other side in front of me. So apologize.

Thank you, Mr. Chairman.

For both of you, thank you for being here today.

There have been complaints, and I will use McDonald's as the example here, that the current rules that the NLRB is supposed to work under have been now, you know, interpreted differently when it comes to the relationships with franchisors and franchisees in that the franchisee is being dinged, and then also you are now interpreting the rules so that the corporation, franchisor, is being held responsible for something that the franchisee did on the ground that the franchisor has no control over.

And that is a different response, as is my understanding, as what the rule requires. And I would like for you to address that, but you know, this could be—have a, you know, huge effect when we start looking at contractors and subcontractors, go down the list of how our economy works.

So if you could address this, this is very concerning to me that this rule is, all of a sudden, being interpreted differently.

Mr. GRIFFIN. I would be happy to address it, and because it is a matter of such significant concern, I think it is very important that our office's position is crystal clear. And so, I am not going to talk specifically about the McDonald's cases because those cases are in ongoing litigation, and I think it would be inappropriate to do that.

Mrs. ROBY. That is fine, but the issue itself and moving forward, if you can talk about why you feel as though the NLRB has the authority to change their interpretation of these rules?

Mr. GRIFFIN. Okay. That is what I would like to do.

Mrs. ROBY. Right.

Mr. GRIFFIN. The issue that is involved has to do with the question of joint employer status, and from the very beginning of the National Labor Relations Act, going back to 1935, there was a standard that was applied, which we characterize as the traditional joint employer standard. And that standard was applied from 1935 until 1984. And then the Board changed the standard in 1984 in two cases, the TLI and the Laerco case.

And what they did in those cases was they took certain factors that had previously been looked at by the Board as among the factors to determine joint employer status, and they made those particular factors the minimum for determining joint employer status.

Now fast forward to last spring. The Board asked for briefing on the question in a case called Browning-Ferris. The Board asked for briefing on the question of whether or not it should continue to use the same joint employer standard, or it should change the joint employer standard.

Mrs. ROBY. Well, can you give me some examples of the joint employer standards? I mean—

Mr. GRIFFIN. Yes.

Mrs. ROBY. Because what I am concerned about is where do we draw the line?

Mr. GRIFFIN. And each one of these cases is very fact specific, and so it involves looking at a number of factors. But to summarize the current standard, essentially it is that the putative joint employer has to have involvement in determining directly substantial terms and conditions of employment.

The prior standard allowed not just direct, but indirect involvement in the determination of terms and conditions of employment. And so, that was the way—

JOINT EMPLOYER STANDARDS

Mrs. ROBY. Now when you say terms and conditions of the employer, are you saying so if a franchisor has a contract with the franchisee requiring that certain things—certain standards be met, that that would be considered direct involvement?

Mr. GRIFFIN. No. In fact, and in the brief that we filed in *Browning-Ferris*, we addressed this very specifically. There are prior cases under the traditional standard that we are asking the Board to return to that say if the franchisor's involvement in the franchisee is for the purpose of maintaining the uniformity of the brand or product, that does not make them a joint employer.

And specifically in the brief that we filed, we said we are not asking the Board to overturn those cases. So there will be many, many, many franchisee/franchisor relationships under the standard that we are advocating that will not be affected at all, even if the standard is changed, because we are saying don't overturn those old cases.

However, if the involvement of the franchisor with the franchisee is greater, goes beyond maintaining the independent and quality of the brand or product, then we say under certain circumstances, then the franchisor can be a joint employer with the franchisee.

And one thing—I have been asked about this on a number of occasions in congressional inquiries, and I have responded I think on four separate occasions to different groups of Congress people who have asked about this. And one thing that I have said, and I have said it most recently in a response to the two Senate committee chairmen as well as to Chairman Kline, we do not have any cases in the United States open right now that allege joint employer status solely under the position we are advocating in the *Browning-Ferris* case.

In every case that we are seeking to have somebody held as a joint employer, we are doing it under the Board's current standard and then arguing in the alternative for *Browning-Ferris*, and that includes McDonald's.

Mrs. ROBY. Okay. So my time is expired, but one thing that I would—because I am very concerned about this again as an overreach in determining how this rule functions. I would like if your office would get to my office copies of the letters that you have responded. You don't have to rewrite me a new letter.

Mr. GRIFFIN. I would be happy to supply those—

Mrs. ROBY. If you would get me copies of what you have already done, that would be great.

Mr. GRIFFIN. Be happy to supply those, and I also had attached with some of those the Browning-Ferris brief, which lays out what we are arguing in favor of. And I would be happy to supply those.

And if it would be useful for the committee, Mr. Chairman, I am happy to supply the questions——

Mr. COLE. I would appreciate it. I actually think it would be very useful.

So thank you very much.

[The information follows:]



UNITED STATES GOVERNMENT

NATIONAL LABOR RELATIONS BOARD

Washington, D.C. 20570

November 4, 2014

The Honorable John Kline
Chairman, Education and the Workforce Committee
The Honorable Phil Roe, M.D.
Chairman, Subcommittee on Health, Education, Labor, and Pensions
U.S. House of Representatives
2181 Rayburn House Office Building
Washington, DC 20515-6100

Dear Chairman Kline and Chairman Roe:

I write in response to your letter dated September 16, 2014, wherein you request certain information and documents to better inform the Committee about the joint-employer test under the National Labor Relations Act (NLRA).

Your letter references our recent filing of an amicus brief in *Browning-Ferris Industries* regarding the joint-employer standard, as well as our recent authorization to issue complaints against McDonald's USA, LLC and McDonald's franchisees as joint-employers. Specifically, you seek the following:

- 1) A list of all open complaints in which joint-employer status is an issue;
- 2) Any documents and communications related to closed complaints in which joint-employer status was an issue; and
- 3) A thorough description of the current joint-employer test the General Counsel's office is applying, particularly regarding its application to franchises.

In response to your first inquiry, I am enclosing the list of open complaints in which joint-employer status is an issue. The same list was provided to your staff on October 15, 2014.

Regarding your second request, I am enclosing a list of closed complaints in which joint-employer status was an issue. This information was provided to your staff on October 28, 2014. The Office of the Chief Information Officer is now engaged in identifying the universe of responsive documents and communications related to those closed cases. Once it has concluded its efforts in that regard, we will be able to more fully respond to this request.

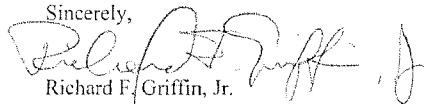
As to your final inquiry, the Board's recent decision in *CNN News Network and Team Video Services, LLC*, 361 NLRB No. 47 (2014), details the current joint-employer standard. That is the current joint-employer standard that the Office of the General Counsel continues to apply to all, including franchisees.

As you note in your letter, on May 12, 2014, the National Labor Relations Board (Board) issued a notice and invitation to file briefs in *Browning-Ferris Industries*, seeking briefing on various joint-employer issues. Among the questions on which the Board's notice sought input was whether the Board should adhere to its existing joint-employer standard or adopt a new standard. In response to the Board's notice, the Office of the General Counsel filed an amicus brief, a copy of which is attached for your reference. The brief is the best statement of the Office of the General Counsel's view of what the Board's joint-employer standard should be.

I conclude with the following comments. First, there are no open cases where the General Counsel's office is alleging that an entity is a joint-employer solely under the test that the *Browning-Ferris Industries* amicus brief urges the Board to adopt. Secondly, it is not unprecedented for the Office of the General Counsel to pursue complaints against franchisors and franchisees as joint employers. See, for example, *Love's Barbeque Restaurant*, 245 NLRB 78 (1978). Lastly, I note that, as stated in our amicus brief in *Browning-Ferris Industries*, my office is not seeking to have the Board overturn the line of cases that stand for the proposition that, where franchisors' indirect control over employee working conditions is merely related to the franchisors' legitimate interest in protecting the quality of their brand or product, such indirect control is insufficient to make the franchisors joint employers with their franchisees.

I trust this letter responds to the concerns you raised in your inquiry. We will continue to work to provide you with the documents and communications you requested. I am committed to working with the Committee to accommodate its oversight needs. If you have additional questions, please do not hesitate to contact Celine McNicholas, Director of the Office of Congressional and Public Affairs, at 202-273-1991.

Sincerely,



Richard F. Griffin, Jr.
General Counsel

Enclosure



UNITED STATES GOVERNMENT

NATIONAL LABOR RELATIONS BOARD

Washington, D.C. 20570

November 10, 2014

The Honorable John Barrasso
United States Senate
307 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Barrasso:

I write in response to your letter dated September 25, 2014, wherein you request that I make public supporting reasoning for the Office of the General Counsel's decision to authorize complaints against McDonald's USA, LLC and McDonald's franchisees as joint-employers.

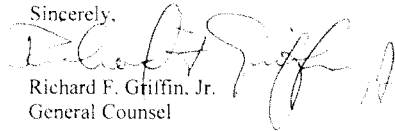
The National Labor Relations Board's (Board) recent decision in *CNN News Network and Team Video Services, LLC*, 361 NLRB No. 47 (2014), details the current joint-employer standard. That is the current joint-employer standard that the Office of the General Counsel continues to apply to all, including franchises.

On May 12, 2014, the Board issued a notice and invitation to file briefs in *Browning-Ferris Industries*, seeking briefing on various joint-employer issues. Among the questions on which the Board's notice sought input was whether the Board should adhere to its existing joint-employer standard or adopt a new standard. In response to the Board's notice, the Office of the General Counsel filed an amicus brief, which is available to the public on the Agency's website. I am also attaching a copy of the amicus brief for your reference. The brief is the best statement of the Office of the General Counsel's view of what the Board's joint-employer standard should be.

As you know, the McDonald's matters are open enforcement actions in which the Office of the General Counsel has alleged that McDonald's USA, LLC and McDonald's franchisees violated the National Labor Relations Act. If parties are unable to reach settlement, complaint will issue and these cases will be heard before an Administrative Law Judge. During that hearing, McDonald's USA, LLC and franchisees will have ample opportunity to review and challenge the evidence and legal theories proffered by counsel for the General Counsel, and to present evidence and legal arguments in its defense. Throughout this proceeding, all parties will be afforded due process protections and a right to a fair trial.

We appreciate your need for information in the performance of your oversight responsibilities and I am committed to working with Congress to accommodate its oversight needs. At the same time, I have an obligation as General Counsel to protect the integrity of this process and the rights of the parties involved. Your letter broadly seeks confidential and privileged information. I am happy to meet with you to discuss how we might accommodate further information requests you may have, consistent with my responsibility to protect the integrity of the Agency's legal processes. If you have additional questions, please do not hesitate to contact Celine McNicholas, Director of the Office of Congressional and Public Affairs, at 202-273-1991.

Sincerely,

A handwritten signature in dark ink, appearing to read "Richard F. Griffin, Jr.", with a stylized flourish at the end.

Richard F. Griffin, Jr.
General Counsel

Enclosure



UNITED STATES GOVERNMENT

NATIONAL LABOR RELATIONS BOARD

Washington, D.C. 20570

November 10, 2014

The Honorable Robert Aderholt
United States House of Representatives
2369 Rayburn House Office Building
Washington, DC 20515

Dear Representative Aderholt:

I write in response to your letter dated October 27, 2014, wherein you request that I make public supporting reasoning for the Office of the General Counsel's decision to authorize complaints against McDonald's USA, LLC and McDonald's franchisees as joint-employers.

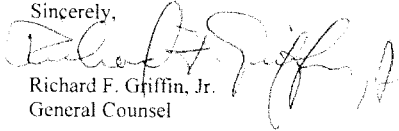
The National Labor Relations Board's (Board) recent decision in *CNN News Network and Team Video Services, LLC*, 361 NLRB No. 47 (2014), details the current joint-employer standard. That is the current joint-employer standard that the Office of the General Counsel continues to apply to all, including franchises.

On May 12, 2014, the Board issued a notice and invitation to file briefs in *Browning-Ferris Industries*, seeking briefing on various joint-employer issues. Among the questions on which the Board's notice sought input was whether the Board should adhere to its existing joint-employer standard or adopt a new standard. In response to the Board's notice, the Office of the General Counsel filed an amicus brief, which is available to the public on the Agency's website. I am also attaching a copy of the amicus brief for your reference. The brief is the best statement of the Office of the General Counsel's view of what the Board's joint-employer standard should be.

As you know, the McDonald's matters are open enforcement actions in which the Office of the General Counsel has alleged that McDonald's USA, LLC and McDonald's franchisees violated the National Labor Relations Act. If parties are unable to reach settlement, complaint will issue and these cases will be heard before an Administrative Law Judge. During that hearing, McDonald's USA, LLC and franchisees will have ample opportunity to review and challenge the evidence and legal theories proffered by counsel for the General Counsel, and to present evidence and legal arguments in its defense. Throughout this proceeding, all parties will be afforded due process protections and a right to a fair trial.

We appreciate your need for information in the performance of your oversight responsibilities and I am committed to working with Congress to accommodate its oversight needs. At the same time, I have an obligation as General Counsel to protect the integrity of this process and the rights of the parties involved. Your letter broadly seeks confidential and privileged information. I am happy to meet with you to discuss how we might accommodate further information requests you may have, consistent with my responsibility to protect the integrity of the Agency's legal processes. If you have additional questions, please do not hesitate to contact Celine McNicholas, Director of the Office of Congressional and Public Affairs, at 202-273-1991.

Sincerely,

A handwritten signature in dark ink, appearing to read "Richard F. Griffin, Jr.", written over a horizontal line.

Richard F. Griffin, Jr.
General Counsel

Enclosure



United States Government

NATIONAL LABOR RELATIONS BOARD

Washington, D. C. 20570

March 19, 2015

Dear Chairman Alexander, Chairman Johnson, and Chairman Kline:

This letter serves as my response to your March 5, 2015 correspondence concerning comments that I made about pursuing labor law violations against franchisors as joint employers under the National Labor Relations Act (the Act). In that communication, you questioned my pursuit of these violations because of a purported admission that the legal grounds for doing so are flawed. Specifically, you reference statements that I made at a West Virginia University College of Law conference held on October 24, 2014. In this regard, your request seeks the following information:

- 1) Did any developments occur in the law between your comments on October 24, 2014 and the filing of complaints on December 19, 2014 that named a franchisor as a joint employer?
 - a. If not, please explain your comments made at the October 24, 2014 labor conference.
- 2) Produce all documents and communications between the Office of the General Counsel and the Board referring or relating to the joint-employer standard from November 4, 2013 to present.
- 3) Produce all documents and communications between the Office of the General Counsel and any other federal agency about the joint-employer standard from November 4, 2013 to present.

In response to your first question, there were no doctrinal legal developments between October 24, 2014 and December 19, 2014 that were relevant to the determination to issue complaints on December 14, 2014 naming a franchisor – McDonald's USA, LLC – as a joint employer.

As to question 1(a), I note that my October 24, 2014 remarks were similar to remarks I have made on the joint-employer issue on a number of occasions since becoming General Counsel. Specifically, during my tenure, I have engaged in significant efforts to accommodate as many institutional and organizational group requests asking me to address their respective members on a variety of topics, including recent case developments. For example, I accepted invitations to

address the U.S. Chamber of Commerce's Labor Relations Committee, various American Bar Association groups, and a variety of educational institutions in addition to West Virginia University College of Law.

Generally, at these speaking engagements, I advise the attendees of certain cases in which my Office is involved. One of the topics that I typically address is the National Labor Relations Board's (Board's) joint-employer standard. As you might expect, this topic has been of interest to many because, on May 10, 2014, the Board sought briefing in the *Browning-Ferris Industries* case, about whether it should maintain its current joint-employer standard or adopt a different standard and, if the latter, what that standard should be. On June 26, 2014, my Office filed an amicus brief in that pending matter. I have attached a copy of the brief for your reference.

In sum, the General Counsel's brief argues that the Board should return to its traditional joint-employer standard, applied with court approval from the inception of the Act in 1935 until 1984. In a section of the brief contending that the Board's current joint-employer standard inhibits meaningful collective bargaining, the brief describes changes in the American workplace and uses several examples, including growth in the contingent or temporary workforce and changes in the nature of some franchisor-franchisee relationships.

It is here – in the brief's discussion of franchisor-franchisee relationships – that the issue (or "problem") addressed in my October 24, 2014 remarks arises. There are cases from the pre-1984 period during which the Board applied its traditional joint-employer standard – the standard the General Counsel is urging the Board to return to in the *Browning-Ferris Industries* brief – in which prior General Counsels alleged that franchisors and franchisees were joint employers. In those older cases, notably *Love's Barbeque Restaurant*, 245 NLRB 78 (1979), the Board determined that franchisors were not joint employers where their indirect control over employee working conditions was related to their legitimate interest in protecting the quality of their product or brand. The question then is: in light of the *Love's Barbeque Restaurant* line of cases, how can the General Counsel urge the return to the traditional joint-employer standard and still allege, under that traditional standard, that a franchisor is a joint employer with its franchisee?

As I indicated in my remarks on October 24, 2014, the Office of the General Counsel's answer to this question, as put forward in the *Browning-Ferris Industries* brief, is not that the *Love's Barbeque Restaurant* line of cases should be overturned. In fact, the brief is very clear, stating, in footnote 32 on pages 15-16, "The Board should continue to exempt franchisors from joint-employer status to the extent that their indirect control over employee working conditions is related to their legitimate interest in protecting the quality of their product or brand," and citing *Love's Barbeque Restaurant*. Rather, only where the franchisor's involvement in employee working conditions goes beyond that necessary to protect the quality of the brand or product does the *Browning Ferris Industries* brief contend that such involvement may give rise to joint-employer status for the franchisor. Under these circumstances, the *Love's Barbeque Restaurant* line of cases is distinguishable.

Turning to the significance of this for the complaints in the McDonald's cases, as those cases are currently in litigation, it is inappropriate for me to discuss any further details concerning them. However, as I advised Chairman Kline in my November 4, 2014 letter to him and Chairman Roe in response to their joint September 16, 2014 inquiry concerning the joint-employer test, "there are no open cases where the General Counsel's office is alleging that an entity is a joint employer solely under the test that the *Browning-Ferris Industries* amicus brief urges the Board to adopt." That statement remains true today, and, specifically, that is the case in the McDonald's matters. In cases involving putative joint employers, where authorized (and this includes the McDonald's cases), counsel for the General Counsel will be contending that facts are present sufficient to make out joint-employer status under the Board's current test (most recently described by the Board in *CNN News Network and Team Video Services, LLC*, 361 NLRB No. 47 (2014)), and, in the alternative, urging that joint-employer status can be made out under the joint-employer standard urged by the General Counsel in the *Browning-Ferris Industries* amicus brief.

In response to your second inquiry, I again reference the attached amicus brief filed by my Office in response to the Board's May 10, 2014 invitation for briefs in the *Browning-Ferris Industries* case. This brief, submitted to the Board, communicates the Office of the General Counsel's views related to the joint-employer standard. I have instructed my staff to continue to work to provide you with any other documents and communications related to your request. I expect that this information will include any pleadings or other documents submitted to the Board involving cases where the General Counsel is contending a joint-employer relationship exists and/or enforcement actions initiated at the behest of or on the explicit authorization of the Board, as the Board's attorney. See, our June 3, 2014 Guidelines Memorandum, which is also attached for your reference.

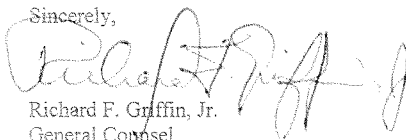
Similarly, as to your third inquiry, I have instructed my staff to work to provide you with any documents and communications related to your request to the extent any exist.

Finally, as you know, I have responded to previous requests for documents and communications relating to the joint-employer standard involving closed cases. I felt comfortable providing that information because it related to closed cases where parties were no longer engaged in active litigation. However, to the extent that requested information goes beyond documents officially filed in open unfair labor practice cases involving ongoing litigation and covers internal deliberative documents and communications, I believe that disclosures in those latter matters would compromise the integrity of our administrative processes. As General Counsel, it is my responsibility to ensure that all parties are afforded due process protections in fair and unimpeded administrative proceedings. I remain committed to safeguarding the public's interest in this regard.

In conclusion, I trust that I have been fully responsive to your inquiries and have demonstrated my respect for your legitimate oversight functions. If you have any additional questions, please

do not hesitate to contact Celine McNicholas, Director of the Office of Congressional and Public Affairs, at 202-273-1991.

Sincerely,

A handwritten signature in dark ink, appearing to read "Richard F. Griffin, Jr.", written in a cursive style.

Richard F. Griffin, Jr.
General Counsel

UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

BROWNING-FERRIS INDUSTRIES
OF CALIFORNIA, INC., D/B/A BFI NEWBY
ISLAND RECYCLERY

Employer &

Case 32-RC-109684

FPR-II, LLC, D/B/A LEADPOINT
BUSINESS SERVICES

Employer &

SANITARY TRUCK DRIVERS AND
HELPERS LOCAL 350,
INTERNATIONAL BROTHERHOOD OF
TEAMSTERS

Petitioner

AMICUS BRIEF OF THE GENERAL COUNSEL

Submitted by:
Meghan B. Phillips
Counsel for the General Counsel
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Washington, D.C. 20570
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UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD

**BROWNING-FERRIS INDUSTRIES
OF CALIFORNIA, INC., D/B/A BFI NEWBY
ISLAND RECYCLERY**

Employer &

Case 32-RC-109684

**FPR-II, LLC, D/B/A LEADPOINT
BUSINESS SERVICES**

Employer &

**SANITARY TRUCK DRIVERS AND
HELPERS LOCAL 350,
INTERNATIONAL BROTHERHOOD OF
TEAMSTERS**

Petitioner

AMICUS BRIEF OF THE GENERAL COUNSEL

On April 30, 2014, the Board granted Petitioner’s Request for Review of the Acting Regional Director’s Decision and Direction of Election and thereafter, on May 10, 2014, the Board issued a Notice and Invitation to File Briefs, which invited the parties and *amici* to address one or more of the following questions:

1. Under the Board’s current joint-employer standard, as articulated in *TLI, Inc.*, 271 NLRB 798 (1984), *enforced mem.*, 772 F.2d 894 (3d Cir. 1985), and *Laerco Transportation*, 269 NLRB 324 (1984), is Leadpoint Business Services the sole employer of the petitioned-for employees?
2. Should the Board adhere to its existing joint-employer standard or adopt a new standard? What considerations should influence the Board’s decision in this regard?
3. If the Board adopts a new standard for determining joint-employer status, what should that standard be? If it involves the application of a multifactor test, what factors should be examined? What should be the basis or rationale for such a standard?

We have not addressed Question 1, for the reasons explained in Section 1 of the Argument section of our brief. We address Question 2 in Section 2 and Question 3 in Section 3 of our Argument.

I. Summary of Argument

The Board should abandon its existing joint-employer standard because it undermines the fundamental policy of the Act to encourage stable and meaningful collective bargaining. The Board's current standard is significantly narrower than the traditional standard, under which an entity could be a joint employer if it exercised direct or indirect control over working conditions, had the unexercised potential to control working conditions, or where "industrial realities" otherwise made it essential to meaningful bargaining. The current standard also ignores Congress's intent that the term "employer" be construed broadly in light of economic realities and the Act's underlying goals, and has particularly inhibited meaningful bargaining with respect to the contingent workforce and other nontraditional employment arrangements.

The General Counsel urges the Board to adopt a new standard that takes account of the totality of the circumstances, including how the putative joint employers structured their commercial dealings with each other. Under this test, if one of the entities wields sufficient influence over the working conditions of the other entity's employees such that meaningful bargaining could not occur in its absence, joint-employer status would be established. In essence, this would mark a return to the Board's traditional approach prior to *Laerco Transportation* and *TLL, Inc.*, and would better effectuate the Act's underlying purposes and policies.

II. Argument

1. The General Counsel Maintains an Interest in this Proceeding, But Expresses No View on the Merits of this Case.

Representation proceedings are non-adversarial in nature, and the General Counsel does not take a position on the merits in representation cases. Therefore, he expresses no view on what decision should be reached in this case.

But, while not formally a party to representation proceedings, the General Counsel maintains an interest in this proceeding for three reasons. First, the General Counsel shares the Board's concerns that "questions preliminary to the establishment of the bargaining relationship be expeditiously resolved." *NLRB v. O.K. Van Storage*, 297 F.2d 74, 76 (5th Cir. 1961), and that representation proceedings must also serve the goals of resolving questions of representation accurately and fairly. *See, e.g., NLRB v. A.J. Tower Co.*, 329 U.S. 324, 330-31 (1946). Second, the General Counsel has a direct involvement and a substantial interest in the processing of representation cases because of his supervisory authority over the activities of the Regional Directors and their staffs, to whom the Board delegated the authority to process representation cases. Third, the General Counsel maintains an interest in this proceeding because he is responsible for prosecuting unfair labor practice charges which allege interference with, or restraint or coercion of, the exercise of Section 7 rights of employees of alleged joint employers, as well as those which allege refusals to bargain by alleged joint employers in an appropriate unit. Accordingly, the General Counsel believes that his views, set forth below, of the appropriate test to be used in determining whether entities constitute joint employers, can be of assistance to the Board in resolving issues raised by this case.

2. The Board Should Not Adhere to its Existing Joint-Employer Standard Because it Undermines the Fundamental Principles of the Act.

The Board should not adhere to its existing joint-employer standard and should instead adopt a new standard, which will be explained in Section 3, below. The Board’s current standard, which is significantly narrower than the prior “traditional” standard the Board had applied from the inception of the Act, is inconsistent with the purposes and policies of the Act.

a. The Board’s current joint-employer standard is significantly narrower than the Board’s prior standard.

Determining joint-employer status has always been a factual issue regardless of how the Board has defined the standard. Prior to 1984, however, the Board consistently held, with court approval, that an entity was a joint employer where it exercised direct *or* indirect control over significant terms and conditions of employment of another entity’s employees:¹ where it possessed the unexercised potential to control such terms and conditions of employment;² or

¹ See, e.g., *Indus. Personnel Corp. v. NLRB*, 657 F.2d 226, 229 (8th Cir. 1981) (reasoning that shipper with a cost-plus lease terminable on thirty days’ notice “presumably has some control over [the] wages” that could be paid under any collective-bargaining agreement the lessor negotiated with the union, even absent evidence of direct involvement in the negotiation of that agreement), *enforcing B.F. Goodrich Co.*, 250 NLRB 1139 (1980); *Floyd Epperson*, 202 NLRB 23, 23 (1973) (user firm dairy company had indirect control over employee discipline and wages where it informed the supplier firm trucking company that a particular driver was consistently late to a transport station and thereafter the trucking company removed the employee from that route, and where trucking company increased drivers’ wages when it received an increased contractual rate from the dairy company), *enforced mem.*, 491 F.2d 1390 (6th Cir. 1974).

² See, e.g., *Hoskins Ready-Mix Concrete*, 161 NLRB 1492, 1493 n.2 (1966) (actual exercise of control set forth in a contract and power retained in a contract but not exercised are separate indicia “of coemployment,” and are each sufficient to find that an entity is a joint employer).

where “industrial realities” otherwise made it an essential party to meaningful collective bargaining.³ This “traditional” standard had been applied since the inception of the Act.⁴

The Board’s current joint-employer standard was first applied in *Laerco Transportation*, 269 NLRB 324 (1984), and *TLI, Inc.*, 271 NLRB 798 (1984). Although the Board in those cases purported to apply the traditional standard for finding a joint employer, it did not in fact do so. In *TLI*, for example, the Board refused to find a client that leased drivers from a separate agency was a joint employer, even though the client had the authority and responsibility under the lease agreement for maintaining operational control, direction, and supervision over the drivers, including “scheduling and dispatching of the drivers, routing instructions, loading and unloading procedures, and all other matters relating to day-to-day” delivery operations; the drivers reported daily to the client’s facility for instructions on deliveries, returned their trucks to the client’s premises when they finished their routes, and reported mechanical problems or other problems on the road to the client; the client’s foremen notified the drivers when they were required to work during their vacations; the client took the initial step in many disciplinary matters by giving the leasing agency an “incident report” when the driver engaged in “conduct adverse to” the

³ *Jewell Smokeless Coal Corp.*, 170 NLRB 392, 393 (1968) (“industrial realities” made coal company a “necessary party to meaningful collective bargaining,” even though it played no role in hiring, firing, or directing employees, and retained no right under the parties’ oral contract to affect those matters), *enforced mem.*, 435 F.2d 1270 (4th Cir. 1970).

⁴ *See, e.g., San Marcos Tel. Co.*, 81 NLRB 314, 316-18 (1949) (client was a joint employer of accountants’ clerks when it reimbursed accountants for the wages paid to and expenses incurred by the clerks); *Solvay Process Co.*, 26 NLRB 650, 653-56 (1940) (finding that a company which hired a contractor on a cost-plus basis was a joint employer because it “maintained control over employment to the extent that it sent men out of the plant if their work was unsatisfactory,” “owned and managed the plant in which the employees worked [,] [and] was the sole source of money with which [the contractor] paid them.”); *Sierra Madre-Lamanda Citrus Ass’n*, 23 NLRB 143, 150 (1940) (finding that a fruit grower who controlled the packing houses in which the employees worked, and “supplied the money with which they were paid” was a joint employer).

client's operations, and the leasing agency investigated the incident and determined whether disciplinary action should be taken against the driver; the client kept driver logs and records; drivers worked exclusively for the client; and in collective-bargaining sessions between the leasing agency and the drivers' union, the client participated and made clear that without transportation cost savings of a certain amount, the lease agreement would be jeopardized and alternatives were being considered. 271 NLRB at 798-99.⁵

The indicia of control in *Laerco* and *TLI* was clearly greater than what previously had been required to find joint-employer status. For example, the Board had found the following to be indicative of joint-employer status: veto power over hiring or the right to reject the supplier firm's employees;⁶ retaining the contractual right to direct or supervise the contractor's employees;⁷ requiring employees to abide by the user firm's rules;⁸ dealing with employee

⁵ See also *Laerco Transportation*, 269 NLRB at 325-26 (finding no joint-employer relationship where driver service agreement provided that drivers were to perform trucking services under the client's direction and comply with its safety regulations and that client could refuse to accept any driver that did not meet its qualifications; drivers' assignment to client's facility was usually permanent; and, because the contractor had no supervisors at the client's facility, the client attempted to resolve minor personnel problems, the drivers reported to the client's warehouse to receive initial directions regarding deliveries and routes to be followed, and sometimes the client's customers would tell a driver to prioritize one order over another).

⁶ See, e.g., *Jewel Tea Co.*, 162 NLRB 508, 509-10 (1966) (licensor retained the right to approve licensee's employees, even though it never exercised that right); *Manpower, Inc.*, 164 NLRB 287, 287-88 (1967) (user firm retained the right to refuse supplier firm's drivers and supplier firm would try to accommodate user firm's request for certain drivers).

⁷ See, e.g., *Jewel Tea Co.*, 162 NLRB at 510 (license agreement provided that licensee's "employees shall be subject to the general supervision" of the licensor, even though licensor never exercised that right).

⁸ See, e.g., *Hamburg Industries*, 193 NLRB 67, 67 (1971) (user firm required supplier firm's employees to follow its plant safety rules and regulations); *Jewell Smokeless Coal Corporation*, 170 NLRB at 392-93 (coal mine owner performed safety inspections and had previously terminated contracts with mine operators for safety practices).

grievances and personnel issues;⁹ affecting employees' work schedules or work hours;¹⁰ affecting employee discipline;¹¹ making recommendations to the supplier firm during the collective-bargaining process or otherwise retaining the right to give such input;¹² and giving employees daily assignments.¹³ Thus, the *Laerco/TLI* Board established a new standard under which evidence that had been considered very strong indicia of joint-employer status under extant Board law became the *minimum* standard for finding joint-employer status.

⁹ See, e.g., *American Air Filter Co.*, 258 NLRB 49, 50 (1981) (supplier firm's employees reported their absences to user firm and scheduled their vacations with user firm); *Syufy Enterprises*, 220 NLRB 738, 740 (1975) (occasional handling of personnel problems, such as approving an employee's request to permit his girlfriend to work the second half of his shift in his stead); *Manpower, Inc.*, 164 NLRB at 287-88 (user firm was entity that received supplied drivers' complaints).

¹⁰ See, e.g., *Sun-Maid Growers of California*, 239 NLRB 346, 350 (1978) (user firm's production schedule controlled supplier firm employees' schedules, and user firm required employees to change their schedules and work weekends when its production schedule so required), *enforced mem.*, 618 F.2d 56, 59 (9th Cir. 1980).

¹¹ See, e.g., *Floyd Epperson*, 202 NLRB at 23 (user firm informed supplier firm that it had learned that a particular driver was consistently late to a transport station, and the supplier firm subsequently removed the driver from that run).

¹² See, e.g., *U.S. Pipe & Foundry Co.*, 247 NLRB 139, 140 (1980) (user firm frequently consulted with supplier firm about bargaining proposals during collective-bargaining negotiations with union, and supplier firm often followed user firm's recommendations); *Jackson Manor Nursing Home*, 194 NLRB 892, 893 (1972) (where the leasing agreement gave nursing home "the right to be present and to fully participate in any and all collective-bargaining sessions that may occur during the term of the lease," and further provided that the lessee must obtain its consent before entering into any labor agreement or contract, nursing home was a joint employer because the contractual provision gave it the "potential for influencing most drastically the lessee's labor policies").

¹³ See, e.g., *Syufy Enterprises*, 220 NLRB at 740 (user firm required supplier firm's janitors to occasionally perform "non-routine" work, non-janitorial tasks when work was "heavy," and work not covered by the scope of the cleaning contract); *Teamsters Local No. 688*, 211 NLRB 496, 496 (1974) (user firm assigned supplier firm's drivers their routes based on seniority and "other historical considerations").

Following these decisions, the Board made clear that the essential element in its current analysis is “whether a putative joint employer’s control over employment matters is *direct and immediate*.” See, e.g., *Airborne Express*, 338 NLRB 597, 597 n.1 (2002) (emphasis added). For example, in *Flagstaff Medical Center*, 357 NLRB No. 65, slip op. at 9 & n.23 (Aug. 26, 2011), the Board found no joint-employer relationship where, *inter alia*, the putative joint employer only recommended individuals for hire rather than directly hiring them; the primary employer retained final authority over hiring decisions; and there was no evidence that the putative employer hired or discharged an employee without the primary employer’s approval.

Further, under the current standard, the Board “looks to the actual practice of the parties,” and will not find that an entity is a joint employer based on its potential, contractually-retained control.¹⁴ For example, in *Goodyear Tire & Rubber Co.*, 312 NLRB 674, 677-78, 687-90 (1993), the Board found that a chemical company was not a joint employer of leased drivers notwithstanding its contractual right to maintain operational control, direction, and supervision of the contractor’s drivers and the fact that its cost-plus contract set forth the formula by which the drivers were paid.

Additionally, the Board’s current standard requires the putative joint employer’s control to be “substantial” rather than “limited and routine,” and the Board has defined “limited and routine” as including “where a supervisor’s instructions consist primarily of telling employees what work to perform, or where and when to perform the work, but not how to perform the work.” *AM Property Holding Corp.*, 350 NLRB at 1001 (citing cases). The Board in *AM*

¹⁴ See *AM Property Holding Corp.*, 350 NLRB 998, 1000 (2007) (employer’s actual role in supervising and directing employees insufficient to establish joint employer relationship despite provision in lease agreement that employer would maintain “operational control, direction, and supervision” of employees).

Property Holding Corp applied this standard and concluded that a building owner was not a joint employer of its cleaning contractor's employees where it instructed employees what cleaning tasks to perform, but not how to perform their tasks; distributed keys and cleaning products to employees at the beginning of their shifts; prepared and signed employees' timecards; and required employees to redo work if it determined that they did not initially properly perform the work. *Id.*

b. The Board's current joint-employer standard is inconsistent with the purposes and policies of the Act.

(1) The term "employer" in the Act was intended to be construed broadly.

The Act's definition of "employer" encompasses more than the technical and traditional common law definition of "employer"; it also "draw[s] substance from the policy and purposes of the Act, the circumstances and background of particular employment relationships, and all the hard facts of industrial life." *NLRB v. E.C. Atkins & Co.*, 331 U.S. 398, 403 (1947); *see also NLRB v. Hearst Publications*, 322 U.S. 111, 129 (1944) (definition of employer "must be understood with reference to the purpose of the Act and the facts involved in the economic relationship[.]").¹⁵ The Act was premised on Congress's "explicit findings that strikes and industrial strife . . . result in large measure from the refusal of employers to bargain collectively and the inability of individual workers to bargain successfully for improvements in their 'wages, hours, or other working conditions' with employers. . . ." *Hearst*, 322 U.S. at 126.

¹⁵ *Cf. NLRB v. Town & Country Elec.*, 516 U.S. 85, 91 (1995) (the Board's "broad, literal interpretation of the word 'employee' is consistent with several of the Act's purposes, such as protecting 'the right of employees to organize for mutual aid without employer interference,' and 'encouraging and protecting the collective-bargaining process'" (citations omitted)).

Although the Act’s definition of “employer” expressly was intended to incorporate “an appreciation of economic realities [and] a recognition of the aims which Congress sought to achieve” through the Act, *see Atkins*, 331 U.S. at 403, the Board’s current joint-employer standard construes “employer” relatively narrowly. Indeed, the federal courts generally apply a broader joint-employer standard under other federal remedial statutes that contain narrower definitions of “employer” than in the Act. For example, Title VII defines the term “employer” relatively narrowly as a person “who has fifteen or more employees,” 42 U.S.C. § 2000e (b), but every United States Court of Appeals that has considered how the term should be applied has determined that it should be construed broadly.¹⁶ The federal courts have applied that broad construction by utilizing either a “hybrid” right-to-control/economic realities test or the Board’s traditional joint-employer standard to assess joint-employer status under Title VII and other federal anti-discrimination statutes that Congress modeled after it.¹⁷ Each of these standards requires less actual or direct control than the Board’s current joint-employer standard.

¹⁶ *See, e.g.*, Brief for the EEOC as Amicus Curiae, *Browning-Ferris Industries d/b/a BFI Newby Island Recyclery*, Case 32-RC-109684 (June 15, 2014), at 10 (citing cases and discussing how the federal courts have determined that the term “employer” should be construed broadly in Title VII cases).

¹⁷ *See, e.g.*, *Lopez v. Johnson*, 333 F.3d 959, 963-64 (9th Cir. 2003) (per curiam) (applying both the hybrid test and the traditional joint-employer test from *NLRB v. Browning-Ferris Indus. of Penn.*, 691 F.2d 1117, 1123 (3d Cir. 1982) in a Rehabilitation Act case); *Bristol v. Bd. of County Comm’rs*, 312 F.3d 1213, 1218 (10th Cir. 2002) (en banc) (applying NLRB’s traditional joint-employer test in an Americans with Disabilities Act case); *Graves v. Lowery*, 117 F.3d 723, 727 (3d Cir. 1997) (applying the traditional joint-employer standard from *NLRB v. Browning-Ferris Indus. of Penn.*, 691 F.2d at 1123 in a Title VII case); *Magnuson v. Peak Technical Servs.*, 808 F.Supp. 500, 508-10 (E.D. Va. 1992) (minimal indicia of control, when viewed against economic reality of the actual working relationship, sufficient to find joint-employer status); Brief for the EEOC as Amicus Curiae, *supra* note 16, at 7-10 (discussing the totality-of-the-circumstances common law of agency test or “hybrid test,” which is often utilized in determining whether an entity is a joint employer under Title VII); EEOC, EEOC ENFORCEMENT GUIDANCE:

(2) The Board's current joint-employer standard inhibits meaningful collective bargaining.

Joint employer questions typically arise in two situations: (1) contingent or temporary employment, including employee leasing; and (2) commercial relationships structured so that one entity is in a position to influence the labor relations policies of the other, such as outsourcing of functions integral to the employer's business or franchising. Both types of work arrangements "alter who is the employer of record or make the worker-employer tie tenuous and far less transparent."¹⁸

The contingent workforce has steadily increased in prominence in the U.S. economy over the past several decades. The principal defining feature of contingent work arrangements is the triangular employment relationship, where the temporary help firm "assigns" workers to a user firm, which utilizes the labor provided, while the temporary help firm "place[s] these workers for legal purposes on [its] own payroll, billing client firms in an amount covering wages, overhead, and profit."¹⁹ This "pushes liability for adherence to a range of workplace statutes . . . outward

APPLICATION OF EEO LAWS TO CONTINGENT WORKERS PLACED BY TEMPORARY EMPLOYMENT AGENCIES AND OTHER STAFFING FIRMS (1997), available at <http://www.eeoc.gov/policy/docs/conting.html> (last accessed June 23, 2014) (discussing, *inter alia*, the standard used in assessing whether an entity is a joint employer under Title VII, which ordinarily involves application of the "control test" from the RST (SECOND) OF AGENCY § 220, and specifically discussing the standard for finding joint-employer status in situations where businesses utilize temporary help agencies and employee leasing firms).

¹⁸ David Weil, *Enforcing Labor Standards in Fissured Workplaces: The U.S. Experience*, 22 THE ECON. & L. REL. REV. 33, 36-37 (2011).

¹⁹ George Gonos, *The Contest Over "Employer" Status in the Postwar United States: The Case of Temporary Help Firms*, 31 L. & SOC'Y REV. 81, 84-85 (1997). See also KATHERINE V.W. STONE, FROM WIDGETS TO DIGITS: EMPLOYMENT REGULATION FOR THE CHANGING WORKPLACE 68 (2004) ("[w]hat characterizes a temporary employment agency job is not the duration of the job, but the relations of power and the locus of legal responsibility," since "even though the individual employee works on the user firm's worksite and utilizes the user firm's tools, the

to other businesses.”²⁰ Before the 1970s, temporary employment agencies generally only offered short-term secretarial help, day laborers, and nursing services, and did not represent a statistically significant portion of private sector employment. Around 1975, however, “temporary employment agencies began to provide workers for many different types of jobs, including maintenance work, custodial services, legal services, and computer programming,” and thereafter began to experience tremendous growth.²¹ The temporary help services industry grew from 518,000 to 1,032,000 workers during the 1980s, and reached over 1% of total employment by 1990. The percentage doubled to 2% by 2000.²² In February 2005, there were 1.2 million temporary help agency workers and 813,000 workers provided by contract leasing firms.²³

The current joint-employer standard inhibits meaningful collective bargaining under contingent workforce arrangements, because user firms typically have only “limited and routine” direct supervision of the employees (as that term has been defined by the Board since 1984) and only indirect or potential control over other terms and conditions of employment. But a user

temporary agency is, legally speaking, the employer.”); Edward A. Lenz, *Co-Employment - A Review of Customer Liability Issues in the Staffing Services Industry*, 10 THE LAB. LAW. 195, 196-99 (1994) (describing various contingent employment arrangements).

²⁰ Weil, *supra* note 18, at 37.

²¹ See STONE, *supra* note 19, at 67.

²² See *Id.* See also U.S. Bureau of Labor Stat., Luo, et al., *The Expanding Role of Temporary Help Services from 1990 to 2008*, MONTHLY LAB. REV., August 2010, at 3, 4.

²³ U.S. BUREAU OF LABOR STATISTICS, CONTINGENT AND ALTERNATIVE EMPLOYMENT ARRANGEMENTS FEBRUARY 2005, at 1 (July 2005). Luo, Mann, & Holden, who are economists at the BLS, provide statistics through 2008, which show a decrease in the percentage of employees working in the temporary help services industry around 2007-2008. Their analysis indicates this decrease was caused by the recession and the fact that temporary workers shouldered a higher share of overall job loss because they were easier to dispose of. See Luo, et al., *supra* note 22, at 4. The BLS has not conducted any more recent surveys of contingent and alternative employment arrangements, and we are unaware of any other sources with updated statistics.

firm that owes no bargaining obligation can still influence the supplier firm's bargaining posture by threatening to terminate its contract with the supplier firm, and therefore eliminate supplied employees' jobs, if their wages and benefits are not below a certain cost threshold. Indeed, in *TLL, Inc.*, 271 NLRB at 798-99, a paper products firm attended collective-bargaining sessions between a truck-driver leasing firm and the drivers' union and made clear that the driver-leasing contract would be jeopardized absent a significant reduction in its transportation expenses. Yet the Board found that the paper company was not a joint employer because "the specific savings . . . were left entirely to [the leasing firm] and the [u]nion to work out." *Id.* at 799. It is difficult to envision how the union and the driver leasing firm could have meaningfully bargained about wages, under those circumstances, without the bargaining obligation also attaching to the paper company. Indeed, "[s]ervice contractors rarely have room to grant wage increases without renegotiating their own contracts with their clients," and therefore, "the clients effectively control the economic terms of employment for the contractors' employees."²⁴ This drives supplier-contractors to reduce their costs, particularly labor costs, which is "the most sizeable cost and the one most easily controlled,"²⁵ leaving little room for employees to achieve better wages and benefits through collective bargaining, a fundamental purpose of the Act.

A user firm that, as in the typical case, is found not to be a joint employer can also thwart collective bargaining by simply terminating its agreement with the contractor and, therefore, its

²⁴ Jonathan P. Hiatt & Lynn Rhinehart, *The Growing Contingent Work Force: A Challenge for the Future*, 10 THE LAB. LAW. 143, 155 (1994). See also *Airborne Express*, 338 NLRB at 599 (Member Liebman, concurring) (questioning how meaningful bargaining could occur between union and local carriers without Airborne's participation, where Airborne's operational requirements "effectively determine [the employees'] conditions of employment that are subject to the Act's bargaining requirements. . . .").

²⁵ Weil, *supra* note 18, at 36-37.

employees. Even if a successor contractor retains the employees, the successor is generally free to cast aside any collectively-bargained terms between the employees and the predecessor contractor. This permits the user firm to retain the benefits of an experienced workforce while dismantling any contractual commitments that the workers secure from their direct employers.²⁶ The current standard also renders employee freedom of choice in a bargaining representative illusory if the bargaining obligation does not attach to one of the entities that is necessary for meaningful bargaining.²⁷

Franchising (and outsourcing arrangements that triangulate employment relationships) also illustrates how the current joint-employer standard undermines meaningful collective bargaining. In these commercial arrangements, an employer inserts an intermediary between it and the workers and designates the intermediary as the workers' sole "employer."²⁸ But notwithstanding the creation of an intermediary, franchisors typically dictate the terms of franchise agreements and "can exert significant control over the day-to-day operations of their franchisees," *id.*, including the number of workers employed at a franchise and the hours each employee works. Although franchisors generally claim that they have no influence over the wages franchisees pay to their employees, some franchisors effectively control such wages "by

²⁶ See Michael C. Harper, *Defining the Economic Relationship Appropriate for Collective Bargaining*, 39 B.C. L. REV. 329, 345-46 (1998); Craig Becker, *Labor Law Outside the Employment Relation*, 74 TEX. L. REV. 1527, 1542-43 (1996).

²⁷ See Harper, *supra* note 26, at 345-46 (positing that contracted employees are unlikely to form a union because their employer will tell them that the contract would likely be cancelled; and, even if they do unionize, their employer will not be able to negotiate effectively with them over many terms and conditions of employment, including wages, because the client firm controls those items).

²⁸ See CATHERINE RUCKELSHAUS, ET AL., WHO'S THE BOSS: RESTORING ACCOUNTABILITY FOR LABOR STANDARDS IN OUTSOURCED WORK 7-8 (National Employment Law Project) (2014).

controlling every other variable in the business except wages.”²⁹ Some franchisors even keep track of data on sales, inventory, and labor costs; calculate the labor needs of the franchisees; set and police employee work schedules; track franchisee wage reviews; track how long it takes for employees to fill customer orders, accept employment applications through the franchisor’s system; and screen applicants through that system.³⁰ Thus, current technological advances have permitted franchisors to exert significant control over franchisees, e.g., through scheduling and labor management programs that go beyond the protection of the franchisor’s product or brand.³¹ Some scholars have posited that franchisors consider avoidance of unionization and the collective-bargaining process to be the “prime advantage of franchising,” and “[i]n some cases, the driving force behind the conversion of fully integrated, employee-operated businesses to franchised operations is an attempt to prevent or remove the supposedly harmful effects of unionization and thereby increase profits.”³²

²⁹ *Id.* at 11.

³⁰ *Ibid.*

³¹ See, e.g., Dana Tanyeri, *High Tech Takes on Big Labor: The Stuff You Can Use Right Now to Ease Your Restaurant Woes*, RESTAURANT BUSINESS, December 2007, at 35-36 (describing various types of software programs available to help manage schedules and labor costs); Kerry Pipes, *Fast Food Franchise Industry is Rushing to Acquire Technology Tools that Will Help it Stay, Well, Fast*, Franchising.com, available at http://www.franchising.com/articles/fast_food_franchise_industry_is_rushing_to_acquire_technology_tools_that_wi.html (last accessed June 20, 2014) (“[F]rom ordering buns and burgers to scheduling shifts, more and more day-to-day operational issues are being orchestrated via technology tools....[and] software programs can handle scheduling employees, tracking their hours”); Kerry Pipes, *Point of Contact: CMO Terri Miller on Great Clips’ Innovative POS System*, Franchising.com, available at http://www.franchising.com/articles/point_of_contact_cmo_terri_miller_on_great_clips_innovative_pos_system.html (last accessed June 20, 2014) (discussing Great Clips Hair Salon’s technology “that helps managers schedule the right number of stylists at the right time,” while managing “a franchisee’s biggest cost item: payroll”).

³² Robert W. Emerson, *Franchising and the Collective Rights of Franchisees*, 43 VAND. L. REV. 1503, 1528 (1990). The Board should continue to exempt franchisors from joint-employer status

With respect to both the contingent workforce and employees working under an outsourcing or franchising model, the current joint-employer standard also undermines meaningful bargaining by precluding employees from exerting traditional economic pressure on a company that effectively controls many of their working conditions.³³ This is because where no joint-employer status can be found under the current restrictive joint-employer standard, each entity is considered a “neutral” in the other’s labor dispute for Section 8(b)(4) purposes.³⁴ Therefore, a union representing the company’s employees cannot lawfully utilize pickets or other economic pressure directed at the other company, even if the other company is necessary for meaningful collective bargaining.

3. The Board Should Adopt a New Standard for Determining Joint-Employer Status Based on the Overarching Principle that the Bargaining Obligation Covers Entities that are Essential for Meaningful Bargaining.

The General Counsel urges the Board to abandon the current joint-employer standard, as articulated in *TLI* and *Laerco* (and *Airborne*), and to instead find joint-employer status where,

to the extent that their indirect control over employee working conditions is related to their legitimate interest in protecting the quality of their product or brand. *See, e.g., Love’s Barbeque Rest.*, 245 NLRB 78, 120 (1978) (no joint-employer finding where franchisees were required to prepare and cook food a certain way because, *inter alia*, the franchisor established the requirements to “keep the quality and good will of [the franchisor’s] name from being eroded”) (internal quotations and citations omitted), *enforced in rel. part*, 640 F.2d 1094 (9th Cir. 1981). The “traditional standard” cases finding that franchisors were not joint employers preceded the advent of new technology that has enabled some franchisors to exercise indirect control over employee working conditions beyond what is arguably necessary to protect the quality of the product/brand.

³³ See Harper, *supra* note 26, at 345-46.

³⁴ *See, e.g., Service Employees Local 87 (West Bay Maintenance)*, 291 NLRB 82, 82 (1988) (because the primary employer and the entity it contracted with were not joint employers under the Act, the union’s picketing at the other entity’s facility “manifested an unlawful object violative of Section 8(b)(4)(i) and (ii)(B) of the Act”).

under the totality of the circumstances, including the way the separate entities have structured their commercial relationship, the putative joint employer wields sufficient influence over the working conditions of the other entity's employees such that meaningful bargaining could not occur in its absence.³⁵ Under this approach, the Board would return to its traditional standard and would make no distinction between direct, indirect, and potential control over working conditions and would find joint employer status where "industrial realities" make an entity essential for meaningful bargaining.

The Act provides that employees have the right "to bargain collectively through representatives of their own choosing," and defines the bargaining obligation as "meet[ing] at reasonable times and confer[ring] in good faith with respect to wages, hours and other terms and conditions of employment . . ." Accordingly, employees should expect that their bargaining representative be capable of addressing their employment conditions with the entity that realistically has the power to implement those terms. Otherwise, the bargaining is not meaningful; it is an exercise in futility. *See Airborne Express*, 338 NLRB at 599 (Member Liebman, concurring) (questioning how meaningful bargaining could occur between union and local carriers without Airborne's participation, where Airborne's operational requirements "effectively determine [the employees'] conditions of employment that are subject to the Act's bargaining requirements. . . .").

³⁵ The view that joint-employer status turns on the putative joint employer's influence over terms and conditions of employment as to be an essential participant in bargaining does not implicate the Board's decision in *Oakwood Care Center*, 343 NLRB 659 (2004), which held that bargaining units that combine employees who are solely employed by a user employer with employees who are jointly employed by the user employer and a supplier employer are multiemployer units and are statutorily permissible only with the parties' consent.

When applying its traditional joint-employer standard, the Board considered that control over the following terms and conditions of employment would make an employer an essential party to collective bargaining: wages;³⁶ employee personnel issues;³⁷ the number of employees needed to perform a job or task;³⁸ establishing employee work hours, schedules, work week length, and shift hours;³⁹ employee grievances, including administration of a collective-bargaining agreement;⁴⁰ authorizing overtime;⁴¹ safety rules and standards;⁴² production

³⁶ See, e.g., *Floyd Epperson*, 202 NLRB at 23 (user firm had indirect control over supplier firm's employees' wages where the evidence established that when the supplier firm received a raise from the user firm, he raised the wages of the drivers); *Hoskins Ready-Mix Concrete*, 161 NLRB at 1493 (because contract provided that user firm would reimburse supplier firm for payroll expenses, the user firm was "the ultimate source of any wage increase for [the supplier's] employees that might be negotiated with a union").

³⁷ See, e.g., *Mobil Oil Corp.*, 219 NLRB 511, 514, 516 (1975) (approving employees' requests for vacation and time off), *enforcement denied on other grounds* 555 F.2d 732 (9th Cir. 1977).

³⁸ See, e.g., *Carillon House Nursing Home*, 268 NLRB 589, 591 (1984) (determining the number of employees employed); *Trend Construction Corp.*, 263 NLRB 295, 299 (1982) (determining the number of unit employees to be employed on the job); *General Electric Corp.*, 256 NLRB 753, 753 (1981) (determining that employees should be laid off because of lack of work); *The Greyhound Corp.*, 153 NLRB 1488, 1491 n.8, 1492-44 (1965) (determining the exact number of employees needed for any shift), *enforced*, 368 F.2d 778 (5th Cir. 1966).

³⁹ See, e.g., *Carillon House*, 268 NLRB at 591 (user firm established the length of the work week and shift hours); *Browning-Ferris Industries of Pennsylvania, Inc.*, 259 NLRB 148, 149 (1981) (user firm established the shift starting times), *enforced*, 691 F.2d 1117 (3d Cir. 1982); *Floyd Epperson*, 202 NLRB at 23 (user firm determined employees' work schedules and had the authority to modify drivers' schedules by calling the drivers directly).

⁴⁰ See, e.g., *Carillon*, 268 NLRB at 591 (supplier firm was required to comply with user firm's collective-bargaining agreement and administered the first step of the grievance process); *U.S. Pipe & Foundry Co.*, 247 NLRB at 140 (putative joint employer administered the grievance provision of the collective-bargaining agreement between the employees and their employer).

⁴¹ See, e.g., *Mobil Oil*, 219 NLRB at 514 (user firm's production foreman authorized employees' overtime); *Hamburg*, 193 NLRB at 67 (user firm had authority to veto employees' overtime).

⁴² See, e.g., *Hamburg*, 193 NLRB at 67 (user firm required supplier firm's employees to follow its plant safety rules and regulations).

standards;⁴³ break and/or lunch periods;⁴⁴ assignment of work and determination of job duties;⁴⁵ work instructions relating to the means and manner to accomplish a job or task;⁴⁶ training employees or establishing employee training requirements;⁴⁷ vacation and holiday leave and pay policies;⁴⁸ discipline;⁴⁹ discharge;⁵⁰ and hiring.⁵¹ The Board correctly did not label control over

⁴³ See, e.g., *Jewell Smokeless Coal Corp.*, 175 NLRB 57, 59 n.3 (1969) (coal mine operator had required mine operator to buy additional equipment to increase productivity), *enforced mem.*, 435 F.2d 1270 (4th Cir. 1970); *Jewell Smokeless Coal Corporation*, 170 NLRB at 392-93 (coal mine owner had previously terminated contracts with coal operators for low productivity).

⁴⁴ See, e.g., *Carillon*, 268 NLRB at 591 (user firm established rules for employee break and lunch periods).

⁴⁵ See, e.g., *id.* (user firm specified supplier firm's employees' job duties in the parties' contract).

⁴⁶ See, e.g., *Hamburg*, 193 NLRB at 67 (user firm instructed supplier firm on what work needed to be performed and user firm's three superintendents constantly checked "the performance of the workers and the quality of the work."); *Greyhound*, 153 NLRB at 1492 (parties' contract specified the cleaning method employees would use in various areas of user firm's bus terminals (e.g., scrubbing and scouring)).

⁴⁷ See, e.g., *Carillon*, 268 NLRB at 591 (nursing home set training requirements for housekeeping contractor's employees); *Moderate Income Management Co.*, 256 NLRB 1193, 1194 (1981) (property management company trained the housing project's superintendent); *Mansion House Center*, 195 NLRB 250, 256 (1972) (user firm required supplier firm's security guards to complete training program with local police department).

⁴⁸ See, e.g., *Jewel Tea Co.*, 162 NLRB at 510 (license agreement required licensee to follow licensor's policies regarding paid vacations and holidays).

⁴⁹ See, e.g., *Carillon*, 268 NLRB at 591 (user firm established rules setting forth the grounds for discharge and discipline); *Checker Cab Co.*, 141 NLRB 583, 586 (1963) (cab association's board of review suggested disciplinary action against association members' employees), *enforced*, 367 F.2d 692 (6th Cir. 1966).

⁵⁰ See, e.g., *Trend Construction*, 263 NLRB at 297 n.13 (user firm discharged supplier firm's employee); *Spartan Department Stores*, 140 NLRB 608, 610 (1963) (license agreement gave licensor the preemptory right to discharge licensee's employees).

⁵¹ See, e.g., *Mobil*, 219 NLRB at 515-16 (user firm's production foremen conducted applicant interviews and instructed supplier firm regarding which applicants it should hire); *Manpower, Inc.*, 164 NLRB at 287-88 (user firm retained the right to refuse supplier firm's drivers and supplier firm would try to accommodate user firm's request for certain drivers); *Jewel Tea Co.*, 162 NLRB at 509-10 (licensor retained the right to approve licensee's employees, even though it never exercised that right).

such terms and conditions as “limited and routine.”⁵² Thus, even if the putative joint employer only controls work assignments, this implicates bargainable topics such as what criteria to use (e.g., seniority or how to assess the quality of employees’ performance), and other important terms and conditions of employment that substantially affect employees’ work life.

Furthermore, under the Board’s traditional test, indirect control over certain terms and conditions of employment was sufficient to find joint-employer status. For example, in *Floyd Epperson*, 202 NLRB at 23, the Board found a user firm to be a joint employer based, in part, on “some indirect control over [the supplied drivers’] wages,” where the evidence established that the supplier firm raised drivers’ wages when it received a raise from the user firm. And in *Hamburg Industries*, 193 NLRB at 67, a user firm that was party to a cost-plus contract was found a joint employer where it had indirect control over supplied employees’ wages, even though the supplier firm could institute unilateral pay raises, because “unless the pay increases [we]re presented to and accepted by [the user firm], the increased labor costs [we]re absorbed by [the supplier firm] alone.” In both cases, the user firm’s commercial relationship with the supplier firm granted indirect control over supplier firm wages and effectively inhibited the supplier firm from independently agreeing to a collectively-bargained wage increase.

⁵² Compare *AM Property Holding*, 350 NLRB at 1001 (applying the current joint-employer standard and finding that a firm was not a joint employer where it told supplied cleaning employees “what work to perform, or where and when to perform the work, but not how to perform the work,” because this oversight was “limited and routine”), with *Trans-State Lines, Inc.*, 256 NLRB 648, 649 (1981) (applying the traditional joint-employer standard and finding that a trucking company was joint employer of fleet owner’s drivers where trucking company screened applicants applying for jobs with fleet companies and referred applicants it approved to the fleet owners, handled dispatching from certain locations, and handled substantial amount of dispatching for “backhauls” (pickups for return trips)).

Meaningful bargaining over wages, under such circumstances, could not occur without the user firm's participation.⁵³

Additionally, the Board's traditional standard treated *potential* control—typically the unexercised ability to control employment conditions reserved in license, lease, or other commercial agreements—as sufficient to find joint-employer status. For example, in *Hoskins Ready-Mix Concrete*, 161 NLRB at 1493 & n.2, a user firm that had the contractual authority to exercise “overall supervision and direction” of the supplier's leased employees was deemed a joint employer because it had the “power to control basic aspects” of the supplied employees' working conditions, even though it had not exercised that power. And in *Globe Discount City*, 171 NLRB 830, 830-32 (1968), a licensor was found to be the joint employer of its licensee's employees where the licensor retained substantial contractual power “to control or influence the labor policies of the licensees,” and retained “the right to terminate either license for default,” thereby insuring “that its wishes in regard to labor relations matters will be carried out by the licensees.” In these cases, the Board implicitly recognized that potential control over working conditions renders an entity essential for meaningful bargaining.

Finally, the traditional standard recognized the potential to control terms and conditions of employment based not on specific contractual privileges but rather on the “industrial realities” of certain business relationships. Thus, in *Jewell Smokeless Coal Corporation*, 170 NLRB at 392-93, the Board found that a coal processor was a joint employer with operators that mined

⁵³ See also *Sun-Maid Growers of California*, 239 NLRB at 350-51 (finding company to be a joint employer and noting that its control over employees' working conditions, including indirect control over their work schedules, made it the only party that “could have bargained effectively with the [union] regarding the indicia of employment over which it possessed control”).

coal on its properties, even though it played no role in hiring, firing, or directing operators' employees and there was no contract granting the coal processor the right to control terms and conditions or employment. The coal processor unilaterally set the reimbursement rate for the coal mined on its properties, without regard to the difficulty and time required to mine the coal, and required that coal removal comply with its engineering plans and "well established mining practices," including safety standards; the contracts between the coal processor and the various coal mine operators were oral and terminable at will; and the processor exercised its right to terminate contracts when, for example, it determined that the operator had low production or had failed "to operate safely in an orderly and prescribed manner." *Id.* In finding joint-employer status, the Board recognized that the nature of the commercial relationship between the coal processor and the operators effectively granted the processor significant control over operator employees' terms and conditions of employment, and made the processor "a necessary party to meaningful collective bargaining" *Id.* at 393.⁵⁴

The Board's traditional joint-employer standard better effectuates the policies and purposes of the Act than the Board's current, narrow standard, and the Board should return to it.

⁵⁴ Compare *American Air Filter Co.*, 258 NLRB at 52 (because user firm provided all of employees' work, user firm effectively discharged supplier firm's employees when it terminated its contract with the supplier firm), and *U.S. Pipe & Foundry Co.*, 247 NLRB at 140 (noting that because the user employer provided eighty percent of the supplier employer's business, the user employer could effectively terminate the supplied employees' employment, notwithstanding that the user could not directly discharge one of the supplier's employees) with *Hychem Constructors, Inc.*, 169 NLRB 274, 274-76 & n.4 (1968) (finding that a manufacturer and a contractor it engaged on a *short-term* cost-plus basis were not joint employers of the contractor's employees under the "traditional" joint-employer standard, notwithstanding the manufacturer's retained right to control wage increases and aspects of daily working conditions, where this retained control was only "consistent with [the manufacturer's] right to police reimbursable expenses under its cost-plus contract" and to "control and protect its premises," rather than "giving it veto power over any collective bargaining in which [the contractor] may engage").

See *Bartlett-Collins Co.*, 237 NLRB 770, 773 (1978) (the Board has the “statutory responsibility to foster and encourage meaningful collective bargaining”), *enforced*, 639 F.2d 652 (10th Cir. 1981). That standard would broadly construe the term “employer,” as intended by Congress. It would allow employees to bargain over their working conditions with the entities that control those working conditions based on economic reality. Collective bargaining involves a give-and-take between the parties, and employees should expect that their union have that give-and-take directly with the employers that have control of whatever employment terms are being negotiated.⁵⁵ Moreover, the broader standard would allow employees to use traditional economic weapons to exert lawful economic pressure on those parties who realistically control the economics of the relationship—even if they do not “directly” control working conditions. Allowing for collective bargaining and the legitimate use of economic weapons, vis-à-vis the entity that in reality controls working conditions, will in turn foster one of the Act’s primary goals—achieving industrial and labor peace.⁵⁶

III. Conclusion

For the reasons discussed above and because the Board, as the agency Congress entrusted to administer the NLRA, has the power to make rational changes in the interpretation and

⁵⁵ This does not mean that either joint employer is restricted in who it chooses to represent it in bargaining. Indeed, it could choose as its agent the same individual who will represent the other employer as well.

⁵⁶ See 29 U.S.C. § 151 (noting industrial strife and unrest and inequality of bargaining power among the reasons for enacting the NLRA, which was intended to “encourag[e] practices fundamental to the friendly adjustment of industrial disputes arising out of differences as to wages, hours, or other working conditions,” and to “restor[e] equality of bargaining power between employers and employees[.]”); *Hearst*, 322 U.S. at 125 (“Congress. . . sought to find a broad salutation, one which would bring industrial peace by substituting, so far as its power could reach, the rights of workers to self organization and collective bargaining for the industrial strife which prevails where these rights are not effectively established.”)

application of the Act in light of evolutions in employment relationships and the American economy,⁵⁷ the General Counsel believes that the Board should modify its joint-employer standard to take into account the economic and industrial realities of employment relationships, which is consistent with the policies and purposes of the Act.

Respectfully submitted,

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Dated at Washington, DC
This 26th day of June, 2014

⁵⁷ See *NLRB v. J. Weingarten, Inc.*, 420 U.S. 251, 266 (1975) (“The responsibility to adapt the Act to changing patterns of industrial life is entrusted to the Board.”).

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the Brief of the General Counsel in Case 32-RC-109684 was served in the manner indicated to the parties listed below on this 26th of June, 2014.

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Mrs. ROBY. Thank you, Mr. Chairman. I yield back.

Mr. COLE. You are welcome.

We next go to the distinguished gentleman from Arkansas, Mr. WOMACK.

NLRB CASE DISPOSITION

Mr. WOMACK. Thank you, Mr. Chairman.

My thanks to the gentlemen for appearing today.

I have a couple of questions. But I want to go back to something that the gentlelady from Connecticut called attention to earlier before she departed, and that was the cases or the complaints, the number. And she threw out the number 98 percent are and I thought she said dismissed, but you, alertly, Mr. Griffin, said that in that category that they are either settled or they are dismissed.

Mr. GRIFFIN. Yes.

Mr. WOMACK. And you didn't have the math to say how that is broken down.

Mr. GRIFFIN. I can give you the numbers in terms of what percentage of cases are dismissed or withdrawn. I can also give you the numbers of once merit is found, what percentage of the cases are settled.

What I didn't have was combining those two numbers, how many cases proceeded to litigation. I can certainly—but if you want me to go through those, I would be happy to.

Mr. WOMACK. No, that is not important. Here is the point I am trying to make, and that is similar to what my friend from Maryland was asserting, that he represents an area that is pretty rural in nature.

And if you looked at my district, I represent an area that is pretty rural in nature. We don't have any major cities, major metropolitan areas in my district. So I am like him. I represent a lot of business owners that are on the average quite small.

And he asserted that because of the size, and you threw out the number between 23 and 28, because of the size, it is, I think, logical to conclude that these small businesses don't have the capacity to hire and staff in-house people that have the subspecialty capability to deal with some of these very complicated matters.

SETTLEMENTS

And so, here is my question. Back to the 98 percent. Is it possible that of those people that are entering into some kind of a settlement are doing so because it not as any kind of admission of guilt, but moreover because it is far more beneficial to them, cost effective for them to enter some kind of a settlement than it is to engage in some kind of costly litigation? Is it possible?

Mr. GRIFFIN. Well, the reason and motivation for why parties enter into settlements and why they ask for non-admissions clauses or why they choose to seek to pay more money and to avoid other things or post the notice and pay less money, those types of things I think are pretty much going to be dependent on the individual circumstances of each case.

Mr. WOMACK. All right. But let us just—let us just—

Mr. GRIFFIN. It is hard for me to speculate.

Mr. WOMACK. Then let me just—let me ask it a different way. Based on individual circumstances, is it possible that they are going to enter into some kind of a settlement because it is—it appears to be a better alternative than costly litigation? Yes or no?

Mr. GRIFFIN. My understanding of why people enter into settlements is that as business owners, they make a judgment about what is best for their business.

Mr. WOMACK. Okay. And so, if it is—back to my theory, back to my example. If they—if because of the fact that this could be very costly to litigate, then I think you are agreeing with me that it is possible that in this 98 percent number that Ms. DeLauro threw out a minute ago, that because a great number of these people have settled, is could be more a factor of it is more advantageous to them to settle than to enter into costly litigation?

I think you are agreeing with me. But don't let me put words in your mouth.

Mr. GRIFFIN. Thank you for that.

I believe that, as I said, people make judgments about settling for reasons that they consider in the best interests of their business. So if a business owner or a labor organization feels that the settlement is better than the litigation, then that is one factor that may enter into the settlement.

There are people who will, for matters of principle, litigate things that would be very inexpensive to settle for a very long time. And those people, obviously, make a different calculus.

Mr. WOMACK. Well, we took the very better part of my 5 minutes in trying to get the shorter answer to that particular question.

I will come back to my others later, and I yield back.

Mr. COLE. I think you will have the opportunity.

You gentlemen have gone through a number of I wouldn't say hostile, but critical questions in a row. So I want to sort of balance this out a little bit. I am going to skip my time, come back to myself.

But I want to recognize my good friend from California, the gentlelady, Ms. Lee, to give you guys a little bit of a break here.

PROTECTED CONCERTED ACTIVITY

Ms. LEE. Thank you very much.

And our ranking member had to go to Ag for a minute, and she will be back very shortly. But I have a few questions that I would like to ask in her stead also.

First of all, when you talk about the NLRB, yes, the conversation usually involves and revolves around unions. But the NLRB and the act protects the rights of all private sector workers, whether they belong to a union or not. So can you talk about the ways in which the NLRB protects the rights of non-union workers also?

Mr. PEARCE. Well, I will take a crack at it, but I think the general counsel will have some things to add. But the act, from its inception, as you stated, Congresswoman, is designed to protect the rights of workers that are non-union as well as unionized workers.

Several cases involving employees who were subject to harsh discipline as a result of social media activity, workers who were subject to discipline because of unfair working conditions, employees complaining about it being too cold in a facility or questioning the

safety of equipment. These are substantially—all of these cases are cases involving employees that there is no union present at all. It is these employees coming together to assert their rights relative to terms and conditions of employment, and it is our responsibility to service those employees.

Mr. GRIFFIN. Yes, I agree 100 percent with what the chairman said. The act covers the entire private sector workforce, and people have rights to engage in discussions and activities surrounding their working conditions and wages together. And that is without regard to whether or not there is a union involved.

And so, the example that he gives of the employees who are in a workplace where it is cold and they want heat to be able to do their job would one example, and there are quite a few others.

Mr. PEARCE. I might add that there are existing today rules that employers have prohibiting employees to discuss their wages with each other. Those have been considered rules that are violative of the National Labor Relations Act from time immemorial, and no unions are involved in those considerations.

Ms. LEE. Let me ask you now, and thank you very much. I hope the other side understands that very clearly. I am sure you do, Mr. Chairman.

But you know, all the attacks seem to be centered around unions, protecting union workers only. But this is about all workers, all employees, and their right to fair working conditions, fair wages, clean, safe work environments. So for union and non-union workers. I just want to make that clear.

SPECIALTY HEALTHCARE

On the specialty healthcare, and let me ask you a little bit about that because I know you have been criticized for creating micro unions. But Congresswoman DeLauro has the data, there doesn't seem to be a decrease in the typical size of a union as a result of the specialty healthcare. And let me just go through these numbers.

In 2010, the median size bargaining union was 27. 2011, 26. 2012, 28. 2013, the median size was 25. In 2014, it was 26.

So the specialty healthcare, has it led to this multitude of horrors that critics are predicting? For instance, there has been a—has there been a mass proliferation of micro unions?

Mr. PEARCE. Absolutely not. In fact, specialty healthcare, what it did was returned to a traditional analysis of how an appropriate bargaining unit is determined. This was an analysis that was endorsed by the D.C. Circuit in a case called *Blue Man Vegas v. NLRB*.

As a result, the representation proceedings have been functioning fairly and efficiently under these standards. And in fact, employers have asserted specialty healthcare as a basis for making determinations regarding appropriate units.

One case, *Odwalla*, was a case where an employer said that based on specialty healthcare, the unit that the unions sought would be a fractured unit, and we agreed with them.

In the clothing departments, we had two cases. One, *Macy's*, where we determined that a unit was appropriate, but then another case on *Neiman Marcus* where we determined, based on the

specialty healthcare analysis, that a unit as proposed by the petitioner was a fractured unit and would be inappropriate.

Ms. LEE. So then why all the criticism? Do you know what this is about, given that it really seems to be about community of interest?

Mr. PEARCE. Well, I am at a loss for that. I wouldn't speculate as to it.

Ms. LEE. You wouldn't know?

Mr. GRIFFIN. Yes, I would just add that the Board's job in the hearing that was discussed, in the time frame that was discussed, the Board's job under the statute is to determine whether or not the petitioned-for unit is an appropriate unit. And the Supreme Court has been very clear that it is not the most appropriate unit or the biggest unit, but whether it is an appropriate unit.

And so, in making these determinations, what the Board is doing is determining whether or not the unit that is petitioned for is an appropriate unit. And I would just note that the unit in specialty healthcare that was found appropriate was more than twice the size of the median units that we are talking about. It was over 50 employees.

The units in the Neiman Marcus case and the Macy's case that in one instance they were found appropriate, in one instance they were found not appropriate, those were well over 40 employees. So I don't think—I think calling it a micro unit issue is kind of a rhetorical device that doesn't really focus on what is at stake.

What is at stake is whether or not the group that is petitioned for is an appropriate unit. And it can be bigger or smaller. As I said, the Neiman Marcus unit that was found inappropriate was over 40 employees, but the Board determined that it was not an appropriate unit.

Ms. LEE. I see. I see.

Thank you, Mr. Chairman. It seems like all this noise really is about nothing, really. But, so thank you very much.

Mr. COLE. Thank the gentlelady.

TRIBAL SOVEREIGNTY

Let me go back to my favorite subject now. So take you back into the tribal sovereignty issue, and I want to pose a hypothetical probably to you, Mr. Chairman. But either of you are more than welcome to answer it because I think both you would be an interesting perspective.

You know, as I look at this thing, and I understand that the agency has tried to make a distinction between governmental functions and commercial activities where tribes are concerned. And you know, it strikes me when I look at State governments, some States run the liquor industry themselves. They get a lot of revenue off of it. Some don't. They leave it in private hands but regulate it.

I think of both State and national workforces at things like parks, where there is lots of recreational activity, and it is you can argue whether it is directly a governmental function or not. So in cases like that, I would assume you don't presume you would have the ability to regulate the Federal Government in areas where it is operating private concessions basically as revenue streams or the

State governments where they are engaged in what are commercial activities but draw revenue, or do you?

I mean, I am trying to understand the distinction between tribes that do that and other governmental units that engage in the same activity and exactly where your authority, in your view, would extend.

Mr. PEARCE. Well, if I understand you correctly, Mr. Chairman, we would not get involved in State regulations unless those State regulations have gone into areas that are within our jurisdiction.

Mr. COLE. Are there—and I don't mean to interrupt. Please, can you give me some examples of where that would be? I mean where you have felt the need to do that? Please.

Mr. GRIFFIN. Just as an example, I think the distinction that is drawn is whether or not—if I am following your question correctly, is whether or not the function is performed by a State government or a Federal Government employee, or it is a function that is performed by a contractor or some other entity. And the line is pretty clear in terms of the jurisdiction of the—of the statute that both State employees and Federal employees are not covered by the act.

There has been over time a varying standard that is applied to the contractors, although it has been pretty much the same standard for a while. And basically, without getting into the nuts and bolts of how the standard gets applied, if the work is done by the contractor, the Board will assert jurisdiction over the contractor, not over the State employee or State employees.

Mr. COLE. I understand that distinction. How would that apply then in a case where take a tribal entity, again, the person performing the work is a direct employee of the tribe, of a governmental unit. They are not a contractor. They are not—they are working directly for the tribe. Their paycheck is drawn there. Their supervision is directly in line with governmental activities or with it.

So that is, to me, where I am having a hard time saying the, well, you can do it to one, but not to the others.

Mr. GRIFFIN. And part of the reason is because there is not an explicit statutory exclusion for tribal governments in the statute.

Mr. COLE. It just says governmental units. They are the only ones who—I mean, I don't know, is there in the statute, and please correct me because I could very well be wrong here, for the District of Columbia or for territorial possessions? Again, places you recognize as governmental units and where, as I understand it, you don't exercise authority?

Mr. GRIFFIN. You are correct that there are other types of governmental units that are specified where they are not—where they are not excluded. There is not—the reason for the assertion in the context of the tribes is there is not a specific statutory exclusion with respect—

TRIBAL SOVEREIGNTY

Mr. COLE. Well, but what I am asking is in all these cases that you choose not to—that has to be listed, I mean, all these entities. Do we list American Samoa or possessions of the United States? We may well. I am just—I am not familiar.

Mr. GRIFFIN. The precedent on the Board taking jurisdiction of employer is that the definition of employer is supposed to be interpreted broadly because of the remedial purpose of the statute. So absent a specific statutory inclusion, the Board's tendency is to assert jurisdiction.

There are circumstances in which the Supreme Court, for example, in the context of religious institutions, for example, has said the fact that they may be private sector employers, there are circumstances under which the Board is well advised not to take jurisdiction because of the potential First Amendment implications. And the Board relatively recently just decided a case in this area, kind of drawing the line where it will and won't assert jurisdiction in those instances.

Mr. COLE. Well, we will come back to this again, but let me just end with this, and I will certainly give you the opportunity to reply.

I mean, this is a real friction point because if you looked at the history of the relationship between tribes and the Federal Government, there has been case after case—and not, this is not directed at you—of overreach by Federal authorities into the legitimate jurisdiction that had been recognized either in statute or by precedent.

And I think that is what we have, this is my personal opinion, in this particular case. I think it is going to be a point of great friction.

With that, and again, if you care to say something, that is fine, or I will come back in another round because I am not quite done with this yet. But fair enough. I just didn't want to end with something and not give you an opportunity to respond.

I want to go to my friend from Arkansas, Mr. Womack.

Mr. WOMACK. Thank you, Mr. Chairman.

SPECIALTY HEALTHCARE

And you know, at the risk of kicking the specialty healthcare horse a little more, I am going to kick a little more. Chairman Pearce, help me, help me understand what the Board found that wasn't working with what I believe is a long-held standard, which held that a wall-to-wall unit of all store employees was the appropriate bargaining unit. What wasn't working?

Mr. PEARCE. Well, I don't believe that that was a long-held standard. A wall-to-wall unit—

Mr. WOMACK. What was the long-held—

Mr. PEARCE. Well, it depends on the industry. There were in the department stores or in certain facilities, the determination as to whether or not a wall-to-wall unit was appropriate depended on the function of the particular store. If there was functional integration and there were sharing of responsibilities to an extent where you had a community of interests so intertwined that it justified that kind of determination, that was what was the case.

Now specialty healthcare, as I said previously, does not introduce something new. What it does is returns to a traditional standard. And it lays out whether there is a question concerning representation for an appropriate unit.

As the general counsel stated before, an appropriate unit was—the parameters of that unit was defined by the Supreme Court

when it said it doesn't have to be the most appropriate unit. It has to be an appropriate unit.

Now if that unit is to be expanded upon, other parties to the process, usually the employer, can expand upon that unit if they can demonstrate that there is an overwhelming community of interest with those employees sought to be represented in the petition.

Mr. WOMACK. It would just seem to me that in a generic store concept that where there might be an opportunity to cross-train employees from one area into another, that if the—if there are multiple bargaining units within that organization that have kind of territorial possession over certain elements of that particular job, that it might discourage or it might prohibit, worse yet prohibit the ability for certain people to be able to cross-train and receive promotions and go up the chain within the framework of that particular generic store. Agree or disagree?

Mr. PEARCE. I don't agree. And I say that strongly in that that is all based on what is negotiated between the parties. The employer has a dog in the race. The employer always has a dog in the race.

So when the parties sit down and negotiate the parameters of what constitutes training and advancement and so forth, all of that is terms and conditions of employment that is subject to collective bargaining.

Mr. WOMACK. Well, I will just end by just saying that you know in a time when we are—as a nation are desperate to create jobs and opportunities for people, that it just seems to me that this is one more example as to how we are making it really difficult.

You know, I have employers in my district that tell me that cost of compliance, just the cost of compliance with the reach of the Federal Government into their business is prohibiting them from being able to create the opportunities, create the jobs and the opportunities for people to be productive Americans in our society. And I just—I shudder to believe what these types of rules and this kind of Federal mentality is going to have on our capacity to create opportunities for our people.

I am going to leave it there. I have got another hearing I have got to get to, and I again thank the gentlemen for appearing before us this morning, Mr. Chairman.

Mr. PEARCE. Thank you, Congressman.

Mr. COLE. Thank you.

Okay. We will go to my good friend, who is also trying to shuttle back and forth between hearings, the ranking member.

TEMPORARY INJUNCTIONS

Ms. DELAURO. Apologize to you all.

I would just say before my colleague Mr. Womack leaves, that many years ago, and you will take this in the spirit in which it is addressed, there were all kinds of businesses who said that they weren't much interested in minimum wage. And clearly, the Nation was going to go to hell in a hand basket. The economy was going to collapse if we didn't do something about a minimum wage to start with.

And then, clearly, we continue to hear that with regard to increasing the minimum wage, which would provide people with what they so desperate need these days, the jobs that pay them enough to be able to live on.

That being said, I just want to make one point, and then with a question here, follow-up question. I think that I am going to mention it again. Nearly two-thirds of charges for unfair labor practices are without merit. And you determined that they are without merit, two-thirds.

If you were to listen to some of the rhetoric that surrounds the NLRB, one would think that, my God, this was 100 percent of the cases were being litigated, et cetera. I would just say it is not your job, it is not our job to get the word out. This is not a, as I said earlier, an activist agency digging into every business and et cetera to address an issue, and it is the long hand of Government.

I think you all need to think about getting that word out as well, as about, you know, what you do and what are the issues that you do take on and what are the importance and relevance of the issues that you take on.

With regard to temporary injunctions, let me go back on that for a second, if I might? Last fall, there was an article in the Washington Post. It was about an employee at Capital Bikeshare, who was fired for organizing his coworkers to form a union. The employer confirmed that this individual was fired for his organizing activity, but they said it was because he had a supervisory role, which the employee disputed.

In the article, it says that, "By some estimates, organizers are terminated in 25 to 30 percent of union organizing campaigns because even if the actions are later deemed legal, they can be effective at squashing campaigns in the short term, and any ultimate consequences, such as paying back taxes, are too small to act as a deterrent for the companies."

10—J INJUNCTIONS

You talk about, and I know we had some conversation earlier, but you talk about the use of temporary injunctions to assist workers who have been fired or penalized. Can you talk about again the circumstances that would lead you to seek a temporary injunction? And your testimony says you sought temporary injunctions in 38 cases last year, and every single one of them was upheld.

Do you think there are additional cases that likely should have been qualified for injunctions, but the evidence was insufficient? How common is it for an employer to fire a worker who tries to organize a union?

Mr. GRIFFIN. Well, if I could make clear one of the things about the statistics, just so we have an accurate record for the hearing? We were authorized by the Board to seek injunctions in 38 cases.

Ms. DELAURO. Okay.

Mr. GRIFFIN. The matters were resolved without having to file in many of those, and in fact, we only had to file 11, and those 11 we prevailed in whole or in part.

The circumstances and what the law requires is, first, that there has to be a reasonable belief that we are going to prevail on the merits, and that is in the nature of making the merit determina-

tion and issuing the complaint. This is pursuant to Section 10(j), which is discretionary authority to seek temporary relief.

And for your example, we would have to determine with respect to this organizing campaign that the individual was fired—we would have to make the *prima facie* case that the person was fired for their activity, that there was knowledge of the activity, that they engaged in the activity, and the action was taken in response to the activity.

Then we have a second piece that we have to demonstrate in order to get, and that is that the remedial relief would be just and proper. And what the courts look at is whether, you know, there are going to be—if we prevail in the underlying administrative proceeding, there ultimately will be a remedy at the end of the underlying administrative proceeding. What we have to demonstrate is that there is some possibility that if we wait until the end of the administrative proceeding, some aspect of what the law protects will not be able to be remedied.

And so, there is a potential for remedial failure. And in the organizing context, what is lost is the party, the employee's ability to engage in that organizing to try and bring it to fruition without being interrupted by the unfair labor practice.

It is not so much the reinstatement and the back pay, although we will seek temporary reinstatement so that the employees realize that this unlawful conduct cannot be engaged in a way to quash the campaign or to quash their efforts to obtain whatever improvements in their working conditions that they seek. But the thing that we have to demonstrate is that second piece, which is the potential for remedial failure if you wait for the full Board processes to take their—run their course.

And so, the three examples that I gave, the concern is if it is in a first contract bargaining situation, and the parties don't have an established collective bargaining relationship and the workers don't know about how the process works and bad faith bargaining frustrates the efforts to get the initial contract, you won't be able to put the parties back in the original situation. Again, that opportunity to achieve the first agreement will be lost.

Similarly, the opportunity to engage in a successful organizing campaign or to bring it to fruition would be lost because people will—belief that they can engage in these rights protected by the law, that belief, their exercise of those rights will be chilled.

Similarly, my successor example that I gave before in response to Congresswoman Lee's question. If a successor employer is successful in not hiring employees because the employer is concerned that if they hire the predecessor's employees they will take on a collective bargaining responsibility and they want to avoid that, if people are not hired, they have to work someplace. They go—they go to work elsewhere.

Even if you get them reinstated, at the end of the day, the union is not in the same position to bargain as they would be if the bargaining obligation was recognized at the inception.

So it is these possibilities for—and you know, we have an administrative process that can be protracted. And so, part of what the courts recognize is that if the administrative process is going to be

protracted, that in certain circumstances, temporary relief is necessary.

Ms. DELAURO. Okay. I would just add, Mr. Chairman, on December 17th, Capital Bikeshare workers voted 41–14 in favor of joining the Transport Workers United Local 100.

So, thank you, Mr. Chairman.

PERFORMANCE AWARDS PROGRAM

Mr. COLE. If I can, I want to go to one issue quickly and then yield back to my friend for whatever final question she might have, and we will draw to a close.

But this is actually more to give you an opportunity to just to address something where I think you have probably already taken appropriate managerial action. But in January 2014, there was an IG report that found the agency's Performance Management Awards Program lacked internal controls to detect and prevent waste and abuse.

The IG report stated that the program lacked certain records, documented policies, and awards were misappropriated by staff. It actually used pretty strong language, "gross mismanagement."

And it is my understanding they made five recommendations to you, that the agency agreed with all five of those, and hopefully, you have had the opportunity to implement them. So I just wanted to sort of see where you were in that—in that process.

Mr. GRIFFIN. Yes, we—actually, I had a monthly meeting with the IG yesterday, and we looked at where we are in implementing all of those things. And we either have them implemented or are in process. We took that report very seriously and want to do what we can as expeditiously as possible to address his recommendations.

Mr. PEARCE. Similarly, I meet with the IG on a monthly basis as well, and we pointedly inquired about those situations. And we have taken internal steps to remedy all of those things that our fiscal controls are much tighter. We have a CFO that is actively responsible for tightening those situations. The circumstances involved in many of those reports involved employees that are no longer with this agency.

CLOSING STATEMENT

Mr. COLE. Well, I appreciate you gentlemen following up on that, and if you would, just keep us informed and let us know when you have reached the point where you are satisfied you have got the internal controls in place.

Does the gentlelady have any additional questions?

Ms. DELAURO. No more questions, Mr. Chairman.

Mr. COLE. Okay. Let me just end with this. First of all, I want to tell you if I am ever in a labor dispute, I am going to hire one or the other of you because I think you are clearly superb litigators, and you have been excellent witnesses.

Obviously, some members of our committee, mostly on our side—well, probably exclusively on our side—have some concerns. And I think the ranking member made a good point in her opening comment when she said a lot of the concerns are not on the day-to-day

management with the agency. Quite the opposite, you have lived within your budget constraints, reasonable.

That doesn't mean you will get what you asked because we are going to have a tight budget year around here, but you know, these are not unreasonable kinds of requests that you have put in front of us in terms of your own budget. And I appreciate the speed with which you followed up on the IG's report and your effort to do the right things there.

So there probably is a philosophic difference, you know, in some of the areas where we see you pushing to expand. You would argue, I assume, that you are responding to the labor market or doing what is in your inherent abilities, and we will just, you know, have those disagreements in areas like franchisees and some of the—particularly tribal governance. We just have a very profound difference of opinion there, which I suspect will be settled in the courts at one point along the way.

But again, I just—I want to thank you for what you do because the right to organize and the right, and Ms. Lee made this point very well, of non-union workers to still be afforded the protections they are entitled to are important. And the fact that you are pushing to look after people sometimes that don't have the ability to organize and look after themselves is not missed by this committee and is appreciated.

Where we differ, we will make those points. But that doesn't lead me to question your professionalism or the dedication of the people in your agency to try and make sure that American workers have the rights to which they are legally entitled and the protections to which they are legally entitled. And I appreciate the fact you both devoted your entire careers or much of your careers to doing exactly that, both private sector and now here in the public sector.

So just thank you very much for your service. Thank you for taking the time to come before the committee. I know we had some questions where we disagree, but I thought you handled them extremely professionally, and I appreciate the attitude with which you approached them.

Mr. PEARCE. Thank you very much, Mr. Chairman.

Mr. COLE. So thank you. With that, our hearing is adjourned.

Labor, Health and Human Services and Education and Related Agencies

Budget Hearing: National Labor Relations Board

Wednesday, March 24, 2015

Questions for the Record from Chairman Cole

Budget

The FY 2016 Budget for NLRB requests an additional \$3.8 million and 30 FTE for a total of \$278 million and 1,640 FTE. Is the requested increase sufficient to cover projected increases in pay and other costs in FY 2016 in addition to the 30 new FTE? What other cost savings measures are assumed in the budget request and what are the estimated amounts of projected savings for each such activity?

Response of General Counsel Griffin: The Agency believes that the budget request of \$278 Million for FY 2016 will fund the Agency's statutory mission for the resolution of labor disputes with an increase of 30 skilled employees, who will offer assistance with investigation, settlement, litigation, adjudication, and compliance. The requested increase for FY16 will cover inflationary costs for pay and rent, and will allow us to hire 30 additional FTE including 20-25 attorneys and field examiners and 10 FTE to support mission-critical functions in our Chief Financial Office and Division of Administration. While we cannot put a figure on all of the anticipated cost savings, we expect to primarily reduce costs by downsizing our headquarters footprint by one third and by migrating IT technical infrastructure to a hybrid cloud environment.

What regional and satellite office have been closed as a result of ongoing restructuring efforts? Are any additional regional or satellite offices expected to be closed and what are the estimated cost savings of those closures? Does NLRB believe it can continue to provide the same level of services in the regions and local areas where offices have or will be closed?

Response of General Counsel Griffin: The only office that has been closed to date as a result of the ongoing restructuring efforts was the Jacksonville satellite office after one of the two Board agents that worked in that office retired. We made the decision to close that location after considering savings related to rent and security, which were estimated at \$25,000 per year. The remaining Board agent became a Resident Agent, who continues to service that geographic area. Later this year, we are considering closing the Des Moines satellite office for similar reasons. Specifically, of the three Board agents, one is retiring and the second was promoted and is transferring. The savings in rent and security by not having the third Board agent remain in the current building is \$44,000 per year. If the Office closes, it is likely that he will transfer to another Regional Office. The NLRB continues to provide the same level of service in Jacksonville and expects to provide the same level of service in Des Moines.

April 13, 2015

Please provide a table showing annual caseload for each of the NLRB's field offices and headquarters for each of the last five years. Please also provide any analysis of caseload trends as is deemed appropriate.

Response of General Counsel Griffin: Please see the attached table.

IG Report

Please provide an update on the status of implementing each of the five IG recommendations from Report No. OIG-AMR-71-14-01.

Response of General Counsel Griffin: With regard to the OIG's January 6, 2014 audit of the Division of Administration Pilot Employee Recognition Program (OIG-AMR-71-14-01), after the Agency agreed with the five recommendations, it developed an action plan to implement them. Below is the current status of those five recommendations:

Recommendation 1 involved a protocol for documenting the receipt, consideration, and approval of administrative policy decisions. The Division of Administration is currently developing appropriate documented procedures for presenting matters to the General Counsel for consideration and approval.

Recommendation 2 involved the Office of Human Resources following the guidance provided by OPM in taking corrective action, if necessary, regarding the unauthorized rating system. The NLRB consulted with OPM, who advised that corrective action would be needed if there was an adverse action using the Pilot Performance Management System. The Office of Human Resources' review of the records revealed no adverse actions ultimately taken. OPM also advised that it was within the Agency's discretion to maintain or rescind the incentive awards granted during that time. The Agency decided not to rescind them. The OIG closed the recommendation as implemented.

Recommendation 3 involved a recommendation that the Division of Administration's Performance Management Official be an official within the Office of the General Counsel. The NLRB has assigned an official of the Office of the General Counsel the Performance Management Official for the Division of Administration, which is consistent with other divisions managed by the Office of the General Counsel. Steps are underway to update the Administrative Policy and Procedure Manual to reflect that assignment.

Recommendation 4 involved the Office of Human Resources reviewing its records and ensuring that all employees have a properly executed performance plan. The Office of Human Resources is currently developing tools and resources, as well as coordinating efforts with the General Counsel-side and Board-side heads of organizational units, to ensure that all Agency employees have appropriate Performance Plans in place and that all Agency managers and supervisors and

April 13, 2015

the Human Resources team have appropriate training and regulatory guidance. This training began in March 2015.

Recommendation 5 involved the Office of Human Resources establishing criteria for when appropriated funds may be used for award ceremonies, including a means to determine the amount of funds that may be used. After consultation between the Office of Human Resources and the Office of the Chief Financial Officer, criteria was developed and appropriately disseminated. The IG closed the recommendation as implemented.

Representation Case Procedures

Under the Board's new election regulations, including the eight day time limit, is it possible for an election to take place before the Board certifies a unit as appropriate for purposes of collective bargaining? Will employees that do not wish to be contacted by union representatives over the phone or by email be allowed an exception to opt out of such communication voluntarily?

Response of Chairman Pearce: No, it is not possible for an election to take place before the Board's regional director has determined, after a hearing, that the unit in which the election is to be held is an appropriate unit, unless all parties have signed an election agreement designating the voting unit. The voter list procedure does not include a procedure for individual voters to opt out of inclusion of phone or email information.

Specialty Healthcare

There is a great deal of uncertainty about the implications of NLRB's Specialty Healthcare decision. Since the case changed longstanding precedent regarding what constitutes a bargaining unit, it raises legitimate concerns regarding what new precedent(s) will be established. The environment of uncertainty this has created has been difficult for both employers and policy makers to navigate. Has NLRB established any kind of guidance or policy statement regarding what kinds of units will be deemed appropriate for purposes of collective bargaining in light of this decision? Has NLRB considered establishing more transparent standards through the formal rulemaking process?

Response of Chairman Pearce: Preliminarily, the Board's decision in *Specialty Healthcare* did not change the standard for determining what constitutes an appropriate unit for collective bargaining. It addressed the question of how to deal with the common situation in which a petitioning union seeks an election in a specified unit, and the employer contends that the requested unit is not appropriate and must include certain additional employees in order to be appropriate. In answering that question, it adopted the formulation articulated by the U.S. Court of Appeals for the D.C. Circuit in summarizing longstanding Board law. First the Board determines whether the employees in the petitioned-for unit are readily identifiable as a group,

and whether they share a community of interest, based on the long-established traditional factors. If the Board determines that there is a community of interest, then the board determines whether the additional employees sought to be included in the unit share an overwhelming community of interest with the employees in the petitioned-for unit. Because there has been no change in substantive standards for unit determinations, no new guidance has been published. There are resources available to the public on the Board's unit determination standards on the Board's website. No rulemaking concerning unit determination standards is presently under consideration.

Joint Employer Standard

NLRB has stated that if the Board accepts the General Counsel's recommendations for changing its joint-employer standard, it would only affect a very small proportion of franchises. What percentage of existing franchises does the NLRB estimate would be affected if the Board does accept the General Counsel's recommendations related to its joint-employer standard? Would contractors and subcontractors also be affected by this new standard and, if so, what percentage of those arrangements does NLRB estimate would be involved?

Response of General Counsel Griffin: Unlike other agencies, the NLRB cannot *sua sponte* initiate investigations. Therefore, the NLRB cannot predict what proportion of franchises may be affected if the Board adopts the General Counsel's recommendations related to its joint-employer standard as that number is completely dependent on charges being filed by individuals, employers and/or labor organizations. Similarly, while contractors and subcontractors may be affected by any change to the joint-employer standard, the NLRB cannot predict the percentage.

Questions for the Record for Chairman Pearce from Rep. Womack

1. Chairman Pearce, can you explain the NLRB's rationale in the "Specialty Healthcare" decision, which radically changed the standard for determining which employees should be included in a bargaining unit, and if there are cases where the Board will still consider a storewide bargaining unit appropriate? I'm greatly concerned with the unnecessary burden and added costs this could place on America's greatest job creators, small businesses, which lack the resources to manage and negotiate the terms of multiple bargaining agreements. Previously, employees forming a separate bargaining unit were required to have interests "sufficiently distinct from those of other employees to warrant the establishment of a separate unit." What did the Board find "wasn't working" with the long held standard, which held that a wall-to-wall unit of all store employees was the appropriate bargaining unit, to warrant this fundamental change?

Response of Chairman Pearce: The Board's decision in *Specialty Healthcare* addressed the question of how to deal with the common situation in which a petitioning union seeks an election in a specified unit, and the employer contends that the requested unit is not appropriate and must include certain additional employees in order to be appropriate. In answering that question, it adopted the formulation articulated by the U.S. Court of Appeals for the D.C. Circuit in summarizing longstanding Board law. First the Board determines whether the employees in the petitioned-for unit are readily identifiable as a group, and whether they share a community of interest, based on the long-established traditional factors. If the Board determines that there is a community of interest, then the board determines whether the additional employees sought to be included in the unit share an overwhelming community of interest with the employees in the petitioned-for unit. If so, they are included in the unit; if not, the petitioned-for unit is appropriate. As adverted to above in describing the source of the *Specialty Healthcare* formulation, the decision simply clarified pre-existing Board law. A store-wide unit or a unit of all selling employees will continue to be found appropriate absent unusual circumstances. It is also still true that the Act requires only *an* appropriate unit, not the most appropriate among all appropriate units. Thus, if a petition is filed for a unit other than a store-wide unit and the unit is appropriate under the Board's long-established standards, an election will be directed in that unit.

2. Chairman Pearce, I worry that the precedent established by the "Specialty Healthcare" case, which paved the way for the Macy's cosmetics and fragrance workers to form their own union, will harm employee's upward mobility in a company. When there are multiple bargaining units in a single store, it is more difficult, and in some cases, even impossible for employees to cross train and earn promotions to new departments because that work is assigned to other bargaining units and therefore, off limits. By allowing multiple bargaining units within the same store or company, how will employees gain the skills and exposure they need to move to other departments and work their way up the ladder?

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Response of Chairman Pearce: There is nothing about separate bargaining units that precludes employees in one unit from cross-training in or transferring to another. Having separate units simply means that the employees in each unit may bargain with the employer as a separate group. Cross-training and transfer opportunities may be negotiated with the employer; if the employees view them as desirable and the employer is agreeable, an agreement to permit them will be reached. If the employer is against such interchange and the employees are unrepresented, they will not have the opportunities in any case.

3. Given that the median number of days between the time a union files its petition and the election is held is 38 days, which is within the NLRB's own guidelines, why is a new election rule needed? Even former Senator John F. Kennedy stated on the Senate floor that there should be at least a 30-day interval between the request for an election and the holding of an election. Do you disagree with him?

Response of Chairman Pearce: The purposes of the amendments to the Board's representation case procedures included modernizing procedures, eliminating duplicative and unnecessary litigation, and promoting transparency. The Board has never established a minimum or maximum timeframe for holding elections. In just the past several years, the Board has conducted elections in units smaller than 5 employees and in units of nearly 50,000 employees, in a vast multitude of different industries and geographic locations. As a result, a mandated, one-size-fits-all timeframe is not workable.

4. As you are aware, privacy breaches have unfortunately become all too common, not only with private sector employers, but also with the Federal government. These breaches have resulted in millions of dollars' worth of damages and the disclosure of millions of individuals' private information. What protections will the Board have in place to safeguard the privacy of employee's personal email addresses, cell phone numbers, work schedules, and home addresses since the new rule requires employers to hand over this information to unions? How much has the Board spent to date in researching, drafting, and preparing for the implementation of this new election rule?

Response of Chairman Pearce: My colleagues and I are aware of the privacy interests of employees and take them very seriously. The amendments to the representation case procedures include a prohibition on any use of the voter list other than for the representation proceeding and related matters. While remaining alert to the potential for misuse, I note that in two rounds of public comments and hearings on the voter list proposal the Board was presented with no documentation demonstrating misuse of contact information provided in voter lists by petitioning unions during the nearly 50 years in which the Board's Excelsior policy has been in place.

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In regards to spending related to the rulemaking, the Agency conducted an analysis of staff work hours and other related costs and estimate our costs to be \$1,367,147.

Questions from Representative Lee

Question 1: Collective bargaining rights and employee rights

I understand that the NLRB played a crucial role in a case in at a San Francisco facility where the Agency was able to secure an agreement with a successor employee to offer jobs and pay \$1 Million to more than 100 current and former employees. I understand that these included people who were not hired because of the successor employer's unwillingness to accept a duty to bargain with its employee's chosen bargaining representative.

I am glad that the NLRB was able to step in and get just compensation for these employees, but am concerned that a successor company would refuse to bargain with the chosen representative.

Can you tell me how prevalent this is? Also what has been done in the past to rectify it, and how well has this approach worked in the past? Lastly, what you are doing now to make sure that the case I described in San Francisco never happens again?

Response of General Counsel Griffin: In the past three years, we have had approximately 204 cases alleging successor refusals to hire predecessor employees and/or bargain with the incumbent bargaining representative. 76.4% of those cases were found to have merit. Of those meritorious cases, 73.7% settled with 2,319 workers receiving offers of reinstatement and backpay reported in cases closed. Of the remaining cases closed, the Agency litigation success rate was 100%.

In GC Memorandum 14-03, the General Counsel specifically advised the Regional Offices to consider seeking injunctive relief in appropriate cases involving a successor's refusal to bargain and/or to refuse to hire its predecessor's employees to avoid such a bargaining obligation. As noted therein, successor cases present the same need for protection as those with a newly certified union. In both, the status of the employees' chosen collective-bargaining representative is particularly vulnerable to unfair labor practices. With regard to a successor's refusal to bargain, unlawful conduct by a new employer that undermines the representative will lead to employee disaffection, concomitant loss of bargaining power, and loss of employee benefits that cannot be restored by a final Board order. Further, in cases where a successor employer refuses to hire employees to avoid bargaining with an incumbent union, the potential scattering of those employees creates an even greater risk that a final Board order will not effectively restore the parties to establish a good faith bargaining relationship. Since that memo issued, we have sought authorization to file for injunctive relief in 6 successor cases. Of those cases, 2 settled and 2 were litigated with the Agency winning one, in whole or in part.

Question 2: Protecting employees through outreach efforts to the workforce

April 13, 2015

Again, thank you again for being here today. I would like to ask you a bit more about the NLRB's efforts to expand its outreach efforts.

As you know, it is so important that workers understand their rights to fair pay and adequate working conditions, and if these rights are violated – they have the right to file claims.

I understand that the NLRB has provided user-friendly information to employees and employers via social media outreach with the creation of a free mobile application.

However, as we work to expand diversity in the workforce - and by this I mean women and for opportunities to communities of color – I am concerned that many employees are not aware of their rights.

The resources you proved help make workers aware of their rights and help employers better understand the protections available under the law.

How you are working your outreach team to ensure that all workers know their rights – regardless of race, gender, and English speaking language abilities?

Response of General Counsel Griffin: The Agency is a strong proponent of outreach to the public to broaden awareness of workers' rights protected under the National Labor Relations Act and of services the Agency provides to workers, employers and unions to guarantee those rights. It is of utmost importance to provide the public with information, guidance and access to resources regarding rights and responsibilities under the National Labor Relations Act, and to develop ways to most effectively communicate such information. In that regard, last year, the Agency consolidated the Congressional and Public Affairs Office and those staff members have supported the Agency's initiatives by enhancing the public website, expanding the use of social media, updating the app, and developing resources materials, news releases and announcements. The Agency has also focused its attention on educating those from the Asian American and Pacific Islander communities, and continues its efforts to engage with foreign embassies/ministries/consulates to finalize agreements promoting the education of workers and business owners. As always, Board agents from around the country are ready, willing, and eager to inform management and labor organizations, community advocacy groups, academics, and the public at large about our statute and processes, whenever requested.

April 13, 2015

	2010	2011	2012	2013	2014	2015 up to 4/16/15
Region(s)						
Region 1 - Boston	1033	885	877	849	823	477
Subregion 34 - Hartford	488	464	460	347	341	185
Region 2 - New York	1300	1170	1012	1190	1184	662
Region 3 - Buffalo	668	560	590	569	592	313
Region 10 - Atlanta	715	760	693	660	642	384
Subregion 11 - Winston-Salem	532	568	502	496	459	228
Resident Office - Nashville		61	135	121	138	72
Region 22 - Newark	889	981	818	787	759	383
Region 29 - Brooklyn	1090	1090	1188	1489	1048	553
District 1	6715	6539	6275	6508	5986	3257
Region 4 - Philadelphia	1024	987	1088	938	889	631
Region 5 - Baltimore	1358	1308	1190	1294	1363	650
Region 6 - Pittsburgh	622	510	521	591	540	236
Region 8 - Cleveland	831	675	862	977	831	430
Region 9 - Cincinnati	1053	951	848	884	743	434
Region 12 - Tampa	596	574	541	510	492	291
Subregion 24 - Hato Rey	434	454	412	430	514	232
Region 15 - New Orleans	652	622	628	680	610	317
Subregion 26 - Memphis	403	360	306	307	237	155
District 2	6973	6441	6396	6611	6219	3376
Region 7 - Detroit	1288	1250	1091	1085	1045	571
Region 13 - Chicago	1240	1107	1203	1124	1168	563
Region 14 - St. Louis	463	475	412	399	406	206
Subregion 17 - Overland Park	433	404	433	431	379	217
Region 16 - Fort Worth	972	865	806	759	743	380
Region 18 - Minneapolis	598	496	430	469	483	244
Subregion 30 - Milwaukee	476	451	389	296	335	200
Region 25 - Indianapolis	777	515	594	383	487	232
Subregion 33 - Peoria	315	335	286	257	248	143
District 3	6562	5898	5644	5203	5294	2756
Region 19 - Seattle	868	865	916	918	873	418
Subregion 36 - Portland	344	301	237	237	267	112
Region 20 - San Francisco	938	801	913	716	642	358
Subregion 37 - Honolulu	382	247	291	247	234	145
Region 21 - Los Angeles	832	773	789	808	755	463
Region 27 - Denver	600	812	442	391	422	165
Region 28 - Phoenix	728	784	794	874	851	494
Region 31 - Los Angeles	829	732	772	769	798	438
Region 32 - Oakland	938	805	792	761	752	335
District 4	6459	6120	5946	5721	5594	2928
National Total	26709	24998	24261	24043	23093	12317

WEDNESDAY, MARCH 25, 2015.

CENTERS FOR DISEASE CONTROL AND PREVENTION

WITNESSES

THOMAS FRIEDEN, M.D., M.P.H., DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION

BETH BELL, M.D., M.P.H., DIRECTOR, NATIONAL CENTER FOR ZOONOTIC, VECTOR-BORNE, AND ENTERIC DISEASES

ANNE SCHUCHAT, M.D., ASSISTANT SURGEON GENERAL, U.S. PUBLIC HEALTH SERVICE, AND DIRECTOR, NATIONAL CENTER FOR IMMUNIZATION AND RESPIRATORY DISEASES

Mr. COLE. We will go ahead and open the hearing.

Let me make a couple of remarks ahead of time. Number one, I will be stepping out, and I think Dr. Harris will be here a little bit latter to actually sit in the chair. I have got some constituents at another committee, and then I will be coming back. So, when that happens, please excuse me for that. Don't do it often, but, you know, nobody wants to tick off the Choctaws and the Cherokees. So just not a good thing to do. So we will go do that.

Second, I believe our ranking member of the full committee, Ms. Lowey, will be coming at some point, and when she does, she is trying to move through a lot of committees. So we will—whoever is questioning will finish up and go to her for any opening statement she wants to make or whatever. So that will—that might change the order a little bit.

But good morning. It is my pleasure to welcome you to the subcommittee on Labor, Health and Human Services, and Education to discuss the fiscal year 2016 Centers for Disease Control and Prevention budget request.

Genuinely looking forward to your testimony, Dr. Frieden. I would like to publicly thank you and your staff at CDC for hosting Dr. Harris and myself recently on my first visit and for giving us a briefing and tour of the campus. I think it is safe to say that that certainly all of us that were on that left CDC with a profound appreciation for what you do and for the wonderful work that goes on there for the American people and, frankly, for people all over the world.

The CDC is the leading public health agency monitoring, investigating, and taking action to resolve complex public health problems in the United States and, frankly, around the world. Your budget assumes many areas of enhanced focus for antibiotic resistance, global health, prescription drug abuse, and continuation of eradication of polio. Of course, the CDC is still actively engaged in the Ebola fight, and in fact, we expect to have an oversight hearing on Ebola in the near future and very appreciative of the work that you have done in that area, again, not just for people in our country but around the world.

Public health is an important Federal role and certainly something that we all generally support. Unfortunately, right now sequester is still the law of the land, although we can work on that, and maybe we can work through that over the course of this fiscal year. And given the reality of funding, we may not be able to do everything in every area that the administration is proposing, but I certainly think this is an area where there is genuine bipartisan desire to get something done.

I look forward to having a discussion with you this morning on your top priorities for the year given our funding constraints. I also look forward to discussing in greater detail priorities I know we all share, such as reducing opioid abuse and antibiotic resistance in our country. There are many public health threats facing our Nation, and we on a bipartisan basis want to give you the resources you need to combat them.

I want to caution you, however, that we also want to ensure that precious taxpayer dollars are not wasted on politically motivated activities and that we maintain the appropriate focus.

Today we welcome Dr. Thomas Frieden, the CDC Director, to the subcommittee. Dr. Frieden is accompanied by two of his center directors who can assist in answering specific member questions. They are Dr. Beth Bell, who was, again, kind enough on our tour to join us and was extremely helpful, Director of CDC's National Center for Zoonotic, Vector-Borne, and Enteric Diseases; and Dr. Anne Schuchat—I hope I got that right; Dr. Frieden gave me a little heads up—Assistant Surgeon General of the United States Public Health Service, the CDC's Director of National Center of Immunization and Respiratory Diseases.

As a reminder to the subcommittee and our witnesses, we will try to abide by the 5-minute rule, and before we begin, I would like to recognize my distinguished ranking member, good friend, Ms. DeLauro, for any opening remarks she cares to make.

Ms. DELAURO. Thank you very much, Mr. Chairman, and welcome all, and I would just associate myself with the chairman's remarks about the importance of the CDC, and really it is, in my view, one of the three pieces that are the kind of the crown jewels of our healthcare system. And that is CDC, the NIH, and the FDA, which I think which gives us our edge in both domestically and internationally. So I congratulate you for all that you do.

And, Dr. Bell, Dr. Schuchat—we got it right? Okay, great—thank you for joining us.

And, again, Centers for Disease Control and Prevention is the premiere public health agency in the world. It is an essential part of our country's security apparatus. It is vital to the well-being and safety of American families as any military agency is. And every day its scientists, its medical professionals, other staff work to detect or track emerging threats, fight diseases before they reach the United States, and respond to public health emergencies here and abroad.

Most of CDC's funding supports core public health infrastructure around the country, including State and local departments, public health laboratories, nonprofit community-based organizations. That is the network. That is the infrastructure that is so critical in the country. In short, CDC's efforts have saved countless lives.

Over the past year, we received a terrible reminder of the need for a robust public health system in the ugly shape of the largest Ebola outbreak in history. No county is entirely immune from this disease, but the speed and effectiveness of each nation's response has been directly proportionate to the quality of its public health system.

Dr. Frieden, I would like to thank you, your colleagues for your tireless efforts to stop this horrible disease. Over the past 9 months, over 1,000 CDC staff have deployed to West Africa to battle Ebola at its source. Here in the United States, officials learned from early mistakes in Dallas, moved quickly to strengthen our public health system, which overall has responded extremely well.

At the same time, we know that CDC's ability to protect the public, both home and abroad, has been hampered in recent years by what I view as disastrous reductions in its budget. That is the inevitable result of the indiscriminate cuts and caps known as sequestration.

Adjusting for inflation, CDC's funding has been slashed by \$1.35 billion since 2010. That is almost one-fifth of the agency's entire budget. You take one example. The Public Health Emergency Preparedness Cooperative Agreement Program. That is the frontline effort for States and local readiness. That has been cut by \$132 million, or 17 percent. Recent outbreaks, like Ebola, measles, enterovirus, show just how draconian and shortsighted this policy of sequestration is. We need to be working to prevent these emergencies when we can to ensure that we are ready when they hit us.

The budget request before us today would start to put us back on the right track; requests an extra \$264 million to combat antibiotic-resistant bacteria, which kills at least 23,000 Americans every year. That is a staggering number. I read it two or three times because I couldn't believe the size of the number. It proposes an additional \$54 million to build our Nation's response to prescription drug abuse, one of the leading causes of death among adults under 65. Proposes an additional \$32 million for the global health security agenda, an agenda that increases in importance as people and goods travel more freely around the world.

These are laudable initiatives. Overall this request raises the CDC's budget by only \$140 million. That figure would restore, again, in my view, a paltry 10 percent of the cuts inflicted on CDC since 2010.

Moreover, I am concerned by a number of the reductions and eliminations contained in the request. For example, it cuts \$50 million from immunization programs and reduces breast, cervical, and colorectal cancer screening by \$42 million. It eliminates the Preventive Services Block Grant, which helps health departments in all 50 States respond early to public health risks, as well as the REACH Program, which tackles chronic diseases in minority communities, and funding for Occupational Safety and Health Research Centers.

I understand that the budget requests have to walk a fine line, but I believe that we can do better when it comes to our Nation's public health. So I have said many times we need to start by eliminating the arbitrary and capricious caps set by sequestration. To

do this, we must summon the courage to ask wealthier Americans to do more to support critical national priorities like public health. Every year we spend close to \$1.5 trillion on tax breaks and loopholes. This is spending. We are spending this money, and much of it goes to the wealthy and to the big corporations. That is spending that we should be looking to reduce. When instead we cut funding for public health, we are jeopardizing our Nation's security no less than we would cut funding for the military. That is why this hearing is so important.

I want to say a thank you to the chairman for holding this hearing and for our witnesses being here, and I look forward to our discussion this morning.

Thank you, Mr. Chairman.

Mr. COLE. Thank you very much.

And, Dr. Frieden, we will go to you. Obviously, your full statement will be entered into the record, but you are recognized for whatever opening comments you care to make.

Dr. FRIEDEN. Thank you very much, Mr. Chairman. Thank you very much for this opportunity to appear before you.

Thank you, Ranking Member DeLauro, for your comments as well.

CDC works 24/7 to protect Americans from threats, whether they are from this country or abroad, whether they are naturally occurring or man-made.

EBOLA

I also want to thank this committee and Congress for support for emergency funding to stop Ebola. Although there is still much more work to be done in West Africa, there has been enormous progress. CDC professionals have made more than 1,500 missions of weeks to months to West Africa and spent more than 40,000 workdays helping to stop Ebola there. Many people are alive today in West Africa, and Americans are safer today in this country because of the hard work of the these dedicated professionals.

There are still significant challenges in West Africa. Those same things that allowed Ebola to get out of control make it difficult to get to zero, but we will not rest until we do so and we prevent the next Ebola outbreak as well as we can and we protect Americans on our shores.

ADVANCED MOLECULAR DETECTION

I also want to be thank the Congress for support for the Advanced Molecular Detection Initiative. This was our leading priority a couple years back in the budget process. Earlier this year, CDC scientists identified an outbreak of the deadly listeria bacteria before it spread widely. That saved lives.

CDC is a best buy: We save lives, and we save money. And we appreciate your support to do it. We could not do these things without the support of Congress.

Our 2016 priorities are very simple: We want to better protect Americans against growing threats to our country.

ANTIMICROBIAL RESISTANCE

The first of these is antimicrobial resistance, and our request is for \$264 million increase in the budget. Each year, antibiotic-resistant organisms cause at least 2 million infections, at least 23,000 deaths, and at least \$20 billion in healthcare costs. Every community is affected, and the problem is getting worse. Modern medicine is at risk. It is not just routine infections, but the complications of things like cancer treatment, transplants, dialysis, routine medical care that depends on our ability to effectively cure infections, which are increasingly becoming incurable for far too many patients.

We think that we can turn this around. With your support, we can make big progress, and over the course of 5 years, based on successes in this country and elsewhere, we think we can prevent at least 600,000 multidrug-resistant infections, prevent at least 37,000 deaths from multidrug-resistant organisms, and avert nearly \$8 billion in healthcare costs.

CDC has a unique role in detection and response. We support State and local communities, healthcare systems, hospitals, doctors, patients, and communities, and in doing so, we are able to help keep Americans safer.

The antimicrobial resistance project would have four main pillars: The first are programs in every single State to better find and stop outbreaks when they emerge to improve prescribing practices and prevent infections. This builds on successes that we have had so far. For example, Illinois has been able to decrease one of the deadly bacteria that we have a graphic on, what is called CRE, or carbapenem-resistant enterobacteriaceae, by 60 percent over just a few years. This is truly a nightmare bacteria. This bacteria basically is resistant to all or nearly all of our existing antibiotics. It can kill up to half of the patients it infects in hospitals, and it can spread widely not just between patients but also between organisms. So many of the different organisms in our hospitals become resistant. We have to stop this before it gets out into the community, or routine things like urinary tract infections could become extremely difficult to treat.

The second major initiative is to establish a detection network of seven laboratory centers of excellence to rapidly identify outbreaks and use cutting-edge technology to get ahead of the spread of resistant microbes.

The third is to increase the size and scope of our emerging infections program to give us a better sense of how organisms are spreading within communities, between nursing homes and hospitals and outpatient settings. That is the only way that we can focus our prevention efforts by increasing tenfold our testing for organisms such as this.

And, fourth, it would allow us to do innovation. For example, better understanding how the microbiome and disruptions to the microbiome are changing our ability to resist infections. There are lives and faces behind these numbers. Each antibiotic-resistant infection has the potential to devastate a family. Peggy Lillis, a 56-year-old mother of two and beloved kindergarten teacher, lost the battle with *C. diff*, which you have a slide of there, following a routine dental procedure. Nile Moss was a 15-year-old boy who loved

music and art. He died after contracting MRSA, a resistant organism, following a routine test at the hospital. And I had the opportunity to sit with his parents, wonderful people who are advocating for programs like this that will prevent this from happening to other families. With your support we can protect hundreds of thousands of Americans from these infections.

PRESCRIPTION DRUG OVERDOSE PREVENTION

We will also be requesting your support to expand the Prescription Drug Overdose Program. Prescription drugs—prescription opiates, along with heroin, are claiming far too many lives. Over the past decade, 145,000 Americans have been killed by prescription opiates. And in the case of heroin, deaths have doubled since 2010. We want to expand efforts to all 50 States; maximize the effectiveness of prescription drug monitoring programs; improve physician and other clinician prescribing practices; and target services and prevention to communities most at risk.

There are other priority programs here for hepatitis, something that will kill hundreds of thousands of people in this country if we don't act quickly; for foundational detection and control activities around the world so that we can prevent the next Ebola outbreak if possible; and to get over the finish line in polio eradication, something that would be the ultimate in both sustainability and equity because it would be forever and for everyone.

So I want to thank you again for your support for CDC's work and for this opportunity to have this conversation with you, and I will be happy to answer your questions.

Mr. COLE. Thank you very much, Doctor.

[The information follows:]

CDC Congressional Testimony

Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education and

Related Agencies

CDC 24/7: Keeping Americans Healthy, Safe, and Competitive

Wednesday, March 25 2015

Statement of:

Thomas Frieden, M.D., M.P.H.

Director, Centers for Disease Control and Prevention

U.S. Department of Health and Human Services

Accompanied by Dr. Beth Bell and Dr. Anne Schuchat

Good morning, Chairman Cole, Ranking Member DeLauro, and other distinguished Members of the Subcommittee. It is a pleasure to appear before you as Director of the Centers for Disease Control and Prevention (CDC), the nation's health protection agency and an operating division of the Department of Health and Human Services. We thank this committee for supporting CDC through the 2015 appropriations process and essential emergency funding for Ebola response and building the Global Health Security Agenda.

Today I would like to focus on how CDC works 24 hours a day, 7 days a week to protect Americans from health threats and save our nation health care dollars through prevention. I will also focus on two high-priority initiatives for Fiscal Year (FY) 2016: Antibiotic Resistance and Prescription Drug Overdose Prevention.

Working to Provide Health Security 24/7

CDC helps save lives by preventing, detecting, and controlling the growing risks of infectious disease outbreaks, emerging infectious and other diseases, drug-resistant bacteria, and natural and man-made hazards and disasters. We provide emergency response support, technical expertise, and rapid development of prevention solutions, including means to rapidly diagnose health threats, and deliver vaccines and other medical countermeasures.

CDC focuses on high-impact, sustainable programs, including building a public health workforce that is prepared, diverse, and flexible. For instance, CDC assigns fellows for the Public Health Associate Program (PHAP) to serve on the front lines of public health in state and local public health departments. More than 80% of the PHAP fellows have stayed in the public health field. Health departments throughout the United States depend on CDC's expertise and support to provide basic services that protect Americans. In fact, about 80 percent of all CDC funding is awarded through grants and contracts to help accomplish our mission to promote health and quality of life by preventing and controlling disease, injury, and disability. CDC also integrates nearly 800 staff in health departments throughout the

nation to support the critical work of state and local responders and to ensure accountability for our federal investments.

CDC's boots-on-the-ground presence in the United States and throughout the world is essential to sustain public health preparedness and response. From the first week the West African Ebola epidemic was reported, CDC had an expert team on the ground working to contain the rapidly-expanding outbreak with core public health measures like laboratory testing, emergency operations centers, and culturally appropriate public health messaging. As part of this unprecedented Ebola outbreak, CDC developed the Rapid Isolation and Treatment of Ebola (RITE) strategy, which is helping end the epidemic in Liberia and making significant progress in Sierra Leone. CDC RITE team members continue to work around the clock in difficult conditions and harsh terrain. They sometimes travel by jeep, canoe, or on foot for hours to rapidly isolate Ebola patients, transport blood samples for testing, explain safe burial practices, and trace patient contacts for the 21-day incubation period.

Diseases do not respect borders, as we have witnessed during the West Africa Ebola epidemic, Middle East Respiratory Syndrome Coronavirus outbreaks, measles, and ongoing challenges from highly-pathogenic strains of influenza. We all are connected by the air we breathe, the water we drink, and the food we eat. We appreciate Congress' strong support for the Global Health Security Agenda, which enables us to provide sustainable assistance to other countries so they can detect, stop, and prevent the spread of infectious diseases. Sustainable Global Health Security is crucial to stopping outbreaks before they reach our shores. As this year's measles outbreak reminds us, diseases now rare in the United States can be just an airplane ride away, and we need to sustain a strong public health infrastructure here to keep them from regaining a foothold.

Fighting the Leading Causes of Death in America

CDC plays another critically important role protecting Americans from the leading causes of death and disability. CDC leads prevention and health promotion efforts to improve health and reduce

chronic diseases such as heart disease, cancer, stroke, and diabetes, which account for 75 percent of annual United States health care costs. Together with state and local partners, CDC develops, evaluates, and supports implementation of evidence-based interventions to prevent expensive and preventable illness such as heart attacks, strokes, and cancer. For example, CDC collaborates with the Centers for Medicare & Medicaid Services (CMS) and private-sector partners to co-lead the Million Hearts® initiative, which aims to prevent one million heart attacks and strokes by 2017 through proven strategies such as improving blood pressure control and promoting smoking cessation.

Fighting Antibiotic Resistance

Antibiotic resistance (AR)—when bacteria do not respond to the drugs designed to kill them—threatens to return us to the time when simple infections were often fatal. Today, AR causes more than 23,000 deaths, more than two million illnesses, and up to \$20 billion in health care costs in the United States each year¹. We face a fundamental threat to modern medicine: if antibiotics are rendered ineffective by resistant bacteria, we will lose the ability to treat sepsis (blood infection) or cancer, provide organ transplants, or save victims of burns and trauma. Routine surgical procedures, such as hip and knee replacements, would be far riskier, and common complications of life-saving treatments such as chemotherapy could prove fatal. A simple cut of the finger could lead to a life-threatening infection. If antibiotics lose effectiveness, we may have no means to treat otherwise treatable illnesses and our entire health care system would take a huge step backwards.

Now is the time to address this urgent threat to our health. The FY 2016 CDC Budget includes \$283 million, an increase of \$264 million to implement the National Strategy to Combat Antibiotic Resistance Bacteria and support CDC's Antibiotic Resistance Solutions Initiative to detect and protect against antibiotic resistance. We can combat these threats by investing in every state through accelerated

¹ Clin Infect Dis. 2009 Oct 15;49(8):1175-84

outbreak detection, prevention, and innovation; and improved antibiotic use. CDC will establish AR “Protect” programs in all 50 states and ten large cities to better track outbreaks, improve prescribing, and prevent future infections. We will double the number of Emerging Infection Program sites from ten to 20, significantly expanding our ability to track all urgent and serious AR threats through vital partnerships with state and local health departments and academic institutions. Additionally, CDC will establish a “Detect” network of up to seven regional labs to characterize emerging resistance and rapidly identify outbreaks of dangerous AR threats.

By investing in these critical activities and allocating the majority of these funds to states, communities, health care providers, universities, and other groups on the frontlines, we can turn the tide on the mounting threat of AR. The initiative would aggressively attack our biggest threats. For example, CRE (*carbapenem-resistant Enterobacteriaceae*) is a “nightmare bacteria” as it is resistant to nearly all known antibiotics. With the initiative’s funding supporting national prevention activities, we believe we can cut CRE infections by as much as 60 percent in five years. In 2011, nearly half a million Americans were infected by *C. difficile* (*Clostridium difficile*), a deadly diarrheal infection, and 15,000 died as a result of those infections. By implementing this initiative, we believe we can reverse this trend by cutting *C. difficile* infections in half over five years and save \$3.8 billion *C. difficile* related medical costs alone over five years.²

Every antibiotic resistant-infection has the potential to devastate people’s lives and their families. I am reminded of the stories of Peggy Lillis and Nile Moss. Peggy, a 56-year-old mother of two and a beloved kindergarten teacher, lost her battle with *C. difficile*, after receiving antibiotics and accessing health care facilities for routine procedures. Nile was a 15-year-old boy who loved music and art, but his life was cut short after contracting MRSA (Methicillin-resistant *Staphylococcus aureus*)

² Unpublished CDC Data Analysis

pneumonia following routine annual tests at the hospital. I want to extend my sympathies to the families of Peggy and Nile, as well as the millions of patients who acquire antibiotic resistant-infections each year. I also want to salute the families of others who have been sickened by, or died from, AR for working to protect others from similar tragedies. With resources to implement the National Strategy, CDC will work to prevent these infections from killing more Americans.

Curbing the Prescription Drug Overdose Epidemic

We have witnessed a deadly epidemic quietly unfold in rural areas and on the main streets of America: deaths from drug overdose have been rising steadily over the past two decades, and have become the leading cause of injury death in the United States. Every day in the United States, 120 people die as a result of drug overdose, and another 6,748 are treated in emergency departments for the misuse or abuse of drugs. As the nation's health protection agency, CDC has applied public health principles to identify the connection between inappropriate opioid prescribing and resulting overdose deaths. The prescription drug overdose epidemic is driven largely by fundamental changes in the way health care providers prescribe opioid pain relievers: 259 million prescriptions were drafted for painkillers in 2012, enough for every American adult to have their own bottle of narcotics.³ As the amount of opioids sold has increased, so has the number of deaths. Just as troubling, there is growing evidence that the sharp increase in prescription opioid abuse plays a role in the large increase in heroin overdose deaths, which have more than doubled since 2010.

We can prevent abuse of prescription drugs while at the same time making sure patients receive safe, effective, and appropriate pain treatment. CDC's FY 2016 budget requests an increase of \$54 million, which will support expansion of the Prescription Drug Overdose Prevention for States Program to all 50 states and Washington, D.C. This national response will provide state health departments with funding

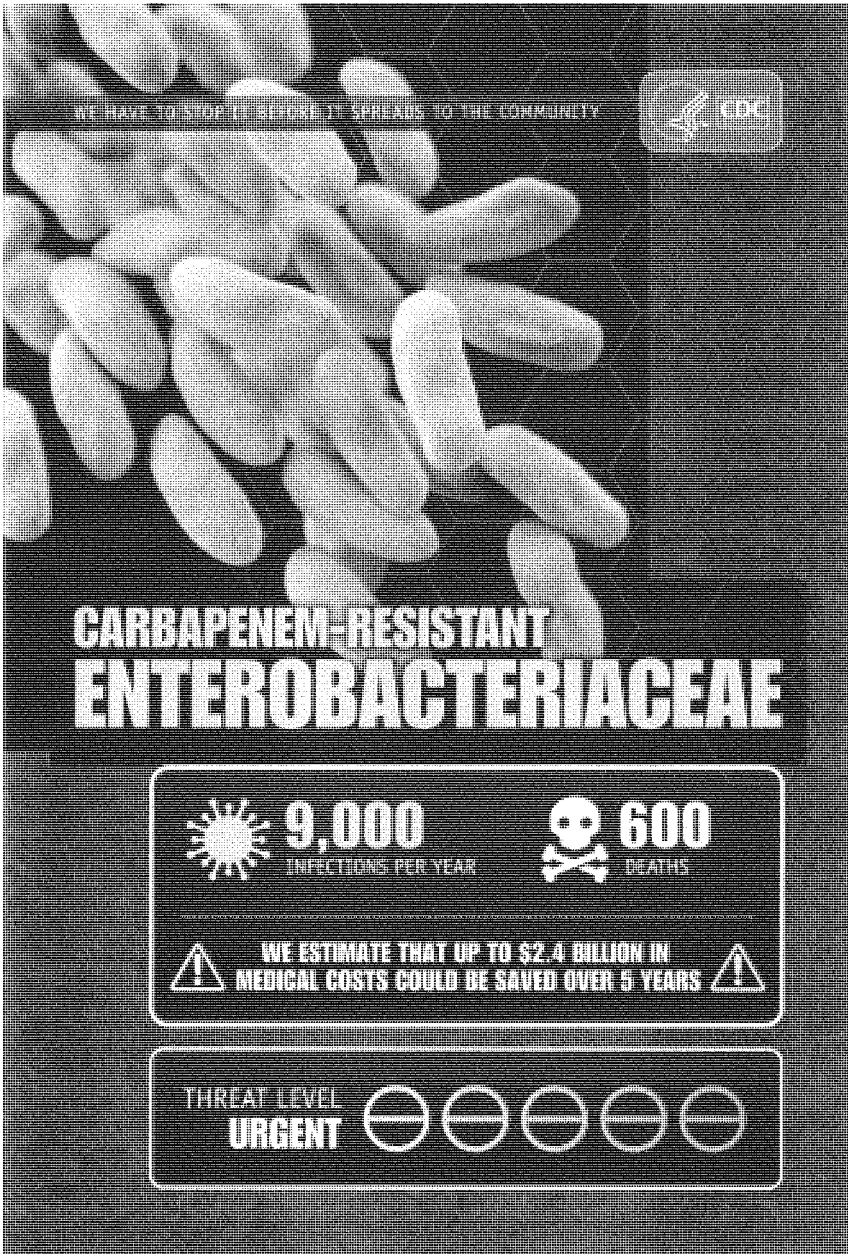
³ <http://www.cdc.gov/vitalsigns/pdf/2014-07-vitalsigns.pdf>

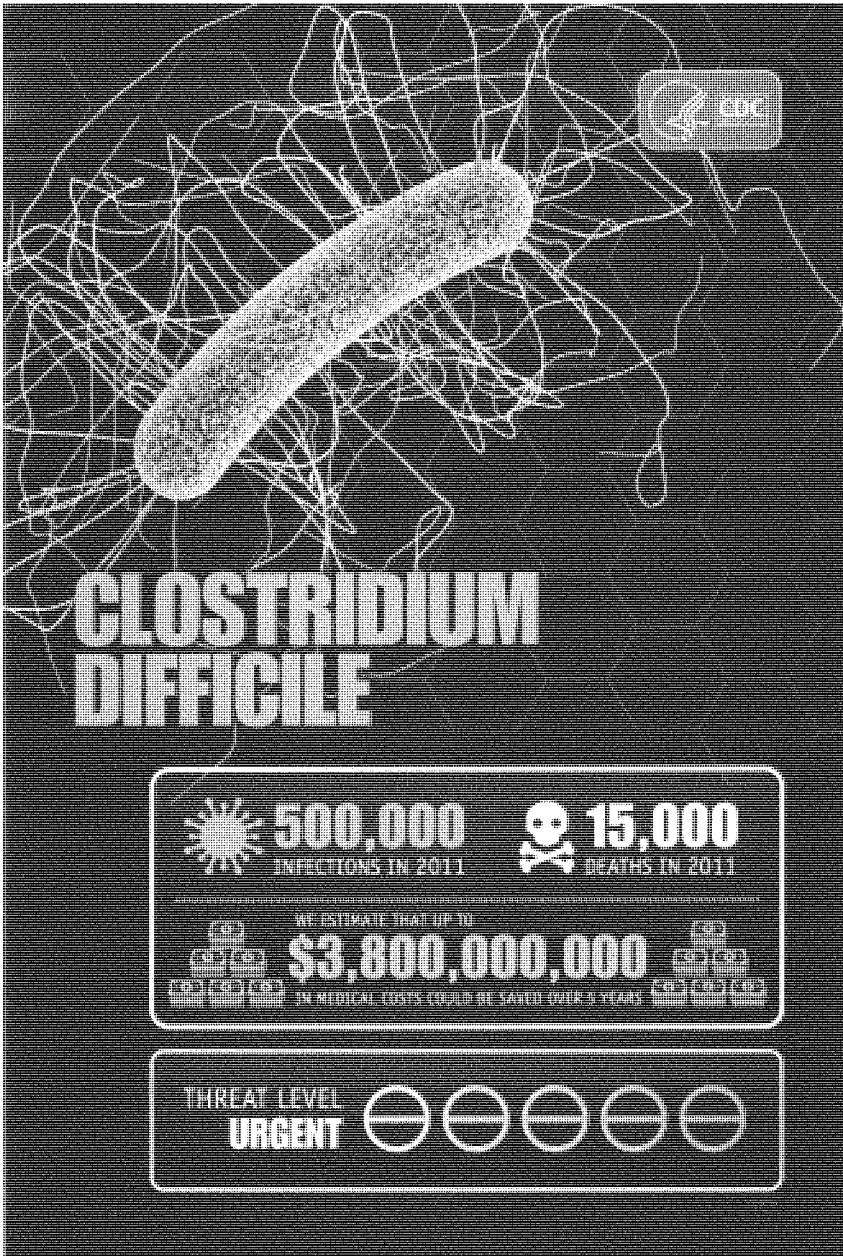
and scientific expertise to enhance and maximize the effectiveness of prescription drug monitoring programs, improve adoption of opioid prescribing guidelines, and target communities experiencing the highest burden of drug overdose. This CDC investment complements other FY 16 proposed investments and work across the Department to reduce the misuse and abuse of opioids.

Additionally, CDC's work to reverse the prescription drug overdose epidemic will continue to have important implications for understanding and addressing the troubling increase in heroin overdose deaths. The requested increase for FY 2016 will strengthen heroin overdose prevention by improving heroin-related surveillance and further investigating the relationship between prescription drug abuse and heroin use. The Budget also includes an increase of \$5 million for Health Statistics to expand electronic death reporting to provide faster, better quality data on deaths of public health importance, including Prescription Drug Overdose deaths.

Keeping Americans Healthy, Safe, and Competitive

Over the past year, CDC and our nation have addressed difficult challenges to protect our health security. CDC will continue our vigilance to detect and quickly respond to numerous, unpredictable disease threats. We will protect Americans from the leading causes of death and disability that threaten our economic productivity and global standing. Thank you for your continued support of CDC's important work serving our nation; I am happy to answer your questions.





Mr. COLE. Whenever we have the full chairman of the committee—or the chairman of the full committee and the ranking member, I like to go to them first because they usually are juggling a schedule.

And so, with that, I want to yield to my good friend, the ranking member for the full committee from New York, Ms. Lowey.

Ms. LOWEY. You are very gracious, Chairman Cole, and thank you, Ranking Member DeLauro.

And I apologize to my good friend, Dr. Frieden, but we do have four hearings this morning. I am not quite sure who did all the scheduling, but thank you very much, and I really appreciate your coming before the committee.

This afternoon, the House is expected to consider the Republican budget resolution. By 2025, it would cut nondefense discretionary funding, including the CDC, by 25 percent below the amount needed to maintain purchasing power at this year's level.

While budget resolutions don't detail specific cuts, there is no way to make such severe reductions without slashing important investments.

Could you share with us the impact on public health should it face a 25-percent cut?

Dr. FRIEDEN. Well, as you say, without knowing the details, we wouldn't be able to identify which specific programs would be affected. I would say first that most of our resources go to State and local public health entities for vaccination, for outbreak detection and control, for core services to find threats when they first emerge, respond rapidly, and prevent them wherever possible. So all of those activities would potentially be at risk.

I will say from my career, I spent many years working on tuberculosis. In tuberculosis, we thought we had made a lot of progress, and the programs to control tuberculosis were eliminated before tuberculosis was eliminated. Because of that, there was a costly and deadly resurgence of tuberculosis and multidrug-resistant tuberculosis, which took many years and many dollars to control.

EBOLA

Ms. LOWEY. And specifically, first of all, I would like to express my appreciation to everyone who responded to the Ebola outbreak. You were extraordinary.

At the same time, you have acknowledged some early mistakes in response to Ebola in the United States. Two of the nurses who treated the first Ebola patient became infected with the disease. Thankfully, both received world-class medical treatment. Shortly thereafter, Bellevue Hospital in New York City successfully treated an Ebola patient, Dr. Spencer, without any secondary transmissions.

Could you share with us what lessons we have learned about the Nation's emergency preparedness and response system, and how can we ensure that we are better prepared for the next outbreak of a deadly infectious disease?

Dr. FRIEDEN. I think the first lesson is that we really are all connected by the air we breathe, the water we drink, the food we eat, and by the plans we fly on. So an outbreak anywhere is potentially a threat anywhere else in the world. And that is why it is so impor-

tant that we continue to invest in programs to strengthen capacity in other countries so they can find emerging infections before they get out of hand.

We have for years, for example, worked in Uganda to help that country establish a stronger system of finding and stopping outbreaks. They have outbreaks of Ebola and other viruses like Ebola not infrequently, and they go in quickly and stop them. If that had happened in West Africa, this would not have happened in the first place.

The second key lesson is the need to improve our global response capacity. The World Health Organization, in particular, needs to be stronger in its ability to find, coordinate, and stop health threats when it is beyond an individual country's capacities.

We at CDC have surged maximally. We activated our Emergency Operations Center on July 9 of this year. We have had more than 200 of our top scientists and disease control professionals in West Africa for many, many months, and they have been pivotal to the response. But that kind of global collaboration is needed.

Within this country, we need to improve infection control in our hospitals, not just because of the risk of Ebola, but each year about 75,000 Americans die from infections caught in the hospital. And the antimicrobial-resistance initiative that is our top budget priority would help us to greatly improve control of drug-resistant organisms and reduce risks in hospitals.

We also know that to respond to emergencies, it is critically important to have strong everyday systems that can be scaled up in an emergency. And that is something we are looking at closely.

Ms. LOWEY. Thank you very much.

And I know many of us have been very focused on this issue of improving and working with hospitals on addressing this huge, huge challenge.

Thank you very much, Mr. Chairman.

Mr. COLE. Thank the gentlelady.

If I may, Doctor, I want to—we will be talking about a lot of different things. So I am going to pose a question and then shortly after that just—I am going to need to leave and turn over the gavel to Mr. Harris, and then I will come back.

NATIVE AMERICAN FUNDING

So but CDC budget for fiscal year 2016 makes critical investments in many areas with funding prioritized for preventing opioid abuse and overdose, which you have discussed in your testimony, reducing viral hepatitis-related illnesses and deaths and other critical areas. There is a key opportunity to ensure that some of the most underserved areas of our country are receiving public health investment. However, many of the grant programs CDC administers are geared towards State level public health entities. Historically, this has meant that tribally operated public health centers are often left out of the funding. I know you have made some exceptional efforts to begin to reverse that. So I would like you, if you would, to inform the committee of some of the initiatives underway to try and make sure that in Indian Country, historically one of the most underserved parts of the country, we are seeing that our fellow Americans are getting adequate health care.

Dr. FRIEDEN. Thank you very much.

Our first approach here has been to work on a nation-to-nation basis with tribal leaders. We have twice-a-year consultations—once at CDC, once at one of the tribes—to have a free and open discussion of what the issues are, and one of the things that we heard loud and clear is they want better data about what are the problems in their communities. So what we have done is to begin to unlock that data and provide it for them. We have worked closely with tribal epidemiology centers, and we hope to see those centers grow and become essentially the health departments for tribal areas.

Then looking at those tribal areas, we always try to make sure that any of our funding opportunity announcements that can be directed to tribes are directed to tribes. We fund 51 tribes directly at CDC. When funding goes to States, one of the things that they told us loud and clear was they weren't happy with how things went. So we have met repeatedly with the State health departments, and we have put into their requirements that they work closely with the tribal leaders on the grants that do go through them, but wherever possible, we work directly with the tribes.

We also, for the first time ever, based on the data that we saw with higher rates of diabetes, higher rates of other chronic health problems, we issued a 5-year, \$70 million first ever comprehensive initiative aiming to prevent heart disease, diabetes, stroke in American tribes and Alaska Native villages. This is something that has resulted in 11 specific awards and support tribal organizations to provide leadership and technical assistance. One of the challenges that we have is we have had some very successful programs. For example, to reduce motor vehicle fatalities with individual tribes, but with so many tribes, our challenge is to try to get as broad as possible. So, in this approach, we are funding some tribes specifically but also funding tribal organizations to do a cross-tribe effort to increase the health promotion and health prevention activities there to better protect tribal members from avoidable health risks.

One of those has been in the motor vehicle area. We have been able to show real improvements. The numbers in motor vehicle fatalities are very, very concerning. American Indians and Alaska Natives are injured or killed in motor vehicle crashes far more often than any group in the U.S., as so many health disparities fall disproportionately on tribal populations. And we have shown that by working with tribes to find the strengths within those communities, we have been able to greatly increase things like seatbelt use, car seat use; reduce things like alcohol-impaired driving. And those are successes that we now want to generalize to other tribes. Similarly, going back to some of the healthier tribal nutritional habits has been very successful. We want to identify those successes, support communities, and spread them to other tribal nations.

Mr. COLE. Well, I want to take this opportunity to thank you very much. You have been a real leader and a game changer in Indian health and the sorts of programs you are pursuing, frankly, we should have been doing a long time ago. I am really pleased

that you have taken some of your resources and directed them in this way.

With that, I am going to recognize my good friend, the ranking member of the full committee, and switch the chair, if I may.

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

Dr. Frieden, just a very—a quick question, and you can get back to me on this because I want to talk about antibiotic-resistant bacteria.

FOOD SAFETY

I have a citation here that says, in 2012, the U.S. Centers for Disease Control and Prevention found that imported fish were the most common source of foodborne illness outbreaks from imported foods between 2005 and 2010.

Just a yes or a no. That is a verifiable fact from—from all of you? Or could you check on that for me because I don't—

Dr. FRIEDEN. We will have to get back to you.

[The information follows:]

4/15/2015

CDC Online Newsroom - CDC research shows outbreaks linked to imported foods increasing, March 14, 2012



Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People.™

Press Release

For Immediate Release: March 14, 2012

Contact : CDC Division of News and Electronic Media (<http://www.cdc.gov/media>)

(404) 639-3286

CDC research shows outbreaks linked to imported foods increasing

Fish and spices the most common sources

Foodborne disease outbreaks caused by imported food appeared to rise in 2009 and 2010, and nearly half of the outbreaks implicated foods imported from areas which previously had not been associated with outbreaks, according to research from the Centers for Disease Control and Prevention, presented today at the International Conference on Emerging Infectious Diseases in Atlanta.

"It's too early to say if the recent numbers represent a trend, but CDC officials are analyzing information from 2011 and will continue to monitor for these outbreaks in the future," said Hannah Gould, Ph.D., an epidemiologist in CDC's Division of Foodborne, Waterborne and Environmental Diseases and the lead author.

CDC experts reviewed outbreaks reported to CDC's Foodborne Disease Outbreak Surveillance System from 2005-2010 for implicated foods that were imported into the United States. During that five-year period, 39 outbreaks and 2,348 illnesses were linked to imported food from 15 countries. Of those outbreaks, nearly half (17) occurred in 2009 and 2010. Overall, fish (17 outbreaks) were the most common source of implicated imported foodborne disease outbreaks, followed by spices (six outbreaks including five from fresh or dried peppers). Nearly 45 percent of the imported foods causing outbreaks came from Asia.

"As our food supply becomes more global, people are eating foods from all over the world, potentially exposing them to germs from all corners of the world, too," Gould said. "We saw an increased number of outbreaks due to imported foods during recent years, and more types of foods from more countries causing outbreaks."

According to a report by the Department of Agriculture's Economic Research Service (ERS), U.S. food imports grew from \$41 billion in 1998 to \$78 billion in 2007. Much of that growth has occurred in fruit and vegetables, seafood and processed food products. The report estimated that as much as 85 percent of the seafood eaten in the United States is imported, and depending on the time of the year, up to 60 percent of fresh produce is imported. ERS also estimated that about 16 percent of all food eaten in the United States is imported. The types of food causing the outbreaks in this analysis aligned closely with the types of food that were most commonly imported.

Gould warned that the findings likely underestimate the true number of outbreaks due to imported foods as the origin of many foods causing outbreaks is either not known or not reported.

"We need better - and more - information about what foods are causing outbreaks and where those foods are coming from," Gould said. "Knowing more about what is making people sick, will

4/16/2015

CDC Online Newsroom - CDC research shows outbreaks linked to imported foods increasing, March 14, 2012

help focus prevention efforts on those foods that pose a higher risk of causing illness.”

Recently, the Food and Drug Administration has stepped up its efforts to conduct environmental assessments to determine the root cause of outbreaks. With lessons learned from outbreaks, measures will be taken to prevent such outbreaks in the future. The newly enacted FDA Food Safety Modernization Act is also a major step in establishing a prevention based food safety system that would address domestic as well as imported foods. CDC, FDA and USDA will continue to work together to prevent foodborne illness and stop harmful products from entering commerce.

Additional information on CDC's foodborne outbreak surveillance is available at:

http://www.cdc.gov/outbreaknet/surveillance_data.html

(http://www.cdc.gov/outbreaknet/surveillance_data.html)

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[†]Historical Document: March 12, 2012

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Ms. DELAURO. Would you please check for me? I want you to check on it for me quickly. I need it for another meeting today. Okay? I will be very direct. I need that information.

ANTIBIOTIC RESISTANCE

Dr. Frieden, it was a terrifying article in the New York Times in December about antibiotic-resistant bacteria in India. It noted that, quote, that a significant share of the bacteria present in India in its water, sewage, animals, soil, and even its mothers are immune to nearly all antibiotics. The director of India's National Institute for Research in Tuberculosis said that tuberculosis in India may soon become untreatable. In the U.S., CDC reports, as you have said, it is a 2 million illnesses, 23,000 deaths annually.

Percentage of those deaths that are preventable if we were to address this? That is very—again, very quickly because I want to go on.

Dr. FRIEDEN. At least half.

Ms. DELAURO. At least half. Okay.

I make the point here that we know this every year, this happens. 9/11 we lost almost 3,000 people. We were not prepared for that. We didn't know that was going to happen and so forth. And I use this analogy all the time. We went to war, as we should have, to deal with the loss of 3,000 lives.

Now, we know that 23,000 people every year die from something that we can prevent and save half, at least half, of those lives. So what you are doing is critical, and what we can facilitate your doing is critical.

Back to—the human costs, economic costs are devastating: Up \$20 billion in direct healthcare costs; up to \$35 billion in lost productivity.

I have two questions. We know that antibiotic-resistant microorganisms in India and other countries will eventually find their way to the United States. How are we working with the poor and developing countries to address antibiotic-resistant bacteria?

I asked Dr. Fauci this question at the NIH hearing, but we were running out of time. So let me ask you this question as well.

I was recently in Haiti, and I met a young doctor who is one of your folks there, was a remarkable young man. He described the devastating effects of antibiotic-resistant tuberculosis. How is the CDC working to prevent and treat drug-resistant TB?

Dr. FRIEDEN. I have spent more than a decade of my career working on drug-resistant tuberculosis, 5 years in India. Fundamentally, we can prevent many resistance infections by ensuring that we get it right the first time so that when patients have tuberculosis, they are fully treated and they don't develop a resistant organism.

Second, by identifying the drug-resistant cases quickly so they don't spread in hospitals, which often become amplification points for drug-resistant tuberculosis and other bacteria.

And, third, by making sure that we treat people as effectively as possible so they stop being infectious and can get cured.

When we do those things, drug resistance can go away.

In New York City, where we had a large outbreak of multidrug-resistant tuberculosis, we were able within a few years to reduce drug resistance by 90 percent.

But we are needing to work around the world, and that is one of the things that the global health security agenda—

Ms. DELAURO. Quickly, how does that work? I am going to run out of time.

Dr. FRIEDEN. Establish laboratory facilities and improve treatment.

Ms. DELAURO. That was quick.

And then, with regard to resources, do you have adequate resources to deal with that issue looking long—short term and long term to do it, and how are you managing the resources to be able to address that?

Dr. FRIEDEN. Public health is a best buy, and we try to make as effective and efficient use of all of the dollars that are entrusted to us. With more resources, we can always do more prevention. The challenge here is making sure, in the case of tuberculosis, that countries around the world are finding drug-resistant and drug-susceptible tuberculosis quickly, are stopping the spread in hospitals, and are ensuring that outbreaks stop when they occur.

Ms. DELAURO. How many folks do you have abroad? I met this young doctor in Haiti. I believe there may have been someone in the Dominican Republic as well. I am trying to recall.

Can you get us information as to where CDC personnel is around the world and in some of these countries which have these very, very difficult problems, especially as we engage with this resistant drugs.

Dr. FRIEDEN. Absolutely.

Ms. DELAURO. Okay. Thank you very much.

Thank you, Mr. Chairman.

Mr. HARRIS [presiding]. Thank you.

I recognize Dr. Simpson for 5 minutes.

Mr. SIMPSON. Thank you.

Thanks for being here, Doc, and thanks for the work that the CDC does. And it is a great amount of work, and there is unanimity, I think, among this committee of the importance of the work that you have done.

ORAL HEALTH

As you might guess, I have some dental questions, being the only dentist on the committee.

The stated mission of the CDC's Division of Oral Health is to work to improve the oral health of the Nation and reduce inequality in oral health.

Could you please tell me if oral health burden in a State, that is the rate of oral health disease in an area, is used as a factor when the CDC awards oral health grants and how are the CDC programs and resources targeting areas with the highest demonstrated burden of disease. And please explain how the CDC is working with State health departments to utilize established metrics that capture prevalence of disease when awarding grants.

Dr. FRIEDEN. I will have to get back to you on the details of that, Doctor, but we totally agree with the importance of oral health. It

is a source of untold suffering, and it is particularly problematic in many underserved communities.

One of the things that we have done is to identify the effectiveness of certain interventions, such as fluoridation. As you have pointed out, it is now the 70th anniversary of fluoridation. We have seen big reductions in dental caries as a result of fluoridation. We have also tried to scale up things like school-based application of sealants at communities where they are most needed, but I will have to get back to you with the details of the formula.

Mr. SIMPSON. Are we doing anything to educate communities of the importance of fluoridation and the benefits of fluoridation on this 70th anniversary, as you mentioned, or I think the CDC said fluoridation was one of the 10 great public health achievements of the 20th century.

Are we doing anything to promote this?

Dr. FRIEDEN. We are. We were looking at all of the fluoridation policies. We have been able to increase somewhat the number of communities that are using fluoridation in recent years. Sometimes, because of the way the water supply is for certain communities, that is more difficult if you have a distributed supply, but we work systematically, community after community to educate, to inform. There are many misconceptions about fluoride, but as you point out, in publications, CDC identified fluoridation as one of the 10 great accomplishments of public health in the 20th century. Many, many children and adults don't have caries. Many adults have their teeth in tact because of fluoridation. So it is a very important program, and we work hard with communities and with community leaders to inform them about that and document the impact.

Mr. SIMPSON. It was interesting, when I was practicing dentistry, I had two brothers that were patients of mine. Was one of—a good friend of mine and other one was an older brother. They lived in an area when the older brother was born didn't have fluoridated water, and they lived in an area that had fluoridated water when my friend was born, and the two of them were entirely different. The one had fillings in almost every tooth in his mouth, and the other one had never had a cavity, and these are two kids that eat the same things and everything else with their—you know, in the same family and stuff. So it is demonstrable how beneficial that has been.

The fiscal year 2016 budget request eliminates funding for the Education and Research Centers. Originally created almost 40 years ago, the ERC program has addressed the limited number of academic programs focusing on industrial hygiene, occupational health, nursing, occupational medicine, and occupational safety. The ERCs reach and impact have grown substantially across the Nation since the program's inception.

Why are we eliminating funding for it?

Dr. FRIEDEN. We wish we had the resources to address every public health need. This is a proposal that has been made in prior years in the final budget. Those centers have continued to be funded. We are proposing a budget that does have some difficult choices in it. With more resources, we can protect more Americans.

Mr. SIMPSON. Is it—has it outlived its usefulness after 40 years, or is it just a lower priority than other things that you put money into?

Dr. FRIEDEN. There are difficult choices to be made in the budget, and we wish we had the resources to do everything that we know has value for Americans.

Mr. SIMPSON. Well, I thank you for being here today, and I thank you for the work that the CDC does. I know sometimes you took a little bit of abuse during the Ebola breakout and those types of things, but I think you all did a great job. And the lessons learned from it will be valuable for the future. So thank you, all of you, for that work, and.

I apologize, but I have got to go start an Energy and Water hearing. So thank you.

Dr. FRIEDEN. Thank you very much.

Mr. HARRIS. Mr. Fattah.

Mr. FATTAH. I thank you.

HEALTHY BRAIN INITIATIVE

And welcome to the committee. A couple questions on the healthy BRAIN Initiative. As you know, I am very interested in brain health, neuroscience, and I know that the CDC has been engaged in a variety of efforts.

AUTISM

So let's start with autism. You know, the number of children identified has risen greatly over the last decade. Still from 1 in every 150 to now like 1 in every 68. Can you talk a little bit about the work that you are doing in that regard. And you don't have to be brief, but we do need to get to a question about dementia. So go right ahead, please.

Dr. FRIEDEN. CDC is the lead for documenting and monitoring autism rates in our communities. We have worked in cities and areas, States throughout the country to document the rate of diagnosis of autism. That rate of diagnosis has increased substantially. We are not yet certain if that is a reflection of an actual increase in the rate of autism or in the recognition of autism. But, in either case, there are many children who need services.

One of the programs that we have emphasized is something called "Learn the Signs. Act Early." The "Learn the Signs. Act Early." program encourages caregivers, parents, childcare providers, and others to identify children who may be at risk for autism early so that they can be referred to services. There is emerging evidence that services early on may be able to mitigate some of the adverse outcomes.

Mr. FATTAH. As you know, you have been involved in the work at the Children's Hospital in Atlanta, where they have been looking at the eye as a window into this question about diagnostic—early diagnostic evidence.

Now, it is 1 in every 42 boys. So boys are much more prevalent in this case, and do you—do we have any indication as to why this is this case?

Dr. FRIEDEN. We really are not certain. There are many theories, but we don't have certainty about any of them.

DEMENTIA

Mr. FATTAH. Okay. And let's move to dementia. So, on the other side of the spectrum, the world is facing a major challenge. Obviously, the U.S. has a significant—you know, close to 5 million cases. It is the fifth leading cause of death now for people over 65, just in terms of Alzheimer's, let alone the other dementias. So talk to me about the BRAIN Initiative relative to this work.

Dr. FRIEDEN. There are many areas where we work that are related to this. One of them, in our National Center for Health Statistics, is to track the rates of death from dementia or Alzheimer's. As you point out, dementia is broader than Alzheimer's. And there are many causes of dementia that are preventable or treatable. So it is important that those be identified. One of the things that we have emphasized is the Million Hearts Initiative. Although it says "hearts," it is about preventing heart attacks and strokes. And there are many dementias that are related to multiple strokes, and many, maybe even most, strokes are preventable by better management of blood pressure, cholesterol—

Mr. FATTAH. Diet.

Dr. FRIEDEN [continuing]. Smoking cessation, and using an aspirin when indicated. So—

Mr. FATTAH. In our Southern States, right, we call it the Stroke Belt of just, again, some work that you have been engaged in. There also seems to be some nutrition or diet issues correlated to the prevalence of stroke.

Dr. FRIEDEN. We—you are absolutely correct, and we are not certain of what the cause of that is, but diet is the leading—

Mr. FATTAH. See, I am a politician. I can jump to a conclusion. I am sorry.

Dr. FRIEDEN. Certainly a leading suspect is the diet.

Mr. FATTAH. All right.

ALS

Okay. Thank you very much, and I guess we some time for ALS. So let's jump to that, Lou Gehrig's disease. This is also part of some of the work that you are doing.

Dr. FRIEDEN. It is. We started a registry for ALS that allows patients to register so that they can both share their experience and work across different parts of the country to participate in clinical trials if those occur; and for us to better understand where it emerges, why it may emerge, and this may help us with clues on how to prevent it and information on how to treat it most effectively.

Mr. FATTAH. The EU has set up the JPND effort to broaden clinical trials. Is there any reason—well, I am interested in whether the U.S. may participate in this effort. Canada and Israel is now involved with some 28 European countries. We have not yet decided to participate in a broader clinical trail network.

Dr. FRIEDEN. The National Institutes of Health would really be the lead entity to address that issue.

Mr. FATTAH. All right. Thank you.

Dr. FRIEDEN. Thank you.

Mr. FATTAH. Thank you, Mr. Chairman.

Mr. HARRIS. Mr. Rigell.
Mr. RIGELL. Thank you.

GUN VIOLENCE RESEARCH

And, Dr. Frieden, good to see you again, and thank you so much for coming by my office. That was very helpful to me.

And I appreciate, really, the line of questioning by all my colleagues, Mr. Fattah, and I think particularly there about autism. My observations are just anecdotal, but it seems like my families, we look at our friends, that we are just seeing more and more of this. I am not sure if it is just that it is being diagnosed, or there is really something here. My sense is that it is the latter. So I appreciate the work that is being done by the CDC on all these matters.

One of the adages that I would use in my private sector experience, occasionally I would share with my team is that, you know, the main thing is to keep the main thing the main thing.

And that can be said different ways, but, you know, focusing on the mission, staying true to mission is really important because we are always—there are things that come at us and try to take us off track, and I want to go down this line questioning about the proposed \$10 million that are going to research. And let me say we are so often stereotyped and just put in these little boxes that I think are horrid, but, you know, reducing gun violence is a shared objective. So I want to establish that premise. But, with that established, I really—I really can't grasp how this is the right use of funds, that it is the proper even jurisdictional domain of the CDC, if you will, and I won't concede for a moment that, you know, I lack an appreciation for this or a desire to reduce gun violence, but that doesn't prevent me, though, from really questioning the wisdom of what you are proposing here.

So make your best case for this. Let's hear it. Okay? Thank you.

Dr. FRIEDEN. Well, first off, CDC fundamentally gets information so that people can make more informed decisions. And one of the requests in the proposal is to expand the National Violent Death Reporting System to all States. That system has been very well received by many States and it has been used, for example, in Oklahoma to identify a need to improve response to domestic violence; in Oregon State to improve the ability to respond to seniors who may have depression and are at risk for suicide. So much of what we do is to support State and local entities so that they can better understand the trends in their communities and take whatever action they think is appropriate. That is NVDRS plus—

Mr. RIGELL. I am—I appreciate that.

Now, I am familiar with the NVDRS. Researched it. So is it—and I am unclear on this. Is it just that you are proposing a \$10 million increase for that program specifically, or is this a slight diversion, if you will, or maybe a new tack in addition to the work being done at NVDRS? The \$10 million is research proper. It is—you know, it is related to but not exactly what we are doing now with the NVDRS.

Dr. FRIEDEN. They are distinct programs. So both have been in the budget request for several years and are in this year as well. The NVDRS is one program. A separate program as proposed is a

\$10 million initiative for research. The Institute of Medicine did a review of priority research on gun violence, things like what kind of locks, if people would chose to use locks, would be most effective to prevent children from having access to guns. This is the type of research project that could be done with—

Mr. RIGELL. I have such high regard for you—and that continues—but I do think it is important for me to share with you that we separate on this issue and that I think some things are just obvious by observation. And, you know, there is some legislation out there I actually introduced with some of my colleagues on the other side to keep guns out of the hands of felons, those who otherwise do not qualify to have—to purchase a gun lawfully, and also gun runners, gun traffickers. These things seem to me—and then, of course, the responsibility of a parent or homeowner to properly secure a personal weapon—these things are just obvious to me and they don't really require a lot of research because every dollar that is taken for a program like that, even though \$10 million is in Washington terms not a whole lot, in every meeting you attend and your staff attends to advance something like, you know, more gun research, and—I think it is the purview of other areas because your mission is so clear. This work that you are doing to confront and to address antibiotic resistance, this must be elevated and always kept center.

So I am going to be a strong proponent of some sequester relief; I am for a host of reasons. It is the right thing to do. Mandatory spending reform, that is needed as part of that equation, but I can't support you on this, but everything else, you have my full support, and I appreciate what you and your colleagues are doing.

Thank you so much, and I yield back.

Dr. FRIEDEN. Thank you.

Mr. HARRIS. Ms. Roybal-Allard.

VACCINES

Ms. ROYBAL-ALLARD. Good morning, Dr. Frieden.

As you know, southern California has been at the epicenter of the recent measles outbreak. The reemergence of this disease, which had essentially been eliminated in 2000, is a frightening example of what can happen when herd immunity is lost because increasing number of parents are choosing not to immunize their children. In fact, some California schools report personal belief vaccine exemption rates as high as 25 to 50 percent.

I have a series of questions. I am going to try to get them all in in the time I am allotted.

First of all, what did the public health response to this measles outbreak entail, and what did it cost to contain it?

Dr. FRIEDEN. I will turn that over to Dr. Anne Schuchat, who runs our National Center for Immunization and Respiratory Disease.

As you know, vaccines are one of the great success stories of the 20th century and have saved literally hundreds of millions of lives, and in some ways, they may become in some communities victims of their own success because people may not recognize that they are continuing to protect us.

For the details, Dr. Schuchat.

Dr. SCHUCHAT. Yeah. The measles outbreak in California that spread to seven States, and currently we have 178 total cases this year. The public health response relies on the front line public health infrastructure in every State and every community. Every single suspect measles case is responded to quickly to figure out if it is really measles and to identify contacts and interrupt spread.

We estimate from previous outbreaks that even a small outbreak can cost hundreds of thousands of dollars, and this one was larger than that. Measles, like many of the infectious diseases is a plane ride away. And so one of the key efforts to interrupt measles spread around the world is to strengthen immunization programs overseas. Right now, Sierra Leone is experiencing an enormous measles outbreak because their health system was interrupted with the Ebola response.

So, day in and day out, in counties around the country, public health workers are responding to measles.

We have also needed to improve clinician recognition. We are really a victim of our success here where many clinicians have never seen measles. And so it can be misdiagnosed and give opportunities to spread.

The only good thing about the Disney outbreak is most people heard about it, and clinicians, parents, grandparents are really on guard now. And I hope that we are seeing the end of that one.

Ms. ROYBAL-ALLARD. Okay. Well, given the recent increase in vaccine hesitancy and underimmunization among both children and adults, what recurrence of disease do you expect to see if these trends do continue, and what should States and Federal governments be doing to minimize school vaccine exemptions?

Dr. SCHUCHAT. You know, although our national immunization rates are very good, less than 1 percent of toddlers have received no vaccines at all. And most parents know that vaccinating their kids is the right thing to do. There are communities and micro-communities where vaccination is no longer a norm. Many places have the ability to have a personal belief exemption. All States have medical exemptions and religious exemptions.

But it is quite important that parents understand what the risks are. We are seeing some changes in attitudes after this Disney outbreak, but we think it is vital that parents get good information; they trust their doctors. And CDC works hard to make sure doctors and nurses have the facts and have the tools to have good conversations. But we also think States can have administrative rules around exemptions to make sure that people who are exempting actually understand what the risks are for their children. Most people are motivated by protecting their kids and keeping them healthy and safe. And when they get the right facts, we think they will do the right thing.

Ms. ROYBAL-ALLARD. Okay. Well, what amount of funding do you think is needed to conduct the crucial prevention, education, and outreach to ensure that providers and the general public have the necessary information to make informed vaccine decisions?

Dr. SCHUCHAT. You know, we put resources into every State through the immunization funding. And we also do national communication work and laboratory and epidemiologic activities. We think this job is never done because diseases can resurge like mea-

sles and that every day thousands of babies are born totally susceptible to vaccine-preventable diseases. So every family needs to know about this issue. Every doctor, nurse, pharmacist needs to know about this issue. So it is a big job, and we use the resources we can—that we get to really focus on the frontline public health infrastructure that really keeps us safe.

Ms. ROYBAL-ALLARD. So you think the resources are adequate to do the job that needs to be done?

Dr. SCHUCHAT. We know that the resources that we get are really focusing on the highest priority public health needs, and as Dr. Frieden mentioned, with more resources we could do more.

Mr. HARRIS. Thank you.

I am going to recognize myself for 5 minutes from when I sat down there.

Good to see you, and, Dr. Bell, Dr. Schuchat, good to see you as well. Good to see you here as well as when we visited with you in CDC.

You know, it is interesting, Dr. Frieden. As you know, as a public health person, you have a different perspective than, you know, the perspective I had when I take care of patients. When I take care of patients, just—you know, what is important for that patient front of me? To you, it is kind of, what is important to the population in general?

SODIUM REDUCTION

And one issue that has come up—and not only now here in this subcommittee but in the Agriculture Subcommittee—is the looming controversy on salt intake. As you are well aware, Wall Street Journal, I guess it was Monday morning. It was Monday of the weekend, had the article, the pro and con about restricting salt. And the new evidence, as you know, indicates that for a significant portion of the population who are not—probably not at risk for high blood pressure for reasons we don't understand yet, you know, who is at risk and who is not, that restricting salt intake actually can be harmful.

You know, unlike the analogy with the vaccines where no one has ever really shown that the vaccine is harmful to a particular individual, there is now evidence that restricting salt intake may be harmful to a fairly broad amount of American population.

What is the CDC doing to address that controversy? And is it appropriate to tell people at this point that the evidence is that for some people—for a lot of people, it is helpful, but for some people, it might be harmful. And we are just not smart enough to know entirely, you know, into which camp you fall.

Dr. FRIEDEN. The issue of sodium intake is one about which there is not unanimity, but there is very strong and consistent evidence from studies throughout the U.S., and throughout the world that the higher the salt intake, the higher the blood pressure—the higher the blood pressure, the higher risk of heart attack, stroke, and other health conditions. So we have looked carefully at the methodology of the various studies.

One of the things that we do at CDC is to collect information on the actual salt intake of Americans. This had not been collected be-

fore. It is not easy to collect, but this is something which, for the first time, we are collecting so that we can track this over time.

Mr. HARRIS. But you know that, you know, the trouble with those studies are that, you are right, on average blood pressure goes up, and on average, yes, the risk goes up. But you are aware of the recent evidence that in fact in a group of patients and in some subgroup, you know, triglycerides go up 7 percent; cholesterol goes up with salt restriction. So it is not clear that this is a—and, again, this is the—I guess the quandary of a public health official. You know, when you have to make a decision that says, for the good of the population as a whole, we may actually be asking things that are not good for an individual.

Dr. FRIEDEN. I think one of—

Mr. HARRIS. Are we at that position with sodium? Because my reading of the latest literature is, yeah, you know, I wish I—you know, if I don't have high blood pressure, I may be placing myself at risk for restricting to 1,500 or 2,300 when the average sodium intake, as you know, in the average human, they tend to modulate it up to 3,700. I mean, that is something built into us. You know, a demand for salt.

Dr. FRIEDEN. My read and the read of the CDC scientists of the literature suggest that we are not there, that we don't have that kind of a friction between what might be best for some individuals and what is best for the population as a whole. And one of the things that the approach has been proposed is really to put more power into consumers' hands for them to determine how much salt to take rather than have it in food that you may not know it is in in the first place. And scientific studies have shown that if you remove a lot of the sodium, people actually don't put back most of it. So we want to put choice—I think it would be best to put choice into the consumers' hands of how much sodium to take in.

Mr. HARRIS. That might be a reasonable approach.

Let me just move on to one other issue before we move on.

FOOD SAFETY

The CDC is now partnering, I understand, with a large grocery chain—I think it is Wal-Mart—to decrease pathogens of salmonella and *Campylobacter* in chicken products. But I have to tell you, you know, of concern is, you know, in one of the other subcommittees I am on, the Agriculture Subcommittee, I mean, there is a part of the Department of Agriculture that deals specifically, you know, the Food Safety Inspection Service, that deals specifically with jurisdiction over meat and poultry food safety activities. Why is the CDC—and, you know, the CDC—I get it, the epidemiology and you are kind of the quick-response group, but this really bridges over into an area that one might say the FSIS is a more long-term—they should be in charge of this because that is where the government puts poultry and meat inspection and safety. Why is the CDC going into what looks like a chronic issue?

Dr. Bell.

Dr. BELL. Thank you, Dr. Harris.

You know, what we at the CDC are about is data and data for action. And so we try to use the data to help others, whether it be other parts of the government or people—parts of private industry.

We try to provide our data in ways that can help other parts of the government or industry focus whatever strategies they might want to be implementing, and I think this is a reasonable example of that so that we have basically the best data about what diseases caused by foodborne pathogens are most affecting people—not agriculture, not poultry—but the people. That is our bailiwick. And in this particular situation with Wal-Mart, it really was more a matter of them asking us, What can you tell us about where—if we wanted to do something—where could we best target our prevention strategies to get the biggest bang for the buck?

So you are absolutely correct. We are not a regulatory agency, and really our interaction with Wal-Mart has not been about regulation or about their decisions; more about providing them the kind of data that we have available which they might use to target whatever policies they might be thinking about implementing for their own reasons really.

And we are happy, certainly, that these policies, I think, potentially might have a big impact in terms of preventing disease in people.

Mr. HARRIS. Sure. And if I could get more of that in the second round—I think, our time is up and we will have another round.

Ms. Lee.

HIV/AIDS

Ms. LEE. Thank you very much.

Good morning and thank all of you for being here.

Okay. First of all, let me just ask you with regard to HIV and AIDS. In 2010, the largest number of new infections amongst men who have sex with men occurred in young Black men age 13 to 24. Even though they just represent 1.4 percent of the African American population, they represent 53 percent of all new HIV infections among Black Americans.

So can you take a moment and just express and let us know how this budget will address the reduction of HIV and AIDS across the country, especially with young gay Black men.

SICKLE CELL

Secondly, with regard to sickle cell, over 100,000 children and adults are living with sickle cell disease, and last year CDC published—it was a report estimating that over 73 cases per 1,000 among African Americans have the trait. Your study also found that there were no standardized methods or protocols for alerting families or healthcare providers of a newborn of the sickle cell trait and educating them about the potential health outcomes that might be associated with the condition, including the impact this might have on the family's future.

For many years I have been concerned about this because many people have the sickle cell trait; they don't know they have it; there is no required testing. And so could you tell us kind of what you are doing and how we can get this solved because it is a real problem in the Black community.

Dr. FRIEDEN. Thank you very much for both of those questions.

HIV/AIDS

In terms of HIV, there are two broad areas where we are acting. As you say, the challenge is in young gay men. That is where we have seen continued increases in infection rates, whereas we have seen decreases in most other groups in society. And currently 13- to 24-year-olds account for about 26 percent of all new HIV infections, and that proportion seems to be increasing, if anything.

So one of the things we have done is take our existing portfolio, the dollars that Congress entrusts to us, and focus that more on the communities most at risk and the programs that will make the biggest difference.

We are also, in this budget, proposing an increase of the \$12.6 million to increase focus on young people and services and prevention to avoid HIV. There are some new technologies, including preexposure prophylaxis that we hope to see tried in different communities to see if those can work. We have to do more. We still are having too many HIV infections. There has been some success. We are now up at last check to 86 percent of Americans who have HIV know their status. But too few of those who know their status are being effectively treated. That means that they will die sooner and that they may spread HIV to others, and that is what we are focusing in an accountable way on encouraging health departments to do more about with the resources we provide to them.

SICKLE CELL

On sickle cell trait and sickle cell disease, these are two areas where we have focused on in recent years. We will have to get back to you with more of the details of that, but we are expanding both the screening for sickle cell trait and information because there is lots of misinformation about sickle cell trait and the implications for it. So getting that information out to people who have it of all races, because it is not only the African American community that has it. And for sickle cell disease, we have been working very closely with a number of other Federal and private partners to scale up effective treatments for sickle cell disease that can prolong healthy life for people who have it.

Ms. LEE. But how do at-risk populations know to get tested to determine whether they have the trait or not?

Dr. FRIEDEN. Currently, my understanding, if I recall correctly, is that newborn screening programs currently screen for sickle cell trait. And we are working to improve the kind of education and followup that is done when someone screens positive for the trait so that parents can understand what that means.

Ms. LEE. But when a child turns 18 or 21, I mean, they may or may not remember that their mother or father told them they had the trait when they were 8 years old. So what do you do about that because, you know, the dangers in terms of marriage of two people who have the trait and all of the implications, you would think that there is another type of test—part of a blood test regimen would be testing for the sickle cell trait if you are at risk of sickle cell.

Dr. FRIEDEN. Thank you.

I think it would be—what I would like to do is have our scientists, who are very, very focused on this issue, brief you and/or

your staff on this issue and talk about options to increase both testing and information about what the test means for patients. It is something that we have been focusing on, and I agree with you it is an important issue.

Ms. LEE. Okay. Very quickly, the U.N. Commission on—Global Commission on HIV and the Law, I served on that commission for a couple of years. We found that the United States, there are 32 States here that criminalize those with the virus. And last year we asked you to look at a review of all the laws, its impact on public health and fear of stigmatization. And I don't think we have a copy of the report or your report back yet, and we need that update.

Dr. FRIEDEN. We will get back to you. Thank you very much.
[The information follows:]

The National HIV/AIDS Strategy's Federal Implementation Plan requested a report on HIV and criminalization. CDC and the Department of Justice have collaborated to address this critical issue, and published *Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors*. A copy of the report is attached.



Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors

Introduction

On March 15, 2014, the Civil Rights Division of the United States Department of Justice and the Centers for Disease Control and Prevention (“CDC”) published *Prevalence and Public Health Implications of State Laws that Criminalize Potential HIV Exposure in the United States, AIDS and Behavior* (“Article”).¹ The Article examines HIV-specific state laws that criminalize engaging in certain behaviors before disclosing known HIV-positive status. Most of these laws do not account for actual scientifically-supported level of risk by type of activities engaged in or risk reduction measures undertaken. As a result, many of these state laws criminalize behaviors that the CDC regards as posing either no or negligible risk for HIV transmission even in the absence of risk reduction measures.² The majority were passed before the development of antiretroviral therapy (“ART”), which the CDC acknowledges can reduce the risk of HIV transmission by up to 96%.³ Most of these laws do not, therefore, account for the use of ART, condoms, or pre-exposure prophylaxis. The Article encourages states to use scientific findings to, “re-examine [these] laws, assess the laws’ alignment with current evidence regarding HIV transmission risk, and consider whether the laws are the best vehicle to achieve their intended purposes.”⁴ As required by the Committee Report accompanying the Commerce, Justice, Science, and Related Agencies Appropriations Bill, 2014, the Department of Justice is following that Article with this Best Practices Guide to Reform of HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors (“Guide”) to provide technical assistance to states that wish to re-examine their HIV-specific criminal laws to ensure that existing policies “do not place unique or additional burdens on individuals living with HIV/AIDS” and that these policies “reflect contemporary understanding of HIV transmission routes and associated benefits of treatment.”⁵

“The stigma associated with HIV remains extremely high and fear of discrimination causes some Americans to avoid learning their HIV status, disclosing their status, or accessing

¹ Available at <http://link.springer.com/article/10.1007/s12013-014-9272-4>.

² HIV Transmission Risk: Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act, Centers for Disease Control and Prevention, available at http://www.cdc.gov/hiv/data/docs/2012/05/20120501_HIV_Transmission_Risk.pdf.

³ *Id.*

⁴ Article at 1004.

⁵ U.S. House, Committee on Appropriations, *Commerce, Justice, Science, and Related Agencies Appropriations Bill, 2014*, (113 H. Rpt. 171).

medical care.”⁶ There is no question that “HIV stigma has been shown to be a barrier to HIV testing”⁷ and the CDC has unequivocally asserted that HIV “stigma hampers prevention.”⁸ Almost 1 in 6, or 15.8% of individuals, in the United States who carry the virus are unaware of it⁹ and the virus is disproportionately spread by those who are unaware of their status. In addition, “CDC data and other studies...tell us that intentional HIV transmission is atypical and uncommon.”¹⁰ An important component of curtailing the epidemic is to “ensure that laws and policies support our current understanding of best public health practices for preventing and treating HIV,”¹¹ including re-considering whether the vast majority of HIV-specific criminal laws “run counter to scientific evidence about routes of HIV transmission and may undermine the public health goals of promoting HIV screening and treatment.”¹²

Reform

As discussed at length in our Article, there are 33 states that have one or more HIV-specific criminal laws. In addition, in some states, individuals who have been convicted under those laws may face involuntary civil commitment after incarceration¹³ or be registered as sex offenders.¹⁴ These laws criminalize non-disclosure of known HIV-positive status in connection

⁶ *National HIV/AIDS Strategy for the United States*, July 2010 at page ix (“NAS”), citing Mahajan AP, Sayles JN, Patel VA et al. *Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward*. *AIDS* 2008;22(Suppl 2):S67-S69.

⁷ NAS at 36.

⁸ *HIV/AIDS Stigma: An Impediment to Public Health*, Valdiserri, Ronald O, MD, MPH, *Am J Public Health*, 2002, March 92; 341-342 citing Centers for Disease Control and Prevention. *HIV Prevention Strategic Plan through 2005*. January 2001.

⁹ *HIV in the United States: At a Glance*, available at <http://www.cdc.gov/hiv/statistics/surveillance.htm>.

¹⁰ NAS at 36; citing CDC *HIV Prevention in the United States at a Critical Crossroads*, 2009, available at <http://www.cdc.gov/hiv/prevention/strategy/2009/0901/090101a.pdf>.

¹¹ NAS at 36.

¹² NAS at 37.

¹³ Twenty states (Arizona, California, Florida, Illinois, Iowa, Kansas, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire, New Hampshire, New Jersey, New York, North Dakota, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin) and the District of Columbia have enacted laws regarding the post-incarceration involuntary civil commitment of individuals convicted of certain sex offenses under certain circumstances. In addition, the Adam Walsh Child Protection Safety Act of 2006, 42 USC § 1691, *et seq.*, authorizes the federal government to institute involuntary civil commitment proceedings for federal sex offenders under certain circumstances.

¹⁴ All states have sex offender registries. Sex offender registration is also covered by the following federal laws (some of which inform contents of state registries):

- *Sex Offender Registration and Notification Act*, 34 USC § 8031-8032 • Enacted as a part of the Omnibus Crime Bill of 1994, the act:
 - Established guidelines for states to track sex offenders.
 - Required states to track sex offenders by confirming their place of residence annually for ten years after their release into the community or quarterly for the rest of their lives if the sex offender was convicted of a violent sex crime.
- *Megan's Law* • During the mid-1990's every state, along with the District of Columbia, passed a Megan's Law. In January of 1996, Congress enacted the federal Megan's Law that:
 - Provided for the public dissemination of information from states' sex offender registries.
 - Provided that information collected under state registration programs could be disclosed for any purpose permitted under a state law.
 - Required state and local law enforcement agencies to release relevant information necessary to protect the public about persons registered under a State registration program established under the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act.
- *Adam Walsh Child Protection and Safety Act*, 42 USC § 1691-1698 •
 - Required the Attorney General to establish a national database (the National Sex Offender Registry or “NSOR”) by which the FBI could track certain sex offenders.
 - Mandated certain sex offenders living in a state without a minimally sufficient sex offender registry program to register with the FBI.
 - Required the FBI to periodically verify the addresses of the sex offenders to whom the Act pertains.

with engaging in certain behaviors such as while sharing needles, while engaging in sex work (regardless of risk of the act), or during the commission of a sex crime. Others criminalize behavior such as biting, spitting, and the throwing of bodily fluids by individuals who know they are HIV-positive, often in the context of interaction with law enforcement or corrections

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- o Allowed for the dissemination of information collected by the FBI necessary to protect the public to federal, state and local officials responsible for law enforcement activities or for running background checks pursuant to the National Child Protection Act (42 U.S.C. § 5119, *et. seq.*).
 - o Set forth provisions relating to notification of the FBI and state agencies when a certain sex offender moved to another state.
 - 1997 - The Jacob Wetterling Improvements Act - Passed as part of the Appropriations Act of 1998, the Act took several steps to amend provisions of the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act, the Pam Lychner Sex Offender Tracking and Identification Act, and other federal statutes. This law:
 - o Changed the way in which state courts make a determination about whether a convicted sex offender should be considered a sexually violent offender to include the opinions not just of sex offender behavior and treatment experts but also of victims' rights' advocates and law enforcement representatives.
 - o Allowed a state to impart the responsibilities of notification, registration, and FBI notification to a state agency beyond each state's law enforcement agency, if the state so chose.
 - o Required registered offenders who change their state of residence to register under the new state's laws.
 - o Required registered offenders to register in the states where they worked or went to school if those states were different from their state of residence.
 - o Directed states to participate in the National Sex Offender Registry.
 - o Required each state to set up procedures for registering out-of-state offenders, federal offenders, offenders sentenced by court martial, and non-resident offenders crossing the border to work or attend school.
 - o Allowed states the discretion to register individuals who committed offenses that did not include Wetterling's definition of registrable offenses.
 - o Required the Bureau of Prisons to notify state agencies of released (or paroled) federal offenders, and required the Secretary of Defense to track and ensure registration compliance of offenders with certain UCMJ convictions.
 - 1998 - The Department of Justice Sex Offender Management Assistance (SOMA) Act -
 - o Directed the Bureau of Justice Assistance (BJA) to carry out the Sex Offender Management Assistance (SOMA) program to help eligible states comply with registration requirements.
 - o Prohibited federal funding to programs that gave federal prisoners access to the internet without supervision.
 - 2003 - The Victims of Trafficking and Violence Protection Act - Passed as part of the Victims of Trafficking and Violence Protection Act, the Act:
 - o Required any person who was obligated to register in a state's sex offender registry to notify the institution of higher education at which the sex offender worked or was a student of his or her status as a sex offender; and to notify the same institution if there was any change in his or her enrollment or employment status.
 - o Required that the information collected as a result of this Act be reported promptly to local law enforcement and entered promptly into the appropriate state record systems.
 - o Amended the Higher Education Act of 1965 to require institutions obligated to disclose campus security policy and campus crime statistics to also provide notice of how information concerning registered sex offenders could be obtained.
 - 2003 - Federal Bureau of Investigation (FBI) Sex Offender Registration and Notification Act (SORNA) -
 - o Required states to maintain a web site containing registry information, and required the Department of Justice to maintain a web site with links to each state web site.
 - o Authorized appropriations to help defray state costs for compliance with new sex offender registration provisions.
 - 2006 - Adam Walsh Child Protection and Safety Act -
 - o Created a new baseline standard for jurisdictions to implement regarding sex offender registration and notification.
 - o Expanded the definition of "jurisdiction" to include 212 Federally-recognized Indian Tribes, of whom 197 have elected to stand up their own sex offender registration and notification systems.
 - o Expanded the number of sex offenses that must be captured by registration jurisdictions to include all State, Territory, Tribal, Federal, and UCMJ sex offense convictions, as well as certain foreign convictions.
 - o Created the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART Office) within the Department of Justice, Office of Justice Programs, to administer the standards for sex offender notification and registration, administer the grant programs authorized by the Adam Walsh Act, and coordinate related training and technical assistance.
 - o Established the SOMA program within the Justice Department.
 - Department of Justice Office of the Attorney General's Regulations of the Sex Offender Registration and Notification Act (28 C.F.R. Part 72) - this is a federal regulation that the Department of Justice passed to specify that SORNA's registration requirements are retroactive. All available at: <http://www.fbi.gov/about-us/cjis/regist/sorna>.

officials.¹⁵ Finally, the majority criminalize the failure to disclose known HIV-positive status in connection with engaging in adult consensual sexual behaviors of various types.¹⁶

The majority of these laws were enacted at a time when far less was known about risk, likelihood, and mode of transmission of the virus and at a time when the quality of life and lifespan of an individual with the virus was vastly different than it is currently. In fact, “HIV medications and treatments have significantly changed the course of HIV infection since the early days of the epidemic. With daily medication, regular laboratory monitoring, and lifestyle changes (e.g., exercise, adequate sleep, smoking cessation), HIV can be manageable as a chronic disease. People living with HIV can enjoy healthy lives.”¹⁷ As a result, certain of these laws do not accurately reflect the current science of transmission, do not account for risk reduction behaviors and medical protocols that greatly reduce transmission risk, and do not reflect that, with testing and treatment, HIV may be a manageable medical condition.

Generally, the best practice would be for states to reform these laws to eliminate HIV-specific criminal penalties except in two distinct circumstances. First, states may wish to retain criminal liability when a person who knows he/she is HIV positive commits a (non-HIV specific) sex crime where there is a risk of transmission (e.g., rape or other sexual assault). The second circumstance is where the individual knows he/she is HIV positive and the evidence clearly demonstrates that individual’s intent was to transmit the virus and that the behavior engaged in had a significant risk of transmission, whether or not transmission actually occurred.

For states that choose to retain HIV-specific criminal laws or penalty enhancements beyond these two limited circumstances, the best practice would be to reform and modernize them so that they accurately reflect the current science of risk and modes of transmission, the quality of life and life span of individuals who are living with HIV, account for circumstances where the failure to disclose is directly related to intimate partner violence¹⁸, and ensure they are the desired vehicle to achieve the states’ intended purpose in enacting them initially or retaining them in modernized form.

In bringing these laws into alignment with current evidence regarding HIV transmission and current knowledge of quality and length of life for those living with HIV the following facts should be taken into account:

- The CDC categorizes the risk of transmission of HIV from biting, spitting, or throwing body fluids, even in the absence of risk reduction measures, as negligible,

¹⁵ For example, 18 U.S.C. § 4014, Testing for human immunodeficiency virus, sets out the protocol for situations where a federal detainee or inmate intentionally or unintentionally exposes an officer or employee of the United States, or to any person lawfully present in a correctional facility who is not incarcerated there, to the HIV virus.

¹⁶ Article at 1001.

¹⁷ <http://www.aids.gov/hiv-aids-basics/guides/diagnosed-with-hiv-aids/overview-chronic-managing-aids/disease>

¹⁸ Gielen AC, McDonnell KA, Burke JG, O’Campo P. Women’s Lives After an HIV-Positive Diagnosis: Disclosure and Violence. *Maternal and Child Health Journal*. 2000; 4(2):111-120.

defined as exposure routes that are technically possible but unlikely and not well documented.¹⁹

- The CDC categorizes the risk of transmission of HIV during receptive and insertive oral intercourse, even in the absence of risk reduction measure, as low.²⁰
- The estimated per-act probability of acquiring HIV during the following activity per 10,000 exposures is as follows: insertive penile-vaginal intercourse, 4; receptive penile-vaginal intercourse, 8; insertive anal intercourse, 11; and receptive anal intercourse, 138. These risk assessments are in the absence of risk reduction factors.²¹
- Taking ART can reduce the risk of HIV transmission as much as 96%, consistent use of condoms reduces the risk of HIV transmission by about 80%, and the use of ART and condoms in combination reduces these risks of transmission by 99.2%.²²
- With testing and treatment, HIV can be a manageable chronic disease. As of 2013, a 20-year old with the HIV virus who is on ART and is living in the United States or Canada has a life expectancy into their early 70's, a life expectancy that approaches that of an HIV-negative 20-year old in the general population.²³

Conclusion

While HIV-specific state criminal laws may be viewed as initially well-intentioned and necessary law enforcement tools, the vast majority do not reflect the current state of the science of HIV and, as a result, place unique and additional burdens on individuals living with HIV. Generally, states that choose to retain HIV-specific criminal laws should consider limiting criminal liability to the circumstances set forth herein. States that wish further technical assistance with respect to their HIV-specific criminal laws should contact: Allison Nichol, Special Counsel for Disability Resources: allison.nichol@usdoj.gov

¹⁹ HIV Transmission Risk: Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act, Centers for Disease Control and Prevention, available at <http://www.cdc.gov/hiv/policies/law-risk.html>.

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ Closing the Gap: Increases in Life Expectancy among Treated Individuals in the United States and Canada, Hasina Samji *et. al.*, Page 16, PLOS ONE, available at <https://www.plosone.org/article/info:doi/10.1371/journal.pone.0188134#>.

Ms. LEE. Okay. Thank you.

Thank you, Mr. Chairman.

Mr. COLE [presiding]. I thank you very much, and I want to quickly thank Mr. Harris, who chaired while I was gone, and I am delighted to be back.

So next up is Mr. Fleischmann, distinguished Member from Tennessee.

Mr. FLEISCHMANN. Thank you, Mr. Chairman, and welcome everyone.

I want to take a note to personally thank Dr. Frieden for all the members of the committee. I know we are all passionate about the issues that we handle in this committee.

And, Dr. Frieden, you have been especially responsive to me personally on Ebola issues. Atlanta is not too far from my home city now of Chattanooga, about 130 miles down the road, but thank you for always being so responsive. And I want to thank you for your mission at the CDC.

LAB SAFETY

I do have a couple of questions. Dr. Frieden, the past year has been a challenge for the CDC as far as laboratory safety is concerned. It was rather unprecedented, based on our knowledge, with three laboratory events related to potential exposure of anthrax, Ebola, and H5N1 bird flu virus. Fortunately, no one was harmed by these events.

The after-action reports from the June event through the December event seem to have similar findings related to inadequate safeguards, use of approved techniques or unapproved techniques, and a lack of standard operating procedures or processes.

I know you take these issues as seriously as we do. Can you give us an update on the status of your corrective action plan. Specifically, do standard operating procedures now exist for all the laboratory functions? What percentage of the staff have received follow-on training? And how are you implementing a process to monitor the procedures and processes being followed, sir?

Dr. FRIEDEN. Thank you very much.

Our guiding principles for our laboratory work are to ensure the safety of our staff and the community and be as transparent as possible about our work as we conduct some of the highest quality scientific work around.

CDC has more than 150 different laboratories. We have more than 2,000 laboratory scientists and professionals who work in our laboratories, and the incidents of the past year emphasize to us the need to make sure that the safety measures are applied consistently across all of our laboratories.

We have taken a series of steps to do that. I am encouraged by the progress we have made. We have implemented the great majority of the recommendations that have been made. Perhaps the most important is the appointment of an associate director for laboratory science and safety reporting directly to me. I am delighted to say that this week and next I will be interviewing the finalists for that candidate. And we have stellar candidates for it from both inside and outside of CDC who are world class scientists. And I am look-

ing forward to that, because that is a very key position to upgrade the level of the laboratory work within CDC.

We have also required that only validated methods be used to inactivate all pathogens. That has been done in all of our laboratories. We have required verification of sterility of any laboratory sent out of CDC, and that is currently in place. We have had extensive involvement in training of laboratory scientists to improve procedures continuously. This is not a one-time thing. It is an ongoing effort. And we want to encourage reporting. So some of the incidents we hear about may be things that were encouraged that people are reporting about for the first time, perhaps. We have created an external advisory group, and I met with them, I spoke with them several times, and my charge to them was very clear: We wanted a no-holds-barred report. Tell us everything that we need to fix, frankly. They have done that, and we are well on the way to having addressed most of those issues.

We have also begun a program that we are quite proud of to train tomorrow's leaders in laboratory science and safety. For decades, CDC has had something called the Epidemic Intelligence Service. We have now created the Laboratory Leadership Service, based on the pattern of the Epidemic Intelligence Service that we will, we hope, create tomorrow's leaders in laboratory science and safety.

We have in this budget requested some funds to implement the things that we haven't fully implemented. One is a training facility to do hands-on training without any dangerous pathogens present. A laboratory space is expensive. So building that would cost some money, and to upgrade some of our information systems and some of our regulatory oversight systems for other laboratories so we can do more frequent and more intensive inspections.

We also have required secondary verification for all materials being sent out of any of our high-containment laboratories. And we have encouraged reporting and prompt response to any incident.

Mr. FLEISCHMANN. Thank you, and we wish you every success in these endeavors.

ADHD

One follow-up question: Dr. Frieden, can you please speak for a moment as to why we may be seeing continuation of the rates of ADHD expand exponentially? Is this from better identification, or is there a real ADHD problem in the United States? What is the CDC doing to help, and what promising strategies does CDC recommend to States or nationally to help correctly diagnosis, treat, and follow up with children and families who are impacted by ADHD?

Dr. FRIEDEN. We are seeing a big increase in the number of children treated for ADHD. We know that for some of those children, that treatment is effective and important. One of the things that we have been quite concerned about is the use of ADHD medications for young children in whom the FDA has not approved medications for use, and for many of the younger children, some behavioral interventions and counseling and working with families may be both safer and more effective.

We have begun working with some States and some State Medicaid programs to identify ways to perhaps encourage clinicians to start with what may be safer and approved means of treating young children. That early treatment of ADHD is one of the areas where we hope to expand effective programming in the coming year.

Mr. FLEISCHMANN. Thank you. Thank you all.

And, Mr. Chairman, I yield back.

Mr. COLE. Thank you very much.

STRATEGIC NATIONAL STOCKPILE

If I may, Dr. Frieden, let me take you to another area that I got some interest in, and that is the Strategic National Stockpile, which holds, as members of this committee know, a lot of pharmaceuticals, anecdotes, other medical supplies.

Can you give us some idea about, number one, when these various medications expire, if you will, and how do you go about replacing them? What is the control mechanism to have so that we have an outbreak of something you have what you need to respond quickly?

Dr. FRIEDEN. Well, the Strategic National Stockpile is a national resource. It currently holds about \$6 billion of product in it. We have centers for it around the country so we could deliver countermeasures to any community in the U.S. Within hours. It is expensive. The process is overseen by something called the PHEMCE, the Public Health Emergency Management—well, I will have to get the exact abbreviation—Counter Measures Enterprise, and the PHEMCE prioritizes over a multiyear period what we want to try to purchase.

If we purchased everything that the PHEMCE recommends, that would be many billions of dollars more. So one of the things that we have done is to have studies in conjunction with the FDA that allow shelf-life extension of the products in the Strategic National Stockpile. So we can do potency and other studies to determine that, in fact, although they may officially have expired, they are still good. They are still as active and there has been no decrease—they may be freeze-dried or lyophilized so they don't degrade in any way.

Second, we have done some dose-sparing studies to see whether we could use lower dose and get the same results. So we try to be as diligent stewards of the public dollars as we can be.

That is the process in general that we go through. There are some drugs and vaccines that expire, and to the extent resources allow, we then use additional resources to replenish those.

Mr. COLE. When you are dealing with pharmaceutical producers, are you able to, you know, buy in bulk? I mean, just the normal sort of good practices thing that you would do, and, frankly, how cooperative are they in producing what you think you need in volume?

Dr. FRIEDEN. We do find that we are able to negotiate with manufacturers, but sometimes there is only one manufacturer, and that makes the negotiations challenging.

The process of getting them to produce a product is a cross-government process that includes BARDA, which will contract for the

early development and kind of the first batches, if you will, of products, and then the ongoing procurement would fall to the SNS.

Mr. COLE. Well, just for the record, if you need some help on that, I hope you are very forthcoming with Congress because, in many cases, the Federal Government is not only the largest purchaser but has done a great deal of the initial scientific work on these upfront, and this is one where private industry needs to give the Federal Government, I think, a break and certainly be responsive to your needs. It is just—this is not an area to unduly profit from in my view, but thanks for your work in that regard.

WINNABLE BATTLES

Additional question, and I don't—I hope I haven't—not covering ground, having missed a number of these questions, but particularly interested—when you laid out early on in your tenure, which you called the winnable battle, so to speak, at places where you thought we could make a big difference in your tenure, one of those was obesity. And where I think we have had a great deal of bipartisan concern, some wonderful work obviously from the First Lady in this area, but I would like to get an update on your progress there and how you think we are other doing.

Dr. FRIEDEN. We feel that the winnable battles approach has been very helpful. It has allowed us to identify areas that are major health threats where we may or may not succeed, but if we focus on them, we are more likely to succeed. We set accountable specific goals in six different areas. I can say that, in at least five of those six areas, we have made some progress. In some areas, we have actually exceeded our goals. And the approach of setting ambitious goals and holding ourselves accountable for accomplishing them is one that we think is a very important one. It has pervaded CDC and the funding that we provide to State and local health departments, many of which have been adapted or adopted, some of these to their own practice.

In terms of nutrition, physical activity, and obesity, we have seen variable progress. One of this specific areas that we wanted to see an improvement in was an increase in the proportion of women breastfeeding. And we have seen that increase over the years. That is important. That improves the mother's health and the child's health. And there is growing evidence of how important breastfeeding is.

We have also seen some increase in the number of people who are walking regularly, and that is encouraging. In some parts of the country, we have seen reductions in childhood obesity for the first time in a generation. Not nearly as much as we would like, not nearly as widespread as we would like, and honestly not nearly as well understood as we would like, but we are seeing decreases, particularly in younger children in communities throughout the U.S. And now what we want to do is better understand what is driving those decreases and to make sure that they continue, that we extend them, and also that they extend not just for young children but for those children as they age in.

Mr. COLE. Thank you very much, and I want to move now, obviously, to our distinguished ranking member, Ms. DeLauro.

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

Just a couple of points. My colleague Mr. Rigell talked about the line item that talks about intentional injury. I just wanted to make a very quick statement.

I think it is important to understand the prevalence of gun violence, like so many other unintentional injuries or intentional injuries like suicide. So we need better information to help individuals reduce their public health risk. I might also add that CDC surveillance includes information on tobacco use, alcohol use, motor vehicle deaths, birth defects, asthma, industries across different industries, and CDC funds research of how we reduce occupational injuries. So it is in fact about data and collecting it and so forth, and then useful information for decisionmaking in the future.

I am hoping that with regard to Dr. Harris' question, Dr. Frieden, you will speak about CDC's role in food safety because you were dealing with a PulseNet dealing with what your role is in with conjunction with USDA. USDA tries to, you know, work cooperatively because we have to identify the source. We have to look at its prevalence, we have to examine what is going on. So there is a very, very close relationship between you and USDA. So I truly do hope if Dr. Harris pursues this area, that you will talk about this very significant role in food safety that you play, which is not the purview of FSIS.

SPORTS-RELATED BRAIN INJURY

So let me—couple of different areas here. Sports-related brain injuries. CDC Center for Injury Prevention has a number of proposals in the budget. A few of my colleagues are dealing with the prescription drug abuse. I support those efforts. I want to spend a moment discussing the proposal to establish a national surveillance system to accurately determine the incidence of sports- and recreation-related concussions among young people. Everyone has read about Chris Borland, NFL, football player, 24 years; said he was going to retire instead of subjecting his brain to long-term injury. I applaud his courage in doing this. But it seems that there—we don't know about the long-term impacts of some of these activities, the potential long-term damage.

What is CDC proposing to do with this funding? How will it help to reduce brain injuries sustained through sports and other recreations?

Dr. FRIEDEN. This would be a \$5 million increase to establish and oversee a national surveillance system to try to accurately determine the incidence of sports-related concussions among youth aged 5 to 21. That would make us compliant with the recommendations of the National Academy of Science Institute of Medicine. In their 2013 report, this was one of their specific recommendations. So our proposed response to that recommendation, and we would work in partnership with youth athletic organizations, schools, and others to test and develop nationally-representative comprehensive surveillance and reporting models for sports-related concussions and develop survey instruments or questionnaires that can be used to identify those who have sustained concussions such as that.

We also have a program called Heads Up to encourage both reporting and then appropriate action after a concussion.

FOOD SAFETY

Ms. DELAURO. You know what I am going to do, and I—because I have got a bit of time left, I want to ask you if you wouldn't mind going through the effort on food safety and what you do. I think this is a critically important area, and you mentioned listeria in some early comments, and let's talk about that we recently saw a listeria outbreak with ice cream someplace else. Go for it.

Dr. FRIEDEN. Well, let me start, and then Dr. Bell, whose area this is, will continue.

We handle the people side of food safety. So when people get sick, it is us who identify whether it is an outbreak and try to identify not just the organism but the actual nature of the organism. To solve the mystery requires all parts of the government doing their unique roles.

Dr. Bell.

Dr. BELL. Yes. Thank you. As Dr. Frieden says, food safety is a big problem. There are many agencies that have their unique roles, and our role is to prevent illness and disability and death, and detect and stop outbreaks as quickly as possible. And this is what we have been focusing on and will continue to focus on.

We have made, I think, quite a bit of progress over the last few years, although obviously there is a lot more to be done. We mostly—most of the work in food safety really is about State health departments and local communities because that is really where the problem is. And so a lot of our efforts have been focused on strengthening State and local health departments. And you mentioned a PulseNet, and PulseNet is sort of a linchpin, a pivotal part of our program, where every State health department has its genetic fingerprinting methodology. They are all looking together at the same information. We at CDC are looking at this information, and at any one time, we are as a group monitoring anywhere from 30 to 50 clusters which could turn into outbreaks and could turn into multistate outbreaks. And the listeria example, a recent example, tragic example, but could have been a lot worse, is a good example of that.

One of the things that we have been working on, as Dr. Frieden mentioned with the AMD initiative, is to upgrade PulseNet and bring it into the 21st century. And we are starting to see some progress in that regard with this listeria outbreak, which involved the caramel apple outbreak, which involved 32 cases and 7 deaths. We know we detected the outbreak faster, and we know we saved lives.

This recent ice cream outbreak that you mentioned is very, very complicated, actually, and we believe that with the older technology, we probably wouldn't have detected this as being a cluster as we would have.

Ms. DELAURO. Thank you.

Thank you very, Mr. Chairman.

Mr. COLE. Thank you.

And, actually, in the order, Mr. Harris, you are actually next up, and then we will catch the two gentlemen who have come in a little bit later down the line. So bear with us, but it is actually Dr. Harris.

Mr. HARRIS. Thank you very much.

FOOD SAFETY

Let me just continue to follow up as the ranking member suggests I should.

You know, I was just looking at the FSIS mission document. It says they are responsible to food-borne illness when it comes to meat and poultry products. So my question is just very simple. How do you—how do you—in fact, it would seem that it would be just as reasonable for Wal-Mart to have gone FSIS and said, Can you help us with this chain of—I am assuming they are looking at the entire chain of custody, to use that term, of the product, and that they are responsible, it seems, for the entire chain.

So, again, my question is only how—how do we avoid duplication. You know, FSIS has it as their mission. You are claiming it as a mission. Whose mission is it? Who gets the money for this mission?

Dr. FRIEDEN. The challenge is that the food comes to our table from the farm. And every step of the way from the farm to the table is a step where there may be a lapse that results in infection of people. The FSIS, which we work very closely with, doesn't track human infections. We track human infections, and if you have got a cluster of human infections or a pattern, you have to know where it is coming from.

Mr. HARRIS. Sure. But I understand that. So it would seem that the epidemiology is your bailiwick to inform the FSIS about how to handle a product or how to work with Wal-Mart to handle a product. Is that what is—is that what is occurring in this instance? I mean, are you basically saying, Okay, we are collecting data, but we are not telling Wal-Mart how to, you know, how to change their—

Dr. FRIEDEN. We are not experts in managing—

Mr. HARRIS. Great. That is all I needed to know because they—and I will read a little further. Let me ask, do they have epidemiologists on their staff?

Dr. BELL. You know—

Mr. HARRIS. Do you work with epidemiologists at FSIS?

Dr. BELL. We work very, very closely with FSIS. They have maybe epidemiologists that are veterinarians and focus on the epidemiology of illnesses in animals on farms.

As Dr. Frieden says, our part is the illnesses in the people, and we work very closely—they need to understand what we are finding in the people in order to inform their work on the farm.

Mr. HARRIS. Okay. As long as—again, as long as it is not duplicating because if you read what FSIS—they don't say, you know, it is the infection in the animals. I mean, they imply in their statement that they are going to—and I don't begrudge them that. I would imply it too whether or not it is true.

HIV RESEARCH

But let's—you know, we had some questioning about HIV, and HIV research is all over the Federal Government, you know, and, again, we have talked personally about this, you know, this idea that we have these various health topics researched all over the Federal Government. For instance, you mentioned ALS is one of

your—I mean, there is a line item in the DOD research budget for ALS. I would imagine that that is a much less efficient way of dealing with it than putting that line item in the NIH, for instance. So, with regards to specifically HIV, what is interesting is that if you read the budget justification for the CDC and the NIH on HIV, it reads like it could have been written by the same person. I mean, there is research into methods of preventing, biomedical research into microbicides, behavioral research in identifying interventions. The same language appears in both of the budget justifications. Who is in charge? I mean, again, I would imagine that Americans in their framework think of the disease prevention, you know, that your agency might be more in charge of some of the, you know, how do we actually prevent and treat it? The NIH may be in some of the basic research involved, but it seems that in these three topics is total blending, at least by the budget justifications. So who should be the primary agency responsible for disease prevention when it comes to HIV?

Dr. FRIEDEN. The White House has a coordinating office, a National AIDS Office, and that office ensures that there is good coordination across the Federal Government, including within HHS.

I think the outline that you give is the outline that we follow. In general, NIH does the basic research, and CDC is involved in scaling up programs once they have been shown to be effective or in trying out programs in communities. Let me give you an example—

Mr. HARRIS. Let me just interrupt there a little bit because, yes, I am going to differ because the budget justification—I will read it from the NIH budget—the NIH budget justification basically implies that they are doing behavioral research too. Now, behavioral research is not basic science. I mean, or maybe I just have a different idea of what basic science is. And it is just a question that you may or may not choose to answer, but do you believe the CDC should be the primary agency responsible for disease prevention when it comes to HIV?

Dr. FRIEDEN. I believe we are the primary agency responsible for scaling up prevention programs that have been proven. So, for example, when preexposure prophylaxis proven to work, that is an NIH lead. When we try to then implement that and scale it up in communities, that is a CDC lead.

Mr. HARRIS. Operationalize it. Okay.

Thank you very much.

Thank you, Mr. Chairman.

Mr. COLE. Gentlelady from California, Ms. Roybal-Allard.

REACH

Ms. ROYBAL-ALLARD. Dr. Frieden, 4 years ago, HHS released an unprecedented action plan to address racial and ethnic disparities. The Racial and Ethnic Approaches to Community Health, or REACH, program was cited in that action plan as an exemplary program. The GAO also cited REACH as one of the Nation's most effective programs for addressing health disparities. More than 150 journals, articles, have documented the achievements of REACH in reducing health disparities. Yet your fiscal year 2016 budget once again eliminates REACH and instead points to the Partnership to

Improve Community Health, or PICH, as the next stage of CDC's community-based programs which do not specifically target racial and ethnic disparities. Ironically, your budget also cuts the PICH grants by \$20 million or one-quarter of their fiscal year 2015 allocation.

I have a series of questions. I am going to give them to you all to try to get them all answered.

Why did you eliminate the REACH program, and what evidence can you provide to demonstrate that the PICH program has a comparable impact in reducing racial and ethnic health disparities? Have you established benchmarks that measure HHS' progress towards its goal of health disparity elimination? And can you discuss how you will meet the goals of the action plan, particularly with reduced investments in proven programs?

Dr. FRIEDEN. We share your concern for health disparities. We agree that it is critically important that we do more to reduce health disparities in this country. The REACH program had important findings—has important findings. We appreciate the support from Congress for that program. What we are trying to do is to incorporate the lessons from the REACH program into all of our programming in these areas. We have substantial programs in chronic disease in States throughout the U.S., and we are incorporating those lessons to try to achieve the goals set forth in the Healthy People 2020 goals, which include disparity-specific reduction targets.

Ms. ROYBAL-ALLARD. Okay. And you have established the benchmark—

Dr. FRIEDEN. We—

Ms. ROYBAL-ALLARD [continuing]. To measure?

Dr. FRIEDEN. It would depend on the specific area to be looked at. One of the things that we have done for the first time ever is to produce a CDC surveillance summary on health disparities and inequalities. We have produced that on—for both adults and for children now, and we are following that over time. We agree that this is a critically important area where more needs to be done.

Ms. ROYBAL-ALLARD. And you are confident that you can reach these goals of the action plan even with the reduced costs.

Dr. FRIEDEN. We will do the best we can with the resources that are entrusted to us.

Ms. ROYBAL-ALLARD. So you are hoping you can.

Dr. FRIEDEN. We will do the best we can with the resources we receive.

Ms. ROYBAL-ALLARD. Okay. Because, yeah, as you stated, this is extremely, extremely critical issue that we have to address because it has an impact on the health—total health of the country as a whole.

Thank you.

Dr. FRIEDEN. Thank you.

Mr. COLE. I am going next to Mr. Womack.

Oh, were you done?

Ms. ROYBAL-ALLARD. I have—sorry. I do have one more question.

Mr. COLE. Oh, I am sorry. Okay.

Mr. WOMACK. I will yield.

Ms. ROYBAL-ALLARD. I was just thrown back a little bit by “we will do the best that we can.”

PRESCRIPTION DRUG OVERDOSE

Prescription drug abuse and overdoses is obviously a major public health concern. So I was very happy to see that the White House has made addressing this concern a center piece of its fiscal year 2016 budget. Your budget request includes a substantial increase in CDC’s prescription drug abuse initiative, and the agency appears in large part to be enhancing prescription drug monitoring programs or PDMPs around the country.

Given that studies have shown that only 53 percent of physicians use PDMPs, can you explain to the committee how States are to enhance their PDMPs with these funds and what success have you seen to date with this program, and how can States without mandatory PDMPs participation effectively use them?

Dr. FRIEDEN. What we would like to see is PDMPs being used in realtime so that doctors don’t have to take additional cumbersome steps to essentially automatically get the medication history for opiates of their patients. We have seen in pilot projects when that happens, you can have a big reduction in inappropriate prescribing. The key components of the program would be improving PDMPs so they are realtime and universal, actively managed, and followed up so that individual patients and individual physicians who may have problematic prescribing patterns get the services or intervention that they merit. We also want to focus on the communities most at risk and to begin to address the increase in heroin-associated deaths, something that has doubled in the past 3 years.

Ms. ROYBAL-ALLARD. Okay. Do PDMPs in different States have the capability to talk to each other?

Dr. FRIEDEN. Increasingly, many States have compacts where there are agreements. So it is not universal, but it is an area which a number of organizations have been working on and have been making reasonably good progress on.

Ms. ROYBAL-ALLARD. Okay.

Mr. COLE. With that, we will go to the very patient and long-suffering Mr. Womack.

Mr. WOMACK. Thank you. Thank you, Dr. Frieden and your team again for being here. It is always a real delight to have you. And having visited the CDC, I have witnessed firsthand the great work that is happening there.

PRESCRIPTION DRUG OVERDOSE PREVENTION

I want to follow up on the question on prescription drugs. You know, my district is up in a little tight corner in northwest Arkansas. And it is a 15-minute drive to Missouri. It is a 15-minute drive to Oklahoma. And if you are predisposed to going to Kansas, it is another, you know, 5, 10 minutes. So what are you doing in this program to make sure that the information on opioids is being shared between States so that in an area like mine, a person can’t go get their fix, shall we say, in Arkansas and then a few minutes later be in another State?

Dr. FRIEDEN. This is one of the areas that we would like to see more done on, but there are several organizations that have worked out data-sharing agreements among States. We could get you the details of those. I don't know them specifically—

Mr. WOMACK. Is that a legislative fix or is that—

Dr. FRIEDEN. It has not been, and if it were, I think it would likely be at the State level, but we would have to get back to you on that.

The data sharing has largely been a question of identifying the information technology requirements for and then the entities that can actually make it happen. But I think you do identify a very important issue, one that some progress has been made on but what more can we—can be done is something I think we could explore together.

ANTIBIOTIC RESISTANCE

Mr. WOMACK. And then the only other question I have is I want you to give me a little more detail, and I am sure you covered this in your opening because it is in your opening statement on antibiotic resistance. I am assuming that the launching into this area of medicine is somewhat reactive but also very preventative too. I mean, we have got—we see a problem brewing if we don't get our arms around it very quickly.

So can you just kind of—I will throw that idea out on the table, and I want you to tell me what CDC's position on these AR programs, and, you know, you have got a couple of nice little handouts up here on C. diff, particularly that is important to me because before my mother-in-law passed, she encountered this particular problem. So I am just curious, so where are we in this area, in this effort?

Dr. FRIEDEN. We are seeing a problem that is increasing. It is affecting all communities, and it is threatening modern medicine. It is not just you might get a pneumonia. It is not just drug resistance, but if you need cancer treatment, if you need certain medications for arthritis, if you are on kidney dialysis or have an organ transplant, it is very common in a treatment of those conditions, that people get infections. And the common thing that is done in healthcare is to treat those infections. And we just presume that we will be able to treat them because for now several generations, we have been able to rely on the antibiotics that are available to us. But what we are seeing, really for the first time, is an increasing number of people and organisms that are now resistant to every single antibiotic that we have.

I spent many years taking care of patients with tuberculosis, and very rarely we would get a patient or two who had gone through all of the available antituberculosis drugs and had an organism resistant to every single antibiotic. That is now being seen increasingly, not just for tuberculosis but for common infections that people can pick up in the hospital.

And the other graphic you saw of what is called CRE or carbapenem-resistant enterobacteriaceae, this is a nightmare bacteria. This is a bacteria that can spread its resistance genes from one strain of bacteria to another, that can kill up to 50 percent of the hospitalized patients who are infected by it. But what we have

seen is if we focus on it, we can reduce it by 50 or 60 percent. So we think that a public health approach which strengthens the State health department, local health departments, hospital systems working together can make a real big difference because an individual hospital can't do it on its own because it may be getting patients in from a nursing home.

You have to have that community-wide approach to identify what is spreading, where it is spreading, and then to try different approaches to reduce the spread of drug resistance. And that is what the budget proposal asks for.

Mr. WOMACK. Once again, Dr. Frieden, thank you for your leadership and for your team. Great to have you.

Dr. FRIEDEN. Thank you.

Mr. COLE. Thank you.

And we will go next to the gentlelady from California Ms. Lee.

Ms. LEE. Thank you very much.

Now, Dr. Frieden, I know Congresswoman Roybal-Allard is not quite settled with the answer to your last question, nor am I. Okay?

REACH

Now, we have all agreed that racial and ethnic disparities, health disparities, are very—they are very important. They are high, and we have got to address them because we want everyone in America to be healthy. And people because of their race and background should not be subject to diseases disproportionately.

Now, the REACH program was established to address this. This budget eliminates it, and you explained the rationale for that, but then you cut the PICH—is it PICH—the community health program by \$20 million, and yet you say you are going to do the best you can with the resources that you have, yet you are not asking for resources to do the best you can. You are asking to cut the resources. So how are you going to do the best you can when if you want to do the best you can you would say, Look, we want to fully fund, you know, our REACH program? We would want to fully fund every effort we can to begin to address people of color and the health disparities that have plagued us for ever and ever and ever in this country.

Dr. FRIEDEN. I can only say that I agree with you.

Ms. LEE. Well, then why don't you ask for the money?

Dr. FRIEDEN. The budget, as you know, goes through a process, and the REACH program has been proposed for elimination every year since fiscal 2012—

Ms. LEE. Yeah, I know, but why?

Dr. FRIEDEN. What comes out of the budget in the end is what comes out of the budget at the end.

Ms. LEE. Well, would you go back and tell them how important this is to people of color in the United States of America? That we are Americans too. And that it is important that whoever up the food chain doesn't agree with that, that they maybe come to terms with the fact that African Americans, Latinos, Asia-Pacific Americans, Native Americans deserve the same kind of attention that everyone else does?

Dr. FRIEDEN. We do agree that the health disparities in this country are unacceptable, and one thing, regardless of the funding, that we will do is, and we are doing, is to make sure that all of our programs are trying to address disparities in their implementation.

Ms. LEE. I understand that, but still you say you do the best you can with the resources you have. You don't have—and I agree that you are doing the best you can with the resources you have, but you are not asking for the resources to do the best you can.

SICKLE CELL

Now, I want to go back to sickle cell and I agree—I appreciate your offer to meet with your folks, but I want to drill down a little bit on these blood tests. People—when people get blood tests, I know part of a battery of tests would be testing for potassium, cholesterol, creatine, hemoglobin, you know, the whole 9 yards. Why in the world would certain high-risk populations for sickle cell trait, a sickle cell test, blood test is just not part of this battery of tests?

Dr. FRIEDEN. This is something that the U.S. Clinical preventive services—clinical service task force could look at. I think the issue of testing different populations is something that we could explore. We have just gone through this universal newborn screening for sickle trait. I understand your comment that 18, 20 years later, you may not remember what happened then or you may not have a record of it, but we would absolutely be willing to explore with you what are the potential ways that tests could be done, how could you identify the individuals for whom there might be a benefit, and what would be done. There are certain conditions, certain circumstances, in which it is done, and some of those may be concerning, for example, for insurance purposes. So some of the things have to be looked at carefully.

Ms. LEE. I understand that, but we have been trying to get to the bottom of this for years and years and years, and, you know, I hope this year—well, next year, when you come before the committee, we have figured out a way to solve this because going back to the REACH program and to addressing health disparities, this once again is a key component of health disparities in certain populations of people who are Americans also. And they deserve to have their healthcare needs addressed, and not—no one of status, you know, because of whatever insurance issues or whatever the reason is, is just not acceptable.

Dr. FRIEDEN. Well, one of the things that we are working on is to improve awareness and understanding of sickle cell trait, and we have been working with the American Society of Hematology and the Sickle Cell Disease Association of America to try to expand information that is available to the public on this.

The other area that we have been working on is developing standardized methods and educational systems for older people and for families and healthcare providers to address a sickle cell trait positive screen. This is something that we think is also important for reproductive health issues for individuals who may have—

Ms. LEE. Well, two people with the trait, you know, the chances of the child having the disease are very high. So I—you know, I un-

derstand all this, but why in the world haven't we addressed it in this country?

Dr. FRIEDEN. We would be very eager to meet with you and think about ways that we could do more on this issue. I agree with you.

Ms. LEE. Thank you very much.

Mr. COLE. I want to associate myself with the gentlelady's concern in terms of ethnic and racial diversity. And I must say I am going to take your testimony and send it to OMB and tell them they really owe you because you have been very kind not to throw them under the bus, but—

Ms. DELAURO. You don't have to say it, but he can.

Mr. COLE. Yeah, and absolutely right, and, you know, this is one where my friend and Ms. Roybal-Allard make a really good point. And I say that as a Native American, and I know, frankly, that this is something that all of you wrestle with professionally. It is a tough issue, but it is a very important one. I want to thank my friend for putting the spotlight on it because it certainly needed to be done.

In the time I have left, and we—just to give everybody a notice, we are going to try to be careful because we have got a 10:30 hard stop. We could keep you here a long time because there is a lot of bipartisan interest in this, but out of courtesy, we have the President of Afghanistan here, and we want to give him the audience that he certainly deserves in Congress.

But in your budget request, you have \$68 million for prescription drug overdose, and that is something, as you know from the questions, there is a lot of concern with, certainly a lot of concern by the chairman of the entire committee.

In your professional opinion, how much would you really need to turn the tide on this kind of problem? I mean, it is a huge problem with lots of ramifications. And we appreciate what you are doing, but if you were looking and you got a blank sheet of paper and you could do what you wanted to do, you know, give us some idea the dimensions of the problem that we are talking about.

Dr. FRIEDEN. Well, one of the things that we have begun looking at is, what are the costs of prescription drug overdose societally? There is an estimate from many years ago that it was an excess of \$70 billion. There is some methodology issues of how do you calculate it, but it is a lot of money that it is costing society.

What we have proposed is one of several programs on this topic across HHS. Treatment needs to be increased, and that is the purview of SAMHSA primarily. I think there is a real value to increasing education and information about the harms of prescription drugs. I don't think it is well understood, not by doctors, not by patients. These are dangerous medications. They are highly addictive. You only have to take a few doses to become addicted potentially for life.

And they are very dangerous. If you take just a little bit too much, it suppresses the respiratory system in your brain, and you can stop breathing and die.

So I think there are certainly many needs we could get back with the full assessment professional judgement of what it would take to address this, but I remain optimistic that we can turn this around. Not going to be easy. Not going to be quick, but this was

a problem that was fundamentally created by bad prescribing practices, and it can be ameliorated greatly by improving those practices and providing additional services to patients and to physicians.

When I was in medical school, I had exactly one lecture on pain. In that lecture, the lecturer said, If you give an opiate medicine to a patient with pain, they will not get addicted. Completely wrong. But a generation of doctors was taught that, and it is wrong. These are dangerous addictive medications, and I think we could do more to inform both the public and professionals about that.

Mr. COLE. Well, we would appreciate any additional information you could give because this is one of those issues that I really think, you know, we are going to think about a multiyear approach, and how you deal with it, but I think there is genuine interest and commitment on this committee to try and work with you on that. So, again, we appreciate what you are doing now, but your best thoughts on this as opposed to budget-restricted considerations, which I know you have to work with, and I appreciate that you do, but it would be very, very welcome.

I am going to stop my questioning there because I certainly want to give the ranking member an opportunity to pose whatever sort of cleanup questions she wants to pose.

Ms. DELAURO. Thank you, Mr. Chairman.

And I think we can send a bipartisan message to OMB. Thank you.

Mr. COLE. I think we just did.

Ms. DELAURO. Hear, hear.

EBOLA VACCINE

Just a couple of final questions. I understand that researchers are planning to enroll 6,000 to 8,000 health workers in the Ebola vaccine trial in Sierra Leone supported by CDC and supported by MERCK.

Can you give us an update on the status of the vaccine trial? When is it scheduled to begin? How many health workers are expected to enroll? How long will the trial last? And the other question is I have read reports that the health workers in Sierra Leone are concerned about the vaccine trial. What has CDC done to build trust with thousands of individuals who are being asked to participate?

Dr. FRIEDEN. Thank you very much. I will turn to Dr. Schuchat whose program is leading that effort. I will comment that our response to Ebola in West Africa has been the largest response in CDC's history. We have had thousands of our employees working on Ebola in—either in this country or around the world. We have had 40,000 person workdays in West Africa of our scientists and disease-control professionals. And we have seen the CDC staff really be pivotal to the organization and progress that has been made in the outbreak in Liberia, Sierra Leone, and Guinea.

In Sierra Leone, we have pursued a trial of one particular type of trial of the vaccine that complements the work that has been done by NIH in Liberia, with a different vaccine approach, and in Guinea, by the World Health Organization and other international partners, with yet a different vaccine approach.

Dr. Schuchat.

Dr. SCHUCHAT. STRIVE is the Sierra Leone Trial to Introduce a Vaccine against Ebola, and it is expected to launch next week. This week we are actively training in good clinical practices and all the details of the protocol. The large number of Sierra Leone workers who will be implementing the trial, we have had tremendous partnership from the College of Medicine and Allied Health Sciences in Sierra Leone and the Ministry of Health and Sanitation there and leadership in the chiefdoms and districts involved. We have really focused on engagement of the stakeholders, the families, the participants, the leadership of the country to address the questions, concerns, and understanding. The trial targets healthcare workers and frontline workers, who are at higher risk of Ebola. And it is intended to target about 6,000 such healthcare workers and to last for about a year after it is initiated. We have an international Data and Safety Monitoring Board that is overseeing the ethics and the safety of the trial, and we are really pleased with the partnership and the trust-building that has been going on with it.

HPV VACCINE

Ms. DELAURO. Okay. Let me ask another quick question because I want to ask about viral hepatitis where you have increased your budget, but with regard to the vaccine, this is of the HPV vaccine, and only one-third of girls receive all three recommended doses of the HPV vaccine, low rate; 50,000 girls will develop or could develop cervical cancer that could have been prevented. Is this more a matter of information about benefits of the vaccine, combating misinformation? Should we require vaccine for kids, boys and girls, to be able to enroll in school?

Dr. SCHUCHAT. We think there are a number of factors that are delaying the uptake of HPV vaccine among the recommended teen vaccines, and as you say, too many teenagers aren't getting the vaccine compared to the good uptake we are seeing with the meningitis vaccine and the whooping cough booster.

We think one of the key factors from our research is the way clinicians talk about the vaccine. Instead of saying, Today there are three vaccines I recommend, they prevent, you know, cancers, whooping cough, meningitis, they are giving mixed messages. And so we are working now with the American Cancer Society, with clinician groups around the country and with State and locals to really help provide better tools for clinicians.

We think most parents actually when they get the facts are very interested in protecting their kids from future cancers.

Ms. DELAURO. And I know you have had to battle with misinformation on that effort as well. So 4,000 women die every year of cervical cancer. We can look at helping to prevent that.

VIRAL HEPATITIS

Viral hepatitis. You increase—you double the budget. Talk about that and talk about treatment and what your plans are.

Dr. FRIEDEN. We hope to be able to strengthen State and local capacity to find new infections and to link people who are infected to treatment. This is a major health problem in the U.S. We have 3 million people with hepatitis C and other—more than a million

with hepatitis B. Most of them don't know they have it. And a recent estimate by CDC scientists suggest that we could prevent more than 300,000 deaths of Americans by scaling up effective detection and treatment.

Ms. DELAURO. Okay. And it is an expensive treatment, I might add.

Mr. COLE. Thank you very much.

Mr. Dent has valiantly been struggling between various hearings. So I want to give him the opportunity for the last questions from the committee.

Mr. DENT. Thank you, Mr. Chairman.

Actually, I was in between hearings. I have to confess that I would ordinarily not miss a gathering with the CDC, but we have some people who provide valuable medicinal services in my district, Boston Brewing Company, Sam Adams. They do not brew it in Boston. They brew it in Allentown, Pennsylvania. And Mr. Koch, who is a TV celebrity now, and I had to make sure I——

Ms. DELAURO [continuing]. Local.

Mr. DENT. You bet. And we make a lot of beer where I live, and we are very proud of that. But that is why I was detained, to keep the people at home happy.

But a couple of things. First, thank you, Dr. Frieden, and your entire team for keeping me informed on the Ebola diagnostics progress that is being made, or we hope that is being made.

RAPID EBOLA DIAGNOSTICS

And could you just please tell me how the development of a rapid-testing technology is developing or progressing? Is CDC working with other agencies, like BARDA, USAID, DOD, to support this innovation and what happens when a development is complete?

Dr. FRIEDEN. So the testing for Ebola is currently done by something called a real-time polymerase chain reaction. It is a highly accurate way of testing for Ebola. You can do it from an oral swab or from blood. It takes a highly specialized laboratory. Once you get the specimen into that laboratory, it just takes a few hours, but those laboratories can't be everywhere.

We have used something called a lateral flow assay for other pathogens. It looks like a dipstick that is sometimes used for a pregnancy test and gives an answer in 20 to 30 minutes.

We invited any company that wanted to to come sit with us and work in our laboratories and we would help them develop product and help them get it out there because it is in everyone's interest for that to happen. Several companies took us up on that, and at least one of them now has proceeded to—we have worked with them to optimize that test so that it tests against multiple parts of the Ebola virus. We don't think it will be quite as sensitive as that real-time PCR. So there will be some false negatives, if you will. But we are hopeful that it will be just as specific. So there would not be a large number of false positives. That could be extremely helpful because you could then go out to someone who died in the community or in a hospital and, in less than a half an hour, have a preliminary answer. If they were positive—that test was positive—you would know it was Ebola and you could accelerate

your control measures. If it were negative, you couldn't assume it was negative and you would have to do further testing.

But, actually, I believe this week we have our lead laboratory scientists for the Ebola response in both Guinea and Sierra Leone working on a field test of a prototype of this product. And I am personally very excited that this could be an important tool in our response.

Mr. DENT. And which company's product is that?

Dr. FRIEDEN. That is OraSure.

Mr. DENT. That is OraSure. A constituent company, I am pleased to tell you. So—

Mr. COLE. I had a suspicion.

Mr. DENT. Yes. We are the center of innovation in many areas.

But one other quick question, what about the establishment of a stockpile of emergency supplies to identify and treat Ebola cases? Is there a global effort to support this activity when a new threat presents itself, and what would be stockpiling medicines, diagnostics, special protective gear here and abroad to meet these challenges when they present or—and, if so, how and where will these emergency preparedness measures be housed?

Dr. FRIEDEN. Thank you. I answer that. And, if I can, I just neglected to mention one thing in your prior question, which is there is another test which is FDA-approved called—run by a company called BioFire—which we are also implementing in West Africa. That is also a PCR. So it requires a little bit more technology, but it is about a 2-hour turnaround time for a test.

STRATEGIC NATIONAL STOCKPILE

In terms of the Strategic National Stockpile, we have already scaled up to provide protective gear so that that would be available for the number of patients who would be needed. The hospitals have stocked it, but we have also stocked it in the Strategic National Stockpile. We have looked at—currently, there are no proven treatments, no proven vaccines. If there were, then, we would look at potentially procuring those for the stockpile. But the stockpile is important in that response within the U.S.

Globally, we need to strengthen our ability to surge into countries when there is a problem with a stronger World Health Organization, stronger—other entities globally to do what CDC has done and put hundreds of staff on the ground in a question of just a few days or weeks.

HEPATITIS C

Mr. DENT. And, finally, just to follow up on Representative DeLauro's comments on hepatitis C—I came in during her questioning, so I hope I am not redundant.

The hepatitis C screening results are—you can get those within 20 minutes now. The same company, by the company, OraSure, does the HVC diagnostics. This, coupled with dramatically improved treatment options, can improve the lives of many Americans as you know.

How is CDC taking advantage of these developments now for this?

Dr. FRIEDEN. Our budget proposal is to double our funding for viral hepatitis so that we can support State and local entities to scale up testing and linkage to care. We know that many people with hepatitis C and hepatitis B don't know they are infected, and many who are infected have not been treated, including those who have advanced infection and clearly would benefit from treatment.

Mr. DENT. Thank you.

My time is up, and I am going to yield back.

Mr. COLE. Thank you very much.

And our time, sadly, is up as well.

But, Dr. Frieden, Dr. Bell, Dr. Schuchat, I want to thank you very much for taking the time. Your testimony is extremely helpful to this committee. But, more importantly, just thank you and the wonderful people that you work with and represent for what they do for the American people and, frankly, for people all around the world every single day. Your work is greatly appreciated and much admired on this committee on both sides of the aisle. So, again, thank you for coming to testify, and we look forward to working with you through the budgetary process.

Dr. FRIEDEN. Thank you very much.

Mr. COLE. Thank you.

We are adjourned.

Department of Labor, Health and Human Services and Education and Related Agencies

FY 2016 Budget Hearing for the Centers for Disease Control and Prevention

with Dr. Thomas Frieden

March 25, 2015

Questions for the Record – Chairman Cole

(1) CDC's work in Indian Country

Response: The CDC budget for FY 2016 makes critical investments in many areas. With funding prioritized for preventing opioid abuse and overdose, reducing viral hepatitis-related illness and death, and other critical areas there is a key opportunity to ensure that some of the most underserved areas of the country are receiving public health investments. However, many of the grant programs CDC administers are geared toward state-level public health entities. This means Tribally operated public health systems are often left out of funding streams through CDC.

A. Please explain what CDC is doing to ensure that, across CDC, funding is reaching Tribal communities?

Response: CDC is working with the CDC/ATSDR Tribal Advisory Committee, the National Indian Health Board, and others to raise awareness about the needs of Indian Country and CDC's current direct investments, and to discuss ways CDC can improve its support. These efforts have resulted in an increase of \$6.1M in direct grant funding to tribes or tribal organizations in FY 2014 compared to FY 2013. CDC will continue our work to increase support to tribes. CDC also encourages states to work with tribes through funding opportunity announcement (FOA) provisions such as application evaluation criteria. For example, FOA evaluation criteria can provide more points to applications that propose collaborative activities with tribes, if applicable and allowable under the legal and other conditions of each grant. If such a collaborative proposal is funded, during the normal course of cooperative agreement oversight, CDC project officers monitor adherence with and progress on the grantee's work plan.

B. What are CDC's priorities relative to public health conditions in Indian Country over the next five years?

Response: Tribal elected officials who comprise the CDC/ATSDR Tribal Advisory Committee (TAC) have identified through the TAC process the following tribal public health infrastructure **needs** as priorities for its work with CDC and ATSDR:

- Develop the public health workforce supporting tribe or tribal serving organizations (e.g., through providing CDC staff and trainees such as Public Health Associate Program associates or Epidemic Intelligence Service officers to work in tribal public health agencies and tribal organizations);
- Increase direct funding mechanisms for tribes for addressing public health disparities among tribal populations (e.g., fetal alcohol spectrum disorder, injury prevention, infectious disease);

- Improve collection, access to, and quality of tribal health data through HIT or other IT mechanisms (e.g., increase CDC support for Tribal Epidemiology Centers);
- Improve collection, access to, and quality of tribal health data through Health Information Technology (HIT) or other IT mechanisms (e.g., increase CDC support for Tribal Epidemiology Centers); and
- Violence and injury prevention.

Improvements such as these in tribal public health infrastructure will enable tribes to more effectively and efficiently address tribal public health disparities in ways that are culturally appropriate and respect the sovereignty of tribes.

In addition to the crosscutting needs and priorities listed above, CDC's National Center for Chronic Disease Prevention and Health Promotion—through the CDC/ATSDR TAC and other tribal consultations and interactions, and trends revealed by CDC and other data—has identified priority chronic disease health disparities in American Indian/Alaska Native (AI/AN) populations, including elevated rates of type 2 diabetes, end stage renal disease and heart disease. Utilizing a combination of environmental approaches, clinical-community linkages, and health system interventions, CDC will continue to support tribes to prevent heart disease, type 2 diabetes and associated risk factors through activities that reduce tobacco use and exposure to second-hand smoke, increase opportunities for physical activity and improve the nutritional quality of diets in AI/AN communities.

C. What are CDC's priorities for Indian Country in FY 2015 and the FY 2016 request?

Response: CDC's priorities are supported by the following budget lines in FY 2015 and requests in the FY 2016 Congressional Justifications:

Public Health Scientific Services & Crosscutting Activities and Program Support

- The FY 2016 budget request includes an increase of \$15.2 million to support Public Health Workforce Capacity. With this proposed increase, CDC will support up to 667 fellows, which includes almost 80 additional fellows. CDC also will expand staff support for these fellows, enhance access to public health e-learning, increase opportunities for fellows to receive training in population health, and strengthen workforce development for public health surveillance. CDC will accomplish this effort by strategically placing EIS officers, Prevention Effectiveness fellows, Public Health Informatics fellows, Preventive Medicine residents/fellows, and Public Health Associates in high-need areas, including areas serving American Indian and Alaskan Native populations.
- The CDC Office for State, Tribal, Local and Territorial Support (OSTLTS) provided funding to the National Indian Health Board (NIHB) to support public health accreditation readiness among tribal public health departments/agencies. Tribes received sub-grants through NIHB for this activity. CDC also supports the Association of American Indian Physicians to provide technical support to tribes, and coordinates and finances the CDC/ATSDR Tribal Advisory Committee and Consultations.

Chronic Disease Prevention and Health Promotion

Good Health and Wellness in Indian Country, a 5-year, \$13 million per year program, began in FY 2014 and enlists tribes and tribal organizations as change agents to improve the individual and community health of American Indians and Alaska Natives. The program offers a coordinated and holistic approach to chronic disease prevention and health promotion. It is designed to respond to chronic diseases and their risk factors that remain widespread among American Indians and Alaska Natives. The burden in Indian Country is far higher than virtually everywhere else in the United States.

Eleven tribes work on a combination of effective, community-chosen and culturally adapted strategies aiming to reduce commercial tobacco use and exposure, improve nutrition and physical activity, increase support for breastfeeding, increase health literacy, and strengthen team-based care and community-clinical links. CDC expects Good Health and Wellness in Indian Country to demonstrate measurable outcomes that improve health and quality of life. Three long-term outcomes are:

- Reduce rates of death and disability from tobacco use by 5%;
- Reduce prevalence of obesity by 3%; and
- Reduce rates of death and disability from diabetes, heart disease, and stroke by 3%

CDC is working with the Urban Indian Health Institute (UIHI) to coordinate an Indian Country-wide evaluation of the program. Additional awards fund Tribal Epidemiology Centers (TECs) to work with awardees to implement evaluation activities coordinated by UIHI.

Injury Prevention and Control

The FY 2016 Budget includes an increase of \$12 million to expand the NVDRS. CDC staff work closely with states to strengthen their data and surveillance in order to help them understand the underlying causes of violent deaths and to guide state/local prevention efforts. The National Violent Death Reporting System (NVDRS) grantee in Alaska, for example, works with the Alaska Native Tribal Health Consortium-Injury Prevention Program, Alaska Native Epidemiology Center, and other prevention organizations to address injuries and violence, specifically among Alaskan Natives. Together, they produced peer-review articles and collaborate on publications such as an injury and health status report describing patterns of violence among Alaskan Native people, and have worked to develop prevention strategies and interventions.

CDC also provides ongoing technical assistance and scientific support to the IHS Tribal Epidemiology Centers in injury prevention and control activities. Several of these Centers provide support for tribes conducting violence or suicide prevention efforts, such as the Tribal Health – Reaching out Involves Everyone (THRIVE) program, operated by the Northwest Portland Area Indian Health Board. THRIVE seeks to reduce suicide rates among American Indians and Alaska Natives living in the Pacific Northwest.

Some CDC-funded grantees have chosen to focus on assisting tribal populations in preventing intimate partner violence and sexual violence. For example, CDC provides funding to the Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) as part of the Domestic Violence

Prevention Enhancements and Leadership Through Alliances, Focusing on Outcomes for Communities United with States (DELTA FOCUS) program. ANDVSA's CDC-supported activities empower youth, including Alaskan Native youth, to prevent domestic violence and foster more peaceful communities through education, violence prevention training for youth, and the use of media. Much of this work draws upon the native cultures of Alaska. In addition, the Idaho Rape Prevention and Education program is currently working to tailor its Green Dot program, a violence prevention program for middle and high school students, for a tribal population within the state.

D. How are you requiring states to work with the Tribes within their state boundaries? What consequences are levied against states if a state does not use a portion of the CDC grant monies to actively and meaningfully work with Tribes within their state boundaries?

Response: CDC does provide some funding directly to tribes or tribal serving organizations. CDC also encourages states to work with tribes through the provision of higher ratings on some funding applications for those states that propose collaborative activities with tribes. CDC project officers monitor adherence with and progress on the grantee's work plan during the course of cooperative agreement oversight. CDC's Procurement and Grants Office has authority to impose restrictions and/or corrective measures when grantees are not meeting the terms of the specific cooperative agreement.

E. Some of the programs you mentioned reaching Indian Country during the hearing have already expired. What are your specific plans to take those lessons from those successful programs (like the car seat and motor vehicle safety program) and replicate those with other Tribes or sustain the programs that you yourself identified as successful?

Response: CDC's National Center for Chronic Disease Prevention and Promotion (NCCDPHP) is in the early stages of identifying promising practices that produce definable health improvements in the population of interest. The intent is to harvest that information and work with AI/AN populations to disseminate effective interventions on a broader scale across the country.

The CDC National Center for Injury Prevention and Control (NCIPC) has funded Tribal motor vehicle safety programs since 2004. From 2010-2014, through a cooperative agreement, CDC funded eight tribes including Caddo Nation (OK), California Rural Indian Health Board, Colorado River Indian Tribes (AZ), Hopi Tribe (AZ), Oglala Sioux (SD), Rosebud Sioux (SD), Sisseton Wahpeton-Oyate (SD), and Southeast Alaska Regional Health Consortium, to tailor and implement effective interventions in their communities. The programs were successful at increasing seat belt use, increasing child safety seat use, and decreasing alcohol impaired driving.

CDC is developing a manual of best practices and lessons learned from the Tribal Motor Vehicle Injury Prevention Program (TMVIP). The manual will be a beneficial resource to tribal governments, state governments working with tribes, and federal programs that are working toward preventing motor vehicle injuries in Indian country.

CDC is also partnering with the Federal Highway Administration through its Tribal Technical Assistance Program (TTAP). CDC's NCIPC provides funding for technical assistance to tribes in 3 of 7 TTAP centers, reaching 207 tribes in 10 states, comprising 37% of the 566 federally recognized tribes in the United States. This partnership will allow CDC to reach more tribes with the lessons

learned and successes of TMVIPP to ultimately reduce motor vehicle-related fatalities and injuries in Indian Country.

Finally, CDC works with other federal agencies on motor vehicle safety. Indian Health Service, Bureau of Indian Affairs, National Highway Traffic Safety Administration and Federal Highway Administration are important partners and have collaborated with CDC on various projects and initiatives. Examples of ways in which CDC has collaborated with Indian Health Service include the following:

- Development of a surveillance course to assist tribes in developing tribal injury data bases;
- Development of a toolkit with a video and factsheets regarding steps tribal communities can take to prevent MV-related injuries and deaths;
- Development of a GIS-based methodology utilizing zip codes to identify tribe-specific injuries;
- Contributions to the manual of best practices;
- Educating tribes on the components of strong tribal traffic safety policies; and
- Providing training on effective ways to implement injury prevention programs within tribal communities.

F. It is our understanding that most of the funding going to Tribes (about 75%) from the CDC is from the National Center for Chronic Disease Prevention and Health Promotion.

What is CDC doing to ensure that Tribes receive equitable funding from those Centers, Institutes and Offices (CIOs) within the agency that provide funding opportunities?

Response: CDC is working with the CDC/ATSDR Tribal Advisory Committee, the National Indian Health Board, and others to raise awareness about the needs of Indian Country and CDC's current direct investments in Indian Country. CDC is discussing ways that CDC can improve its support to Indian Country.

(2) Gun Violence

CDC is again proposing a new program to conduct \$10 million of gun research. In addition, the National Violent Death Reporting System (NVDRS) program includes a \$12 million increase to collect information from multiple data sources on firearms for future research.

A. Please explain to me how this information is going to be used?

Response:

Research on gun violence

On January 16, 2013, the President released his plan to reduce firearm violence, *Now is the Time*. Part of this plan directed the CDC and other scientific agencies to conduct research into the causes and prevention of gun violence. The FY 2016 President's Budget request includes a proposed \$10 million

for CDC to conduct gun violence prevention research, including investigating the links between video games, media images, and violence.

CDC responded to the President's *Now is the Time* Plan by commissioning the IOM/NRC to produce a research agenda – *Priorities for Research to Reduce the Threat of Firearm-Related Violence* – which was released by the IOM/NRC on June 5, 2013. The FY 2016 request would support some recommendations of the IOM/NRC report.

National Violent Death Reporting System

CDC gathers data on violence-related injuries and deaths, including data on firearm injuries and deaths. CDC supports analyses of this surveillance information and other data to document the public health burden of violence in the United States. Understanding the patterns, characteristics, and impact of all violence, including firearm-related violence, is an important step toward preventing injuries and deaths in the United States.

CDC's National Violent Death Reporting System (NVDRS) equips funded states, researchers, and CDC to better understand the circumstances surrounding violent deaths.

- NVDRS covers all types of violent deaths—including homicides, suicides, and child maltreatment fatalities—in all settings and for all age groups. Information on the mechanism of injury (e.g., poisoning, blunt force trauma, firearm-related injury, hanging/suffocation, etc.) is gathered along with information on a variety of circumstances related to these deaths, including mental health problems; recent problems with a job, finances, or relationships; physical health problems; toxicology data for prescription or other drug use; and other circumstances surrounding the death. Such data are far more comprehensive than what is available elsewhere.
- NVDRS is the only state-based surveillance system that pools information from multiple data sources into a usable, anonymous database. These sources include death certificates, coroner/medical examiner reports (including toxicology reports), and law enforcement reports. The sources are pooled to provide a comprehensive picture of the circumstances surrounding violent deaths.
- NVDRS collects and shares data to support decision making at the federal, state, and local levels. States use NVDRS data to inform the development, implementation, and evaluation of violence prevention strategies. For example:
 - Law enforcement officials in Oklahoma used state NVDRS intimate partner homicide data to inform a new strategy for responding to domestic violence calls. Police officers in Oklahoma responding to domestic violence calls conduct a brief lethality assessment. If they determine the victim is at high risk, immediate coordination with the local domestic violence service provider occurs. The state health department supported an evaluation of the intervention and found that the strategy increased survivors' use of formal and informal protective strategies and decreased the frequency and/or severity of physical violence. (Lethality Assessment Study in Oklahoma 2008-2013).
 - Oregon developed a state suicide prevention plan and targeted prevention efforts among older adults. Oregon focused the intervention on screening by physicians because of the

information gathered through NVDRS. In 2014, the Oregon Violent Death Reporting System (VDRS) issued a report entitled, "Suicide Among Oregon Veterans." The report documented the circumstances that contribute to an increased risk for suicide among veterans. The findings will be used to develop, inform, and focus suicide prevention programs for veterans.

- The Utah Department of Health observed that children involved in domestic violence homicides were not routinely referred to the Division of Child and Family Services (DCFS). Based on recommendations informed by NVDRS information, Utah worked to increase immediate referrals to DCFS. The referrals enable the children and families be assessed and connected to intervention and follow-up services—such as mental health services—to help cope with the homicide and other domestic violence-related issues.

B. Please describe any limitations or safeguards on the information to prevent it from ever (directly or indirectly) from being used to develop or support policies, guidelines, or recommendations to limit access to guns, ammunition, create a list of gun owners, or impede our Second Amendment rights in any manner?

Response: The information collected by NVDRS is anonymous and does not contain personal identifiers. It is not possible to link data in NVDRS to any household. Similarly, it is not possible to create a list of gun owners from NVDRS data.

Beginning in FY 1997, the Labor/HHS/Education appropriations act states that none of the funds made available to CDC may be used, in whole or in part, to advocate or promote gun control. Similar appropriations language was extended to all HHS agencies beginning in FY 2012. Congress has provided specific guidance that prohibits funds from being used to lobby for or against the passage of specific Federal, State, or local legislation and executive actions, including those intended to advocate or promote gun control.

All CDC grantees are educated on all federal laws relating to funding awards including applicable anti-lobbying provisions including advocacy or promotion of gun control. Specifically, CDC Additional Requirement (AR) 12 and the accompanying guidance entitled "Anti-Lobbying Restrictions for CDC Grantees" is set forth in all Funding Opportunity Announcements and lays out in detail the restrictions on applicants' use of HHS funds for lobbying. In addition, CDC has several tools in place to monitor the use of grant funds by grantees and their sub-recipients. These include on-site reviews, regular performance monitoring phone calls, and risk mitigation plans. CDC monitors the use of federal funding, and ensures that grantees comply with federal law and the specific guidance of the Funding Opportunity Announcement and conditions outlined in the AR-12.

(3) Laboratory Challenges

The past year has been a challenge for CDC as far as laboratory safety is concerned. It was unprecedented, based on our knowledge, with three laboratory events related to potential exposure of anthrax, Ebola, and H5N1 Bird Flu virus. Fortunately, no one was harmed by these events.

The after-action reports from the June event through the December event seem to have similar findings related to inadequate safeguards, use of unapproved techniques, and the lack of standard operating procedures or processes.

I know you take these issues as seriously as we do. Please provide an update on the status of your corrective action plan. Specifically, do standard operating procedures now exist for all the laboratory functions, what percentage of the staff have received follow-on training, and how are you implementing a process to monitor that the procedures and processes are being followed?

Response: Comprehensive internal and external reviews were conducted of each laboratory incident, and CDC created both internal and external workgroups to review the agency's laboratory safety procedures and protocols, which resulted in recommendations for improving safety. CDC has begun multiple improvements to lab safety practices and procedures across the agency, with the goal of increasing CDC's culture of safety. CDC reported on these improvements at the April 23, 2015, meeting of the Advisory Committee to the Director, CDC. A copy of CDC's update presentation is available at <http://www.cdc.gov/about/pdf/lab-safety/cdc-labsafetyupdate-acdpresentation-5-05-2015.pdf>. These efforts are ongoing, and CDC scientists and staff remain dedicated to improving the culture of safety across the agency.

Regarding standard operating procedures (SOPs) and process monitoring, CDC established a Laboratory Safety Review Board to conduct safety reviews of laboratory protocols for work in biosafety level 3 (BSL-3) and BSL-4 laboratories. This group will review and approve all existing and new protocols and SOPs for the inactivation and/or transfer of biological materials from BSL-3 and BSL-4 laboratories to lower levels of containment and ensure that processes for submission, review, and completion of protocols are efficient, prioritized, and accurately tracked. All SOPs that involve transfer out of BSL-3 and BSL-4 laboratories must use an approved checklist, and these SOPs also must include secondary verification of when inactivation occurs. Secondary verification is a process by which a second person or method verifies that essential steps in a protocol, such as inactivation of pathogen, are appropriately executed. The SOPs also require that a Material Transfer Certificate be completed for transfer of any material from high containment laboratories to lower biosafety level labs, including internal transfers. To ensure that the procedures are being followed, CDC has implemented a new monitoring and tracking process with quarterly reporting to senior leadership.

The internal and external reviews also identified training and education as a functional area with great opportunities for improvement. CDC is working to establish a standardized, competency-based core safety training curriculum across CDC that will address general safety and biosafety for all laboratory staff and will include online and instructor-led courses. We identified funding in FY 2015 for development of a new laboratory safety training curriculum and products, which are currently being developed within CDC, and some have already been piloted with staff. The FY 2016 budget requests an increase of \$30 million to help advance CDC's laboratory safety and capacity, including expanded laboratory training offerings and other training improvements, and expanded select agent oversight activities for the nation.

(4) Underground Mining Research Facility

The safety of our Nation's underground miners is very important. Over the past 30 years, the Lake Lynn Laboratory and Experimental Mine provided a unique and critical resource for

conducting large scale explosion tests and mine fire research, which are essential components of preventing accidents and disasters in the mining industry.

I understand that the owners of the land upon which this lab was leased decided not to renew the lease in 2012. That was not in CDC's control. However, over the past several years, Congress has sent a strong message that this capacity needs to be replaced to ensure the safety of our miners.

- A. The FY 2015 Appropriations Act requested CDC provide a site selection process and timeline for replacing this research capacity within 60 days after enactment. What is the status of the report and how much has CDC requested in FY 2016 to expedite the replacement of this critical resource for conducting large scale explosion tests and mine fire research?**

Response: We hope to provide The Underground Mining Safety Report to Congress in the near future. CDC currently has \$14.1 million in carryover funding available for a potential site acquisition.

- B. How much funding, in your professional judgment, will CDC require to re-establish a facility with the capabilities that existed at Lake Lynn, such as the ability to conduct large scale explosion tests and mine fire research?**

Response: CDC currently has \$14.1 million in carryover funding available for site acquisition. CDC is actively working with General Services Administration (GSA) on acquisition of a potential replacement site and will work with GSA to expedite the process to the extent possible. CDC will require funding for the reestablishment of a facility with the capabilities that existed at Lake Lynn. The costs for the facility could vary significantly depending on whether it is a new site or existing construction and will compete with other public health priorities for resources.

(5) CDC Win-able Battles

I understand upon your arrival at CDC you developed an initiative called "CDC's Seven Win-able Battles" to address a number of public health issues that you felt were win-able in the short-term. The 2015 Win-able Battle report only provides data through FY 2012 but showed slow progress in childhood and adolescent obesity. I understand the FY 2016 report is coming out in this month and the FY 2016 request asks for an increase of \$23 million to further support obesity prevention.

- A. Please provide an overview on how we are making progress to reduce childhood and adolescent obesity?**

Response: Over the past thirty years, obesity rates among adolescents and children have steadily increased. In more recent years, these rates have begun to level and even drop among the youngest children. Recent data show a decrease in obesity prevalence among children ages 2-5 years, dropping from 14% in 2003-2004 to 8% in 2011-2012.

- B. Further, how does the FY 2016 requested increase allow CDC to focus its efforts on the areas of the country with the highest proportion of obese children and adolescents and what is the expected reduction in children and adolescent obesity based on the requested increase?**

Response: Major areas of work are prioritized to continue this progress on childhood and adolescent obesity:

- **State Public Health Actions Cooperative Agreements:** CDC works with state health departments in all 50 states to prevent and reduce childhood and adolescent obesity by promoting effective strategies to increase access to healthy foods and opportunities for physical activity. Seventeen states awarded funds in FY 2014 for the state and local public health actions cooperative agreement are required to sub-award 50% of funds to support implementation activities in 4-8 communities in their states, selected based on disease and risk factor burden data and combined potential impact. States provide essential leadership and technical assistance to local institutions to support obesity prevention in early childhood centers, schools, and communities.
- **Early Care and Education:** 50% of children who became obese between the ages of 5 and 14 were overweight when they entered kindergarten. CDC works with childcare centers around the country to ensure that the Nation's most at risk children are provided with healthy foods and given the opportunity to be active throughout the day. Currently, the Nemours Foundation is working with CDC in 9 states (AZ, CA, FL, IN, KS, MO, NJ, KY, VA) to identify practical and affordable ways to offer healthy foods and make childcare centers safe and attractive for children to be active. This project spans over 1,400 childcare centers, reaching more than 165,000 children. In addition, CDC has reached over 1.2 million children served by over 16,000 childcare providers across the country through a national, web-based initiative to increase the number of providers that meet obesity prevention practices.

These investments will help contribute to reaching the national Healthy People 2020 goal of a 2.4% decrease in childhood obesity, since 2012, resulting in 1.8 million fewer children (aged 2 to 19) with obesity. The impact would be substantial. A recent study estimated that \$260.4 million would be saved in lifetime medical expenditures based on a one-percentage point decrease in the prevalence of obesity among 12-year olds.

C. How are we doing on the other seven battles areas? How are you measuring winning through FY 2014 data and the FY 2015 projections for each battle?

Response: Please see CDC's most recent Winnable Battles Report:

http://www.cdc.gov/winnablebattles/targets/pdf/winnablebattles2010-2015_progressreport2014_.pdf

D. Further, how does the FY 2016 requested increase allow CDC to focus its efforts on the areas of the country with the highest proportion of obese children and adolescents and what is the expected reduction in children and adolescent obesity based on the requested increase?

Response: The FY 2016 President's Budget proposes a total of \$40 million for nutrition, physical activity and obesity activities, a \$7.5 million reduction from the FY 2015 enacted level. This reduction reflects the proposed elimination of the High Obesity Rate Counties program. The proposal changes the funding source for these activities, which in FY 2015 were funded primarily through the Prevention and Public Health Fund (PPHF). The FY 2016 President's Budget continues the activities described in 5B, above.

(6) Chronic Diseases

Of all of our nation's health problems, chronic diseases such as diabetes, cancer and heart disease are the leading cause of poor health, disability and death, and among the most costly to treat. But they also are the most preventable.

A. Please describe how CDC programs and resources being targeting to areas of the country with the highest demonstrated burden of disease on an age adjusted basis?

Response: Over the last three years, CDC has invested in a number of chronic disease prevention programs that are targeted to areas of the country with the highest burden of disease including:

- **State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease:** intensifies work in 21 state and large city health departments to prevent diabetes, heart disease, and stroke with a requirement to sub-award half of their funds to support implementation activities in four to eight communities with the highest burden of disease.
- **Partnership to Improve Community Health (PICH):** funds the creation of healthier communities by strengthening capacity to implement locally tailored evidence- and practice-based policy, systems and environmental improvement strategies in priority populations experiencing health disparities in chronic diseases and associated risk factors.
- **Good Health and Wellness in Indian Country:** aims to prevent heart disease, diabetes, stroke, and associated risk factors in American Indian tribes and Alaskan Native villages through a holistic approach to population health and wellness.
- **High Obesity Rate Counties Program:** implements public health strategies to address obesity through cooperative extension and outreach services in counties with adult obesity rates over 40%.

In addition, CDC's state-funded chronic disease programs follow an approach where states are responsible for identifying high burden areas and/or populations based on their state-specific needs and context.

B. Please provide a table with the top 50 counties that have the highest level of burden (age adjusted rate) and the funding CDC has provided in each of the past 3 years for each of the following: obesity, diabetes, stroke, heart attack, and cancer. Plus, a list of the top 50 counties that received CDC funds for each of the preceding identified disease areas.

Response: CDC does not have an overall measure of chronic disease burden, but has select measures at a county-level that include the following:

- Diagnosed diabetes, obesity, and leisure time physical activity (<http://www.cdc.gov/diabetes/atlas/countydata/atlas.html>);
- Heart disease deaths, hospitalizations, and hospital discharge (<http://nccd.cdc.gov/dhdspatlas/>); and
- Cancer incidence (<http://www.statecancerprofiles.cancer.gov/incidencerates/>)

CDC does not limit its local funding to counties. Eligible awardees under CDC's community investments include large and small cities and counties, tribal organizations, and national and community organizations. In addition, funding to state governments does not direct states on how to distribute funding among local entities.

C. Please explain how CDC is using established metrics that capture prevalence of disease when awarding grants and using projected impact on the measure when considering which grantee to award for chronic disease programs funded through CDC?

Response: CDC funds grantees based on a number of criteria that are described in our Funding Opportunity Announcements (FOA) that include not only burden of disease, but geographic diversity and capacity to implement the requirements of the FOA.

(7) Preventive Health and Health Services Block Grant (Cole)

State health departments have the unique capacity to target resources to specific local needs. Key to this work is the Preventive Health and Health Services Block Grant. Please describe why, after Congress has repeatedly directed funding to this program, including the recent bi-partisan increase of its funding level, did CDC again propose to elimination of this program?

Response: The FY 2016 Budget request eliminates the Preventive Health and Health Services Block Grant (PHHSBG). These activities may be more effectively and efficiently implemented through state and local chronic disease funding, which provide resources to states to coordinate activities across categorical funding streams. When the PHHSBG was first authorized in 1981, there were minimal resources within CDC's budget allocated for categorical programs such as heart disease, diabetes, immunizations, and obesity, and many states did not receive funding from CDC to support prevention of chronic disease. However, since 1981, categorical programs at CDC have grown and can better address these public health threats. Elimination of this program provides an opportunity to find savings, while expanding core public health activities for other CDC priorities.

(8) ObamaCare Analysis Report

The FY 2014 Appropriations Act included a general provision that required HHS to submit an analysis on how ObamaCare coverage of preventive health services will impact the discretionary programs funded through this bill as part of the FY 2016 budget request. The thought behind this is if more people are getting coverage for preventative screenings, vaccinations, and well-visit checkups, perhaps some of the individual line items we fund that support some of these activities can be reduced. I would think this information would be of interest to the Administration as well, so I was disappointed that the budget justification documents did not include this analysis, as required by law.

Many of these preventative health programs, now mandated to be covered by insurance plans overlap, duplicate, or impact the focus of CDC programs.

- a. **Has CDC has completed its work on this report required by the FY 2014 Appropriation Act**
- b. **Please provide a copy of the work CDC has done for this report?**
- c. **Please provide a date that the Committee should expect to receive the report directed in the FY 2014 bill language?**

Response: The President's FY 2016 Budget anticipates the impact of full implementation of the Affordable Care Act. In the first year of full Affordable Care Act implementation, the rate of uninsured adults fell by more than 26 percent, meaning that 10.3 million more Americans had access to the benefits and financial protections of health coverage. By 2016, this number is expected to be 25 million based on estimates by the Congressional Budget Office. The Administration will continue monitoring the impact of expanded insurance coverage through the Affordable Care Act to ensure that services adapt to the changing health care environment. The President's FY 2016 Budget includes proposals for public health safety-net programs to adapt to expanded access to health insurance by:

- **Supporting the ability of health departments to bill insurance for covered services:** The Budget includes funding in targeted areas to continue working with health departments to expand their capacity to bill private insurance for services provided, including:
 - Up to \$8 million dedicated to building billing capacity for HIV/AIDS screenings; and
 - Up to \$8 million dedicated to building billing capacity for immunization services.
- **Adapting programs for expanded insurance coverage:** The Budget begins to adapt programs that provide services covered by private insurance and Medicaid, including:
 - Breast and Cervical Cancer (\$169 million, -\$38 million below FY 2015), and Colorectal Cancer (\$40 million, -\$4 million below FY 2015); and
 - Section 317 Immunizations (\$561 million total, -\$50 million below FY 2015), and continues the policy begun in FY 2014 to allocate funds for vaccine purchases based on the estimated number of uninsured adults within each awardee's jurisdiction.
- **Helping populations traditionally served by safety net programs understand their insurance options and enroll in affordable coverage:** The Budget continues the Department's commitment to support outreach and enrollment efforts, including:
 - **Health Centers:** The Budget provides \$162 million total, +\$5 million above FY 2015 in dedicated resources to continue outreach and enrollment activities for 1,200 existing grantees nationwide as well as new health centers funded for the first time in FY 2015. These awards expand current outreach and enrollment assistance activities, such as allowing health centers to hire outreach and eligibility assistance workers, and facilitate enrollment of eligible health center patients and service area residents into affordable health insurance coverage through the Health Insurance Marketplaces, Medicaid and the Children's Health Insurance Program. As of September 30, 2014, health centers have helped over 7 million consumers to understand options for gaining affordable health insurance.
 - **Family Planning:** In FY 2016, the Office of Population Affairs will maintain support for Title X grantees to initiate or expand enrollment assistance activities and facilitate eligible clients' enrollment into affordable coverage. Through these investments, the Family Planning program can continue to provide high-quality care to newly insured clients, while leveraging funds to expand services to more individuals in need. In

FY 2014, the Office of Population Affairs awarded 22 outreach and enrollment grants to Title X grantees; additional awards are projected for FY 2015 and FY 2016.

- **Rural Health:** The Budget provides the resources needed to continue funding for a rural benefits counseling pilot within the Federal Office of Rural Health Policy that will help rural residents to understand insurance coverage options in rural areas, including Affordable Care Act coverage options, as well as options for seniors under Medicare Advantage and Medicare Part D and veterans seeking care through the Veteran's Choice Act.
- **Maintaining support for vulnerable populations:** The Budget also maintains support for at-risk populations, while conducting additional analysis on the impact of expanded insurance coverage, including:
 - The Ryan White AIDS Drug Assistance Program (\$900 million total, the same as FY 2015) to provide life saving and extending medications to 212,107 individuals.
 - The Budget also ensures that the Ryan White program will continue its critical role in supporting patients across the HIV/AIDS continuum, by linking patients to care, improving adherence to antiretroviral medicine prescriptions, and achieving viral suppression.
 - HHS will encourage states to monitor for impacts from expanded insurance coverage to more efficiently deliver services to those in need through the Substance Prevention and Treatment Block Grant (same as FY 2015), the Mental Health Block Grant (same as FY 2015) and the Maternal and Child Health Block Grant (same as FY 2015).

(9) Request Allocation Priorities

Please identify your top three priorities in your budget request that this Subcommittee should focus on for FY 2016?

Response: CDC's request includes three high priority initiatives: Antibiotic Resistance (+\$264.3 million), Drug Overdose Prevention (+\$3.6 million), and Laboratory Safety and Quality (+\$30 million).

1. **Antibiotic resistance (AR)**—when bacteria do not respond to the drugs designed to kill them—threatens to return us to the time when simple infections were often fatal. Today, AR annually causes more than two million illnesses and 23,000 deaths in the United States. Tomorrow, if this trend continues, could be even worse.

The FY 2016 budget request for AR will invest in direct action to protect patients and communities, supporting the surveillance, prevention, and stewardship activities outlined in the Combating Antibiotic-Resistant Bacteria (CARB) National Strategy. The budget request establishes "Protect" programs in all 50 states and 10 large cities to scale up effective evidence-based interventions to help reduce inappropriate inpatient antibiotic use by 20%. CDC will also double the number of Emerging Infections Program sites focused on improving national estimates related to healthcare and community AR infections. CDC and its partners will implement proven interventions that reduce the emergence and spread of AR pathogens and that improve appropriate antibiotic use. With this request, CDC will work to prevent current AR threats as well as invest in discovering new interventions—including those based on the

microbiome (the totality of microorganisms and their collective genetic material present in or on the human body)—that could fundamentally alter how we understand and respond to antibiotic resistance and infectious diseases.

2. **Drug overdose** deaths have skyrocketed in the past decade, largely because of prescription opioids. Prescription Drug Overdose (PDO) death rates quadrupled since 1999, claiming more than 16,000 lives in 2013 alone. Overdose deaths are only part of the problem—for each death involving prescription opioids, hundreds of people abuse or misuse these drugs. Emergency department visits for prescription painkiller abuse or misuse have doubled in the past few years to nearly half a million. Prescription opioid-related overdoses cost an estimated \$20 billion in medical and work-loss costs each year. Equally important is the need to address the alarming rise in overdose death from illicit drugs such as heroin.

In FY 2016, CDC will build on state PDO prevention activities initiated in FY 2014–2015, including the PDO Prevention for States program launching this year. The FY 2016 budget requests an increase of \$48.0 million above the \$20.0 million provided in FY 2015 to enable expansion of the PDO Prevention for States program to fund all 50 states and Washington, D.C. for a truly comprehensive response to the national epidemic. CDC funding will scale up existing state Prescription Drug Monitoring Program (PDMP) programs to improve clinical decision-making and to inform implementation of insurance innovations and evaluation of state-level policies. In addition, the increased investment will support rigorous monitoring and evaluation and improvements in data quality, with an emphasis on delivering real-time mortality surveillance. CDC also will scale up activities to improve patient safety by bringing together health systems and health departments to develop and track pain management and opioid prescribing quality measures in states with the highest prescribing rates.

To help inform prescribing practices, CDC is developing guidelines for the prescribing of opioids for chronic pain. CDC's guidelines will include input from national experts, be responsive to the most recent scientific evidence, and will proceed through a development process carefully tailored to minimize any risk of conflicts of interest. These new guidelines will articulate best practices around opioid prescribing for chronic pain and make important advances in protecting patients. The audience for these guidelines will be primary care practitioners, who account for the greatest number of opioid prescriptions compared to other specialties. The process of developing these guidelines is comprehensive and CDC is working diligently to publish the guidelines in 2016.

The request also includes \$5.6 million to support CDC's efforts to address the troubling rise in overdose deaths from illicit opioids such as heroin.

3. The FY 2016 budget request includes an increase of \$30.0 million for laboratory capacity and safety, including CDC's Select Agent Program. This will enable CDC to maintain its ability to respond to outbreaks, determine unexplained illnesses, support state and local diagnostics, improve pathogen identification of emerging and re-emerging diseases, and maintain the world's most advanced, state-of-the-art infectious disease and environmental public health laboratories. CDC is committed to implementing changes identified in recent laboratory safety reviews needed to better protect staff and the CDC community and to safely execute critical diagnostic and research work essential to protecting Americans.

In 2014, CDC carefully reviewed laboratory practices and policies to develop recommendations for improvements in laboratory safety and quality. CDC identified a number of steps to improve quality and safety, including expanding implementation and enforcement of laboratory safety policies and quality systems across the agency's laboratories, as well as expanded training and education. Examples of improved training include post-doctoral fellowship training, dedicated hands-on CDC laboratory training space, and expanded distance learning. CDC's Select Agent Program, which regulates the possession, use, and transfer of potentially dangerous biological agents and toxins in the United States, would increase by 25% the number of annual inspections and unannounced visits for high-risk facilities.

(10) Strategic National Stockpile (SNS)

A. The Strategic National Stockpile holds various pharmaceuticals, antidotes, and other medical supplies. Please describe when you expect the current stockpile of antivirals to begin expiring.

Response: Although CDC employs all available strategies to maximize the value of the emergency medical countermeasures procured for the Strategic National Stockpile (SNS), a small portion of the products held in the SNS expires each month. To replace expiring products and maintain SNS capabilities to deploy appropriate medical countermeasures to state and local public health officials, CDC develops and implements strategic procurement plans to make the most effective use of available funds and address Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) priorities and requirements for the SNS.

CDC currently holds more than 62 million courses of antiviral drugs for use in an influenza pandemic. A significant amount of these antiviral drugs were procured for the SNS prior to the response to H1N1 Novel Pandemic Influenza in 2009 are reaching expiration starting in FY2015 and continuing over the next several years. CDC will pursue shelf life extension of these quantities of antiviral drugs where possible, but replacement of antiviral drugs is included in CDC's budget projections over the next 5 fiscal years.

The FY 2016 budget request includes an increase of \$36.7 million for the SNS, which will allow CDC to replace expiring medical countermeasures and maintain the current preparedness levels. Funds will also support other preparedness-related activities such as science and research, response and training operations, development and maintenance of state and local public health capabilities, and activities to strengthen collaboration between public health and healthcare.

B. Please describe CDC's plan with the annual estimated cost to replenishing the antiviral stockpile prior to its expiring?

Response: To sustain Strategic National Stockpile capabilities for Pandemic Influenza response, CDC is evaluating antiviral drug replenishment plans based on multiple factors including the amount needed, product shelf life, and cost. CDC has started to replenish some antiviral drugs based on these considerations, and will continue to sustain pandemic influenza response capabilities through efficient procurements in the coming fiscal years. Replenishment decisions made thus far have also included negotiations and discussions with the respective drug manufacturers.

As the replacement cost for expiring SNS assets is dependent on the amount of product expiring in a given year, the projections for antiviral replacement fluctuate from year to year. Based on current projections reflected in the PHEMCE Multi-year Budget, the FY15 replacement cost for expiring antiviral drugs is estimated at \$6.1M. The FY 2016 budget request includes an increase of \$36.7 million for the Strategic National Stockpile (SNS), which will allow CDC to replace expiring medical countermeasures and maintain the current preparedness levels. Funds will also support other preparedness related activities such as science and research, response and training operations, development and maintenance of state and local public health capabilities, and activities to strengthen collaboration between public health and healthcare.

C. Has CDC began negotiations with the current manufacturers of the antivirals that are in the supply now?

Response: Yes, replenishment decisions made thus far have included negotiations and discussions with the respective drug manufacturers.

D. Is there considerations being made to replace antivirals with generics?

Response: The currently available antiviral drugs for influenza are produced under exclusive patents in the United States. The exclusivity of the antiviral drug oseltamivir is scheduled to expire in the near future, and CDC is monitoring the situation to determine the impact of this pending shift to generic pricing on future procurement projections and strategies for the SNS.

E. Does CDC have the ability to continue to ShLEP (Shelf Life Extension Program) the current stock of antivirals? If so, what is the expectation of the length of extensions?

Response: CDC participates in the joint FDA/DoD Shelf Life Extension Program (SLEP) to extend the shelf life of eligible drug products held in the SNS. Each SNS product eligible for SLEP testing and possible extension by FDA is further evaluated to determine the cost effectiveness of testing and extension as opposed to direct replacement with new product.

Antiviral stockpiles of oseltamivir have been tested to support 10 years of product stability for capsules (through direct testing by the manufacturer and FDA outside of the SLEP program) and 4 years of product stability for suspension formulation. Products will be retained for this duration, and if possible, further tested for shelf life extension through the SLEP program. Oseltamivir capsules are eligible for SLEP after the initial 10-year product life, allowing up to an additional 6 years of storage contingent on three successful SLEP testing cycles for a total potential shelf life of 16 years.

Antiviral stockpiles of zanamivir have been tested to support 7 years of product shelf life. No additional testing past 7 years is planned for this product. Zanamivir is not eligible for SLEP. Product replenishment is currently underway for expiring inventory.

F. What is the cost to the government; and how much stockpile does CDC lose during ShLEP testing?

Response: The expiration dating of the influenza antiviral oseltamivir has been extended directly by the manufacturer and FDA outside of the joint FDA/DoD Shelf Life Extension Program (SLEP). If possible, additional cycles of SLEP testing will be performed for this product.

CDC, as a participant in the joint FDA/DoD Shelf Life Extension Program, provides FDA with a small sample of each lot of product to be tested, usually less than one case of product. CDC also provides funding from SNS appropriations to FDA to conduct the testing for each product, under an Economy Act arrangement. This funding to FDA for the cost of testing varies based on the type or product and the types of testing required. FDA is funded by CDC to cover the cost of testing, and the only net loss to the government is the small amount of product used in testing which is no longer available for deployment.

G. What is the total FY 2015 and FY 2016 projected amount of SNS stockpile replacement and how much is allocated in the FY 2015 provided level for SNS and projected out of the FY 2016 request for replacement of SNS items as compared to new or expanded purchases?

Response: To maintain accurate projections of SNS requirements and planned procurements, CDC conducts routine updates to the SNS Multi-year Budget to incorporate current inventory and pricing information, as well as any new requirements or recommendations from the PHEMCE governance process. These updates allow CDC to participate fully in the PHEMCE process by conducting timely, effective analysis of recommendations under PHEMCE consideration to identify the implementation costs and the overall increase or reduction in capabilities resulting from the proposed changes in requirements or procurement strategies.

CDC is currently completing an update to Multi-year Budget projections for the SNS. This update, scheduled to be completed at the end of May 2015, could result in significant changes to budget projections.

In FY15, CDC is expanding SNS capabilities through new purchases for personal protective equipment (PPE) appropriate for use in response to Ebola or other infectious diseases, as well as increasing the number of portable mechanical ventilators held in the SNS for use in pandemic influenza or other responses. These procurements to expand SNS capabilities, including the use of Ebola supplemental funds appropriated for additional PPE, are expected to account for approximately 5% of total product procurement costs in FY15, with the remaining 95% funding replacement of expiring product.

In FY16, CDC will implement PHEMCE recommendations from the 2013 SNS Annual Review to make specific increases to SNS capabilities while reducing procurement of other expiring products. The resulting projection results in approximately 4% of total product procurement costs in FY16 going to expansion of SNS capabilities, with the remaining 96% funding replacement of expiring products. The FY 2016 budget request includes an increase of \$36.7 million for the Strategic National Stockpile (SNS), which will allow CDC to replace expiring medical countermeasures and maintain the current preparedness levels. Funds will also support other preparedness related activities such as science and research, response and training operations, development and maintenance of state and local public health capabilities, and activities to strengthen collaboration between public health and healthcare.

(10) Dietary Guidelines

The statute authorizing the Dietary Guidelines mandates they be based on the “preponderance” of current scientific and medical knowledge. Some reviewers of the recently issued report of the Dietary Guidelines Advisory Committee (DGAC) suggest their recommendations to the Secretary

exceed the scope of the statute. Specifically, observers have alleged the DGAC's recommendations regarding "added" versus naturally occurring sugars, "high-caffeine drink consumption", animal proteins, and others either ignored established scientific studies, selectively cited to certain studies that may support policy conclusions, or both.

Given these underlying concerns, can you confirm that you will work with the Secretary to ensure the 2015 dietary guidelines are based on a preponderance of current scientific and medical knowledge as required by law?

Response: The U.S. Departments of Health and Human Services (HHS) and Agriculture (USDA) are in the process of developing the eighth edition of the Dietary Guidelines. The Departments are reviewing the "Scientific Report of the 2015 Dietary Guidelines Advisory Committee" along with comments from federal agencies and the public to develop the *Dietary Guidelines for Americans, 2015*. Nutrition science and policy experts from HHS and USDA write this policy document. It then undergoes external peer review, and review and clearance within the federal government prior to being approved and released by HHS and USDA Secretaries.

(11) Ebola Waste Management

According to HHS "Ebola treatment centers are staffed, equipped and have been assessed to have current capabilities, training and resources to care for a person with Ebola while minimizing risk to health care workers." We understand that more than half of these treatment centers do NOT have on-site waste treatment capabilities.

Further, we understand that Dr. Thomas Frieden, addressing a question on the Ebola funding for medical waste preparedness and how such waste should be treated stated "Funding will go to hospitals to strengthen their waste management systems. Where we are supporting hospitals to deal with Ebola, we would want that done onsite." (Source: Committee on Energy and Commerce, Subcommittee on Oversight & Investigations hearing on "Update on U.S. Public Health Response to Ebola Outbreak," United States House of Representatives on November 18, 2014)

- A. In order to "Assure Readiness of Ebola Treatment Centers and Assessment Hospitals," why isn't HHS or CDC requiring that such hospitals have the capacity to sterilize "all hospital waste used in the care of a patient with Ebola" via a high-volume autoclave? (per Dr. Frieden's statement)**

Response: Medical waste generated in the care of patients with known or suspected Ebola virus is subject to procedures set forth by local, state, and federal regulations. The Assistant Secretary for Preparedness and Response (ASPR) and the Centers for Disease Control and Prevention (CDC) have developed Ebola Medical Waste Management guidelines with input from the Department of Transportation (DOT), the Environmental Protection Agency (EPA), and the Occupational Safety and Health Administration (OSHA).ⁱ DOT oversees the transportation of waste; the EPA has delegated authority for regulating waste disposal to the states.ⁱⁱ CDC has issued guidance to hospitals and healthcare providers that care for patients under investigation (PUIs) for Ebola virus disease (EVD) or with confirmed cases of EVD to provide additional clarity on options for waste management practices to appropriately dispose of Ebola waste.ⁱⁱⁱ Ebola is susceptible to destruction with a number of physical and chemical agents, including but not limited to, a high-volume autoclave. Ebola-associated waste that

has been appropriately incinerated, autoclaved, or otherwise inactivated is not infectious, does not pose a health risk, and is no longer considered Category A Infectious Substance.

B. In addition, how is HHS ensuring that the [Ebola] supplemental funding is getting to the hospitals for capital and infrastructure readiness improvements, as opposed to funding a state level initiative or local reimbursement for money already spent?

Response: The funding provided through the Hospital Preparedness Program (HPP) Ebola Preparedness and Response Activities Funding Opportunity Announcement (FOA) is intended to ensure the nation's health care system is ready to safely and successfully identify, isolate, assess, transport, and treat patients with Ebola or patients under investigation for Ebola, and that it is well prepared for a future Ebola outbreak. As such, 90 percent of the funding provided for direct costs through the HPP Ebola FOA is intended for health care facilities and health care coalitions. HPP defines a healthcare coalition (HCC) as a formal collaboration among healthcare organizations and public and private sector partners that is organized to prepare for and respond to an emergency, mass casualty or catastrophic health event. Capital equipment and infrastructure readiness improvements are allowable uses of these funds; however, funds may only be used for minor alteration and renovation (A&R) activities. Construction and major A&R activities are not permitted.

Specifically, funding provided through Part A of the HPP Ebola funding opportunity is intended to enhance hospital physical infrastructure to ensure infection control for Ebola preparedness and response for state- and jurisdiction-based Ebola treatment centers and assessment hospitals, as necessary, including to:

- Reconfigure patient flow in the emergency department to provide isolation capacity for patients under investigation (PUI) for Ebola and other potentially infectious patients.
- Retrofit inpatient care areas for enhanced infection control (e.g., donning/doffing rooms).
- Establishing dedicated space and procuring separate equipment and supplies for clinical laboratories for Ebola.
- Ensure capability to handle Ebola-contaminated or other highly-contaminated infectious waste (e.g., through purchase or contract to use on-site a high-volume autoclave capable of sterilizing all hospital waste used in the care of a patient with Ebola, or by having a waste management facility within the state or jurisdiction willing and able to incinerate and dispose of Ebola waste, or by having a written agreement with another state willing and able to do so).

The infrastructure requirements to serve as a regional Ebola and other special pathogen treatment center are greater than those of state- and jurisdiction-based Ebola treatment centers and assessment hospitals, and include ensuring the capacity to handle Ebola-contaminated infectious waste. Funding provided through Part B of the HPP Ebola FOA is intended to ensure that the regional facility's infrastructure is ready and policies are established to accept an Ebola patient within eight hours of notification. The funding opportunity details these requirements, which include all of the same requirements for Part A listed above and include the following additional requirements:

- Ensure regional Ebola and other special pathogen treatment center capacity (beds and staff) to treat at least two Ebola patients at one time.
- Ensure respiratory isolation infectious disease capacity or negative pressure rooms (for at least ten patients, preferably, within the same unit).
- Ensure collaboration with a health care partner to provide pediatric Ebola care capabilities (if the regional Ebola and other special pathogen treatment center does not already possess these

capabilities). For example, this may be accomplished by bringing specialized equipment and staff (pre-trained and credentialed) to treat a pediatric patient within the regional Ebola and other special pathogen treatment center from a partner health facility.

- Ensure the ability to provide care to the normal flow of patients and assure normal patient care is not interrupted during the time in which an Ebola patient or patients are being cared for in the Ebola treatment unit.
- During periods without an Ebola patient, Ebola treatment units may have alternate day-to-day uses, such as for other patient care or for research and training purposes.
- Consider the potential for offering labor and delivery services for Ebola patients, and conducting other procedures.

Specifically, regarding waste management, on April 29, 2015, The White House, in collaboration with EPA, DOT, HHS and DOL, hosted a workshop to address the safe handling and disposal of medical waste secondary to the treatment of Ebola patients. The objectives of the workshop were to 1) identify key challenges and barriers that industry and state/local governments are encountering pertaining to managing medical waste from Ebola patients, and 2) identify actionable steps the federal government and stakeholders can take immediately and within existing authorities to address the challenges, identify existing gaps, and identify long term changes that would assist in improving the safe handling and disposal of Ebola medical waste (and waste from potential future similar events).

Over 60 representatives from health care delivery, labor, public safety, waste management, emergency management, and state/local governments participated in the half day workshop. The group identified and discussed several potential follow-up actions. While the need to focus on Ebola was the primary topic of discussion, attendees agreed with the need to have a plan that can address potential future large scale events involving biological or infectious substances in order for the nation to prevent and manage similar challenges.

C. We understand from the recent Ebola experience, the associated waste was very challenging, expensive, and hazardous (not only to frontline healthcare professions, but also support and janitorial staff) aspect of treating patients with such dangerous and infectious diseases. Thus, if one of the funding strategies is to "Assure Readiness of Ebola Treatment Centers and Assessment Hospitals" to treat not only Ebola, but other potentially deadly infectious exotics diseases, like those classified as Category A, MERS, SARS, and others, why is HHS allowing funding for the more expensive and dangerous off-site shipping of infectious waste while affordable 'high-volume' on-site autoclaves are available for facilities designated by CDC to treat patients with such diseases?

Response: The majority of healthcare facilities do not have the capacity to treat waste generated during the treatment of Ebola patients due to several regulatory and expense reasons including, but not limited to, the Clean Air Act and its amendments, the Medical Waste Tracking Act, and high costs.¹ A key challenge in the disposal of Ebola waste is the volume of waste that is generated during the care of an Ebola patient. EPA/Office of Solid Waste and Emergency Response has taken a leadership role in coordinating and addressing waste management challenges, working closely with CDC and DOT.

¹ An article that explains why most hospitals have abandoned in house waste treatment:

<http://www.wastemed.com/treatment.htm>

See also Rutala WA, Mayhall CG, and Society for healthcare Epidemiology of America. SHEA Position paper: Medical Waste. *ICHE* 1992; 13 (1): 38 – 48.

Garcia J. Effective cost-reduction strategies in the management of regulated medical waste. *AJIC* 1999;27(2): 165–175.

Through this collaboration, ASPR, CDC, and DOT developed a mechanism that allowed for the safe removal and legal transportation of contaminated medical waste from civilian health care facilities treating confirmed cases of Ebola.

This waste must be packaged and transported by haulers with special Category A Infectious Substance permits issued by the Department of Transportation (DOT). Most Category A Infectious Substances do not include medical waste from patients of a category A infectious agent. However, any wastes generated from the care of suspected or confirmed cases of exotic viruses (e.g. Ebola, Marburg, Lassa) are considered to be Category A Infectious Substances and should be packaged accordingly. Many of these exotic viruses are susceptible to a wide variety of physical and chemical processes. Ebola-associated waste that has been appropriately incinerated, autoclaved, or otherwise inactivated is not infectious, does not pose a health risk, and is no longer considered Category A Infectious Substance.

(12.1) In your budget request, you have \$68 million for prescription drug overdose, and this something, as you know from the questions, there is a lot of concern with, certainly a lot of concern by the chairman of the entire committee. In your professional opinion, how much would you really need to turn the tide on this kind of problem? (Cole from transcript)

Response: In CDC's professional judgment, an investment of \$300 million above the FY 2016 President's Budget Request is needed to achieve five milestones that are critical to reverse the prescription drug overdose (PDO) epidemic:

- 1) Equipping every state with the infrastructure and resources to combat the epidemic, including making Prescription Drug Monitoring Programs (PDMPs) more timely, easier to use, and able to communicate with the PDMPs of other states; implementing Medicaid or Worker's Compensation interventions to protect patients at risk; and advancing community-level prevention
- 2) Providing timely, accurate, and broadly accessible data to public health, health care, law enforcement, and other policymakers on the behavior of the epidemic
- 3) Addressing inappropriate prescribing by shifting how healthcare providers prescribe opioids
- 4) Promoting wide public awareness of the risks and limitations of opioids for the treatment of chronic pain outside the setting of end-of-life care
- 5) Supporting applied and evidence-based research to help inform and institute prevention programs

Realization of these five milestones would address the key drivers of the epidemic and sharply reduce the number of people losing their lives to prescription opioid addiction and overdose. This estimate represents the professional judgment estimates of CDC staff, and is provided without regard to the competing priorities that the agency, the President, and their advisers must consider as budget submissions to the Congress are developed.

Questions for the Record for Director Frieden from Rep. Rigell

- (1) Why are we continuing to see the rates of ADHD expand exponentially? Is this from better identification or is there a real ADHD problem in the United States? What is CDC doing to help?**

Response: Rates of diagnosed ADHD continue to rise in the U.S. In 2011, about 6.4 million U.S. school-aged children (11% of 4-17 year olds) were reported by their parents to have ever received a diagnosis of ADHD from a healthcare provider. This reflects an estimated increase of 2 million children diagnosed with ADHD, or 42%, in 2011 compared to 2003 with an average annual increase of approximately 5% per year. More information on these findings can be found at: <http://www.cdc.gov/ncbddd/adhd/features/key-findings-adhd72013.html>

Contributing factors to increasing rates of diagnosed ADHD may include:

- Increased developmental screening and other case findings initiatives, to identify and diagnose ADHD;
- Increased public awareness leading to increased clinical recognition and diagnosis; and/or
- Increased ADHD-associated risk factors resulting in a true increase in the actual number of ADHD cases.

To better understand the impact of ADHD and other mental and behavioral health conditions on children and families living with these conditions, CDC:

- Monitors children who have been diagnosed with ADHD through the use of national surveys and administrative claims data to learn more about the number of children with ADHD, their use of ADHD treatments, and the impact of ADHD on children and their families.
- Conducts community-based studies to better understand symptoms and impairments of children and compare these indicators of morbidity to rates of diagnosis in communities. For more information, visit Project to Learn about Youth (PLAY) (<http://www.cdc.gov/ncbddd/adhd/research.html>)
- Supports the National Resource Center on ADHD, a program of Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), which is a Public Health Practice and Resource Center. Their web site (<http://www.help4adhd.org/>) has information based on the best medical evidence about the care for people with ADHD and their families. The National Resource Center operates a call center with trained, bilingual staff to answer questions about ADHD. To learn more about CDC's work in ADHD visit: <http://www.cdc.gov/ncbddd/adhd/index.html>

- (2) There is currently a lot in the news about overmedication – is this a “real” epidemic of overmedicating, or are we just doing a better job of identifying kids and linking them to needed services (e.g. medication)? What is CDC’s role in addressing this issue?**

Response: Rates of medication use in ADHD have been increasing for decades. CDC recently reported on trends from 2007 to 2011 parent-reported data: the percentage of children 4-17 years of age taking medication for ADHD increased by 28% between 2007 and 2011, from 4.8% to 6.1%. This represents an average annual increase of about 7% per year. A full summary of this study can be found here: <http://www.cdc.gov/ncbddd/adhd/features/key-findings-adhd72013.html>.

CDC researchers have recently published findings, *Treatment of Attention-Deficit/Hyperactivity Disorder among Children with Special Health Care Needs*, on a national sample of children with special health care needs, ages 4-17 years, collected in 2009-2010, and how reported treatment aligns with current American Academy of Pediatrics (AAP) guidelines. Prior to the release of the 2011 guidelines, most children with ADHD received either medication treatment or behavioral therapy; however, many were not receiving treatment as outlined as best practice. Current AAP guidelines recommend that preschool aged children receive behavior therapy as the first-line treatment for ADHD. However, survey data indicated that only half of these young children with ADHD were receiving behavioral treatments and 1 in 4 were receiving medication alone. More recent data are needed to understand if the treatment patterns have become more aligned with the current medical practice guidelines. More information about this research can be found here: <http://www.cdc.gov/ncbddd/adhd/features/adhd-keyfindings-treatment-special-needs-children.html>

CDC currently is working to increase the availability, accessibility, and uptake of evidence-based behavioral interventions and policies to help health care providers, parents, educators, and states improve outcomes for children with ADHD.

(3) What promising strategies does CDC recommend to states or nationally to help correctly diagnose, treat, and follow up with children and families who are impacted by ADHD?

Response: CDC has worked closely with the American Academy of Pediatrics on the revision of their diagnosis and treatment guidelines for ADHD. Deciding if a child has ADHD is a multi-step process. No single test exists to diagnose ADHD; and many other problems like anxiety, depression, and certain types of learning disabilities can have similar symptoms. One step of the process involves having a medical exam, including hearing, vision, and sometimes laboratory tests, to rule out other problems that have symptoms like those of ADHD. Another step of the process includes collecting information from parents, teachers, and others who know the child well. This process should include a tool, such as a checklist, to collect ADHD symptoms from parents, teachers, and sometimes the child. More information about the criteria for diagnosing ADHD is here: <http://www.cdc.gov/ncbddd/adhd/diagnosis.html>

No single treatment is the answer for every child, and good treatment plans will include close monitoring, follow-ups and any changes needed along the way. In most cases, ADHD is best treated with a combination of medication and behavior therapy, however treatment recommendations vary by age. Current AAP guidelines recommend that for school-aged children (6-18 years of age) with ADHD, treatment include ADHD medication with or without behavioral therapy, with both medication and behavioral therapy as the preferred treatment. Behavioral therapy is recommended first for preschoolers (4-5 years of age) with ADHD. More information about treatment resources is here: <http://www.cdc.gov/ncbddd/adhd/treatment.html>.

(4) There is a recent initiative by CDC promoting behavioral therapy first before medication. Would you please describe why this is the case and how this would help the child/family?

Response: The AAP guidelines for treating ADHD state that behavior therapy should be used as first-line treatment for ADHD in preschool-aged children (ages 4-5). This recommendation was made because there are known health risks to ADHD medications, and we do not have sufficient information on the effects of ADHD medication on young children. We do know, however, that parent training is a

very effective. The Agency for Healthcare Research and Quality (AHRQ) has concluded that there is “high-strength evidence” that behavioral parent training (BPT) is efficacious for the treatment of ADHD and disruptive behavioral disorders among preschoolers and that BPT is more effective and has no adverse effects compared to methylphenidate alone. Our data indicate that more children would benefit from receiving behavioral therapy, particularly younger children; however, what works best for a child must be determined on a case-by-case basis.

We estimate that about 194,000 US children 2-5 years of age have an ADHD diagnosis, and our survey and claims data suggest that half of them are not receiving the recommended treatment. These data suggest that more could be done to ensure that children receive care consistent with AAP’s best practice guidelines. CDC’s National Center on Birth Defects and Developmental Disabilities (NCBDDD) currently has an initiative aiming to help better align current clinical practices with the AAP recommended best practices for the treatment of ADHD, and the strategies include working with partners to:

- Ensure that there is a sufficient number of trained clinicians to provide the recommended treatment and highlight best practices nationally;
- Evaluate existing policies and practices to identify potential models, such as preauthorization requirements for ADHD medication prescription to very young children and programs that support the provision of evidence-based behavioral therapies and intervention; and
- Collaborate with professional and family support groups to distribute the best information on ADHD diagnosis and treatment.

Questions for the Record for Dr. Thomas Frieden from Rep. Lowey

- (1) Million Hearts, a private-public partnership headed by CDC and CMS, is embarking on a lofty goal—to prevent 1 million heart attacks and strokes by 2017. How this initiative is improving clinical performance and the health of our Nation?**

Response: Million Hearts® is improving the nation's health by galvanizing a diverse group of stakeholders around key priorities that will prevent unnecessary death and suffering from heart attacks and strokes. Million Hearts® has been successful in improving health through clinical care by providing practical tools and resources for healthcare professionals and their patients to optimally manage their ABCS. [Appropriate Aspirin Therapy for those who need it, Blood Pressure Control, Cholesterol Management, and Smoking Cessation]

CDC has accelerated clinical performance improvement by recognizing high performers in hypertension control and widely disseminating the best practices. For example, in 2015 through the Million Hearts® Hypertension Control Challenge, CDC recognized health care providers in Germantown, Tennessee who are using electronic health records to alert them of gaps in patient care and to track patient progress. The providers are also educating patients about how to check blood pressure measurements properly when at home and asking them to bring these reports to follow up visits to discuss their results. These strategies have helped these providers in getting at least 73% or more of their patients with hypertension under control, which exceeds the Million Hearts' goal.

- (2) I am aware that the CDC recently changed the focus of the Interstitial Cystitis (IC) program from an education and awareness program to an epidemiology study. Why was the focus of the program changed? Did CDC consult with IC advocates to learn their views on what is most necessary from this program? Did CDC conduct research to ensure the new five-year IC epidemiology study is not duplicative of epidemiology studies at NIH or from the private sector? Does the CDC intend to continue funding education and outreach activities?**

Response: CDC focused the recently released funding opportunity, DP15-010 Interstitial Cystitis (IC), on public health research and epidemiological research to improve effective provider and public education, inform clinical best practices, and target interventions for groups at high risk for IC. The intent of this project is to improve the effectiveness of education and awareness activities by filling research gaps, including the incidence rate of interstitial cystitis; differences by race/ethnicity, socioeconomic status, or geographic region; estimates of healthcare utilization, diagnosis, and treatment in the US population; and work productivity, impairment/disability, or outcomes related to specific therapies. These research gaps will be identified in collaboration with a workgroup of expert IC partners, collaborators, and stakeholders.

CDC did consult with IC stakeholders and included a requirement in the FOA for education, outreach and dissemination activities. The FOA requires a detailed dissemination plan that describes how data and information collected will serve as a resource to key public health practitioners, academic researchers, governmental agencies, private organizations, and the public.

- (3) An estimated 1.4 million Americans suffer from inflammatory bowel disease (IBD), the collective term for Crohn's disease and Ulcerative colitis. The cause of IBD is unknown, which makes identifying prevention or a cure difficult. CDC, and in particular the IBD Epidemiology study, is making great progress on behalf of this patient community. Please provide the**

Committee with an update on the program's accomplishments regarding prevalence, incidence and contributing factors to disease onset.

Response: The IBD Epidemiology study is making progress towards determining prevalence and incidence of IBD. The study convened a multidisciplinary working group of experts to design a national IBD surveillance program. The results, published in February 2014, concluded that there is no cost-efficient means of creating a national IBD surveillance system in the US at less than \$1 million. CDC's funded partner, The Crohn's and Colitis Foundation of America, published results on 1) determining the impact of IBD on affected persons including body image dissatisfaction, menstruation and sexual function in women, male sexual function, fatigue and health-related quality of life, dietary behaviors in children with IBD; 2) identifying variables associated with IBD including serologic biomarkers, C. difficile infection, radiation exposure, corticosteroid utilization, bone density, and environmental risk factors; and 3) evaluating ways to improve treatment outcomes for people with IBD.

- (4) CDC recognizes community water fluoridation as 1 of 10 great public health achievements of the 20th century. I understand that CDC and HHS are in the process of issuing a final notice on the recommended level of fluoride in drinking water. What is the status of the final review process and when can the Committee expect a final announcement?**

Response: HHS released the final PHS recommendation for the optimal fluoride level in drinking water to prevent tooth decay on April 27, 2015 in Public Health Reports. It was also published in the Federal Register.

- (5) The CDC's Division of Oral Health is tasked with improving and reducing inequalities in oral health. Does the CDC use oral health burden as a primary factor in awarding oral health grants?**

Response: In 2015 the Division of Oral Health reassessed and revised their strategic priorities to assure a focus on the burden of oral health disease and disparities. To implement this priority, the Division has decided to direct resources toward surveillance, research and evidence-based interventions in populations that have the highest burden of oral disease. Future funding opportunities will reflect this new strategic direction.

Questions Submitted by Rep. Roybal-Allard

Antibiotic Resistance

The recent outbreaks in two Los Angeles hospitals of the CRE “superbug” (*carbapenem-resistant Enterobacteriaceae*) and the January case of a Hollywood resident with extensively drug-resistant tuberculosis, are just two of the many worrisome examples of what could become routine events if we do not address the issue of antibiotic-resistant bacteria in this country. So while I was encouraged that the President’s budget included \$264 million for CDC to implement an Antibiotic Resistance Solutions Initiative (ARSI), I am concerned that funding for CDC’s domestic TB program through the Division of TB Elimination has been cut back to the FY2005 level.

1. Is drug resistant TB included in the President’s Initiative to Combat Antibiotic Resistance?

Response: CDC’s FY 2016 CARB National Strategy includes critical near-term public health activities that will support progress to reduce the burden of drug-resistant TB in the United States:

- Expand the screening of immigrants and refugees from high burden TB countries to identify and prevent the spread of more susceptible and resistant TB cases
- Identify critical new interventions against multidrug-resistant TB that have the potential for cutting the costs of TB programs and preventing the development of active multidrug-resistant TB

These investments are consistent with activities outlined in the National Action Plan for Combating Antibiotic Resistant Bacteria and the CDC ARSI. Additional domestic and global activities to address drug-resistant TB will be provided in a companion action plan specific to TB under development and targeted for completion by fall 2015. The companion action plan will build on recommendations of the Federal TB Task Force as well the work of the interagency USG TB working group.

2. Do state and local public health departments have the resources they need to identify, diagnose, treat and prevent drug resistant TB?

Response: CDC currently funds all 50 states, 10 large cities, Washington DC, and eight territories, including Puerto Rico, the Virgin Islands, and the U.S. Asian and Pacific Islands for TB prevention, control and laboratory support. However, State and local resources to prevent, identify, diagnose, and treat multi-drug resistant TB vary tremendously across the country.

Current funding from CDC supports:

- Investigating and reporting every TB case
- Genotyping TB bacteria and testing for drug-resistance
- Ensuring provision of medical care, laboratory testing, and other services to achieve complete cure of TB patients
- Identifying contacts and providing treatment to prevent future TB cases

In addition, CDC’s FY 2016 Antibiotic Resistance Initiative would support:

- Expanded screening of immigrants and refugees from high burden TB countries to identify and prevent the spread of more susceptible and resistant TB cases.
- Rapid development of next generation rapid susceptibility tests for drug-resistant TB

- New interventions against multidrug-resistant TB that have the potential for cutting the costs of TB programs and preventing the development of active multidrug-resistant TB

The initiative will also provide states and communities with resources that will increase overall state and local capacity to prevent, identify, diagnose, and treat antibiotic resistant diseases, including but not specific to multi-drug resistant TB.

3. Can you describe how the CDC's ARSI Initiative will interface with other Federal efforts planned through the National Strategy for Combating Antibiotic-Resistant Bacteria (CARB)?

Response: The FY 2016 President's Budget request would support implementation of activities in National Action Plan for Combating Antibiotic Resistant Bacteria (\$264 million) which will build a robust network to improve detection for all of the AR threats outlined in CDC's AR Threat Report and protect patients and communities from all of these threats—saving lives, and reducing costs. CDC plans to award more than 85% of CARB funding to states, communities, healthcare providers, universities, and other groups to implement the National Strategy. CDC's surveillance, prevention, and stewardship activities under the initiative inform, complement, and reinforce the work of other federal agencies like NIH, FDA, CMS, AHRQ, USDA, and others that are part of the CARB National Strategy. The investments proposed under the FY 2016 President's Budget request, which nearly doubles the amount of Federal funding for combating and preventing antibiotic resistance to more than \$1.2 billion, to implement the National Action Plan for Combating Antibiotic Resistant Bacteria, which outlines steps for implementing the National Strategy on Combating Antibiotic-Resistant Bacteria and addressing the policy recommendations of the President's Council of Advisors on Science and Technology (PCAST) report on Combating Antibiotic Resistance. The AR Solutions Initiative is consistent with the CARB Strategy and National Action Plan.

4. Specifically how will this initiative improve our ability to respond to health threats like the CRE superbug and extensively drug-resistant tuberculosis?

Response: CDC's FY 2016 CARB National Strategy supports comprehensive tracking of AR infections, rapid detection, and faster outbreak response by leveraging existing detection programs and capabilities to:

- Expand and establish State AR Prevention ("Protect") Programs in 50 states and 10 large cities that will improve outbreak detection and control across healthcare facilities and in communities, scale up effective evidence-based interventions, and implement best practices for preventing AR infections and *Clostridium difficile* and improving antibiotic prescribing.
- Establish a "Detect" network of up to seven regional laboratories that will serve as a national resource to characterize emerging resistance and rapidly identify outbreaks of AR threats using state-of-the-art methods to characterize known resistance patterns in real time and identify clusters of resistant organisms more quickly. It will also track the spread of AR organisms in communities and through food to people. This will dramatically improve our understanding of which AR threats are most common in the United States, and which will be critical for new drug and diagnostic development. This network will also provide rapid analysis of local, state, and national-level resistance trends, and rapid dissemination of findings.

- As AR threats change, CDC will tailor the testing protocols of the labs to adapt to new and emerging threats. To ensure that key stakeholders are aware of current AR threats, CDC will establish an AR isolate library that will be accessible to pharmaceutical companies and researchers testing new antibiotic agents, and biotech and diagnostic companies designing the next generation of clinical tests.
- Expand the use of NHSN's Antibiotic Use and Antibiotic Resistance reporting options to track antibiotic use and AR infections to over 90 percent of eligible hospitals. These data allow hospitals to target prevention efforts and assess the quality of antibiotic prescribing to improve how antibiotics are used in U.S. healthcare facilities.
- Double from 10 to 20 the number of CDC's Emerging Infections Program (EIP) sites to expand population-based AR assessments and faster assessments of risk to specific populations in the community and in healthcare

5. How does ARSI aim to change the culture of antibiotic overuse in this country?

Response: The CARB National Strategy in alignment with ARSA will invest in direct action to protect patients and communities by implementing proven interventions that reduce emergence and spread of AR pathogens and improve appropriate antibiotic use. CDC's AR Solutions Initiative directly supports the CARB's national goals of reducing inappropriate inpatient antibiotic use by 20% and inappropriate outpatient antibiotic use by 50%. Specifically, the initiative supports stewardship activities to:

- Expand and establish State AR Prevention ("Protect") Programs in 50 states and 10 large cities that will improve outbreak detection and control across healthcare facilities and in communities, scale up effective evidence-based interventions, and implement best practices for preventing AR infections and *Clostridium difficile* and improving antibiotic prescribing. Inpatient stewardship actions will build on CDC's March 2014 Vital Signs release to ensure every hospital (and some other types of facilities, such as long-term care) has a stewardship program in place.
- Fully implement CDC activities targeting outpatient stewardship and reducing state variations in prescribing. Targeted funding to states where outpatient antibiotic use is highest will support development and implementation of new antibiotic stewardship interventions and refine Get Smart communications and partnerships to optimize reach to professional and private organizations, providers, and the public, helping to reduce inappropriate outpatient antibiotic use by 50%.

In addition, measurement of antibiotic use in hospitals is an integral part of efforts to reduce inappropriate use and stop unnecessary antibiotic exposure, which puts patients at risk of highly resistant infections and secondary complications such as *Clostridium difficile* infection. In support of the National Strategy on Combating Antibiotic-Resistant Bacteria, CDC will use its National Healthcare Safety Network (NHSN) infrastructure to assess the quality of antibiotic prescribing to improve how antibiotics are used in U.S. healthcare facilities. The FY 2016 President's Budget request would extend the use of NHSN's Antibiotic Use reporting option in all 50 states and Antibiotic Resistance reporting option in more than 750 facilities. These data will be used to guide local and regional efforts to reduce resistance and provide national benchmarks to compare antibiotic use.

National Institute for Occupational Safety and Health (NIOSH), Education and Research Centers (ERCs) and the Agriculture, Forestry and Fishing Program (AFF)

As the primary federal agency responsible for conducting research and making recommendations for the prevention of work-related illness and injury, NIOSH understands that all occupations can be made safer through research, education and training, and provides national and world leadership to avert workplace illness, injury, disability, and death. By gathering information, conducting scientific research, and translating this knowledge into products, services and programs like the Education and Research Centers (ERCs) and the Agriculture, Forestry and Fishing Program (AFF), NIOSH is able to support programs in every state and meet the needs of the American work force, to improve the health and safety of workers.

(1) Does your FY16 budget request for NIOSH include sufficient funding to reduce the disparities in occupational health for the most hazardous industries (e.g. agriculture, fishing, construction) and vulnerable workers (e.g. immigrants, contingent)? Please explain why.

Response: The FY 2016 Budget request includes funding for the NIOSH Construction Program, which will be used to improve workplace practices and address emerging issues within vulnerable populations. The FY 2016 Budget request eliminates funding for the National Occupational Research Agenda Agriculture, Forestry, and Fishing (AgFF) sector. Although this program has made positive contributions, given the relation to CDC's mission and the ability to have a national impact on improved outcomes, the AgFF has been proposed for elimination in a limited-resource environment.

In FY 2016, NIOSH will continue to focus on eliminating occupational diseases, injuries, and fatalities among vulnerable working populations in the Construction sector. NIOSH recently collaborated with the American Society for Safety Engineers (ASSE) to produce a co-branded report on the need to address overlapping occupational safety and health vulnerabilities among Latino immigrants working in small construction businesses. This report includes a survey of the academic literature on occupational safety and health for Latino immigrants, small businesses, and young workers in the construction industry, and provides recommendations for outreach activities to address the occupational safety and health training needs of workers that fit into these overlapping categories of vulnerability. It is anticipated that this report will launch an outreach campaign to provide occupational safety and health training to Latino immigrants and small employers in construction. In addition, NIOSH and its partners are also re-launched the National Campaign to Prevent Falls in Construction and will continue working with state-based grantees on outreach materials and ways to collaborate with local organizations and universities to train Hispanic workers in small residential construction companies on fall protection.

(2) Given the evolving climate change concerns, in what innovative ways will the CDC continue to support NIOSH to better understand how the development of nanotechnology and monitoring will impact occupational and public health, farmworker health and protection issues?

Response: NIOSH is using an interdisciplinary approach to determine occupational safety and health issues, identify gaps in worker protection, and make recommendations for worker safety and health improvement in regard to climate change. A number of worker populations, both indoors and outdoors, may be particularly vulnerable to threats from climate change. Some of these workers may include: emergency responders, health care workers, fire fighters, utility workers, farmers, and transportation workers. Climate change can amplify existing health and safety issues and new unanticipated hazards may emerge. Workers may also be exposed to conditions that the general public can elect to avoid, and

workforce increases are likely in jobs that are most affected by climate change (e.g., wildland firefighting), as well as in industries that will emerge in response to it (e.g., renewable energy). For worker populations such as migrant workers and day laborers who may have inadequate housing or other social and economic constraints, the health effects of climate change may be additive from exposures both at work and at home.

NIOSH efforts to study the potential effects of climate change in agriculture have focused mainly on particular exposures that are expected to increase, such as heat-related illness, zoonotic diseases, and valley fever. Several currently-funded projects are studying best practices for preventing heat-related illness and barriers and facilitators to implementing best practices in agricultural operations, including socio-cultural barriers.

In addition to the emerging issue of climate change, NIOSH is also continuing to focus on nanotechnology and its effects on the safety and health of workers. NIOSH will continue to provide national and international leadership on evaluating and controlling worker exposure to nanoparticles and nanomaterials. NIOSH has developed guidance on engineering controls and safe practices for handling engineered nanomaterials in research laboratories and developing partnerships with private companies to evaluate manufacturing process controls. NIOSH will continue to conduct research in this growing field as critical issues related to worker surveillance, predictive hazard assessment, and risk management still need to be addressed.

- (3) Given the projected rapid retirement of baby boomers currently in health and safety positions, how will your budget support NIOSH ERCs to train the next generation of these professionals who are in short supply and sought after by businesses and public health agencies across the nation?**

Response: The FY 2016 Budget request eliminates funding for Education and Research Centers (ERCs). Originally created almost 40 years ago, the ERC program has addressed the limited number of academic programs focusing on industrial hygiene, occupational health nursing, occupational medicine, and occupational safety. The ERCs' reach and impact have grown substantially across the nation since the program's inception, increasing awareness of the importance of coursework specializing in these areas. Although the budget does not include funding for the federal portion of these grants, CDC will continue to provide scientific and programmatic expertise to the ERCs as requested.

- (4) What role do the NIOSH ERCs and Agricultural Research Centers play in translating research into applications that can rapidly detect and address both known and emerging health and safety risks for the civilian American workforce and the armed services?**

Response: The ERCs and Agricultural Research Centers both play an important role in translating research and technologies into highly effective prevention practices and products. In addition to direct training outcomes as measured by graduates, the ERCs play a significant role regionally and nationally in translating and implementing the best science into actual practices in the workplace. The ERCs are expected to undertake projects that have a focus on this translation and to significantly impact the practitioner environment in a measurable way.

A key component of the Agricultural Research Centers is to develop and implement model educational outreach, control technologies, and intervention programs promoting agricultural health and safety for agricultural workers and their families. For example, the Northeast Center for Occupational Health and

Safety (NEC) Agricultural Research Center has created an outreach program aimed to develop engineering solutions to make equipment and vessel design safer and to make these engineering solutions readily and widely available to fishermen. Projects focus on a variety of fisheries, including lobster fishermen in the northeast, Vietnamese shrimpers on the Gulf Coast, and the distant water tuna fleet.

- (5) How will your budget support NIOSH's efforts to better understand how work contributes to the development of chronic diseases like ischemic heart disease, diabetes, and chronic obstructive pulmonary disease?**

Response: NIOSH will continue to build upon the decade-long research arising from the NIOSH Total Worker Health™ program, which funds 4 academic Centers of Excellence to Promote a Healthier Workforce. These Centers study the intersection of work and health, and make recommendations for integrated approaches to safeguarding workers on the job. These 4 academic Centers (Harvard, University of Iowa, UMass-Lowell/University of Conn, and Oregon Health Sciences University) specifically examine the impact work has on the overall health and well-being of workers—both on and off the job. Today it is apparent that the nature and conditions of work are strong determinants and important modifiers of many chronic disease outcomes – from lung disease and cancer to depression, obesity and diabetes. The program is dedicated to creating interventions, trainings and workable solutions that employers of all sizes can implement to both safeguard workers and promote their overall health and well-being. The NIOSH Total Worker Health™ program believes that high-quality work can add years of quality life to our population through integrated workplace safety and health interventions.

- (6) How will your budget support NIOSH's efforts to address the occupational health and safety needs of the new 21st century workforce, particularly for the older workforce and for populations that lack job security, retirement benefits, work as independent contractors, part-time or for multiple employers ?**

Response: NIOSH's National Center for Productive Aging and Work was created in 2015 to specifically address the needs of the modern American workforce, particularly aging workers. Today's workers also face changing employment patterns and shifts in healthcare, workers compensation, and other benefits creating threats to workplace safety and limits to comprehensive healthcare and retirement security. The Center acknowledges these challenges and is dedicated to researching these risk factors to better understand how they impact workplace health, productive aging and the economic productivity of all our workplaces, large and small. The Center seeks to protect and improve the workers across the working life span – from entry as a young new worker to retirement, and often the work that follows after. Additional areas of research for the new Aging Center include examining the health and well-being effects on older workers who lack job security, those who are employed as contractors or work part-time, and those who need to extend their working careers involuntarily because they are financially unable to retire. The Center will also assist employers in crafting workable solutions that address the physical, emotional, economic, and other health challenges common to older workers.

Blood Lead Levels in Children

In 2011, the number of children in California with confirmed Blood Lead Level (BLL) >10 µg/dL was 1,156. Based on new science indicating there is no safe BLL, the CDC's Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) recommended that the term "level of concern" be replaced with an upper reference interval set at the 97.5th percentile with a BLL of 5

µg/dL. Under this new reference level (BLL $\geq$ 5 µg/dL), the new number of confirmed cases in California spiked to 16,641 children; and 535,000 U.S. children aged 1–5 years were estimated to have BLLs $\geq$ 5 µg/dL.

Given the new CDC reference level (BLL $\geq$ 5 µg/dL), how will the CDC support states that now have to address significantly more children with unsafe blood lead levels?

Response: No safe blood lead level in children has been identified, and millions of children are still being exposed to lead in their homes. CDC's Childhood Lead Poisoning Prevention program is helping reduce the number of children exposed to lead which will help reduce healthcare costs and improve academic achievement and later life success for at-risk children.

CDC's Childhood Lead Poisoning Prevention Program helps prevent childhood lead exposure through:

- Surveillance - CDC surveillance data trigger actions to protect children from lead exposure and to serve children who have already been lead poisoned.
 - These data are used by CDC, health departments, and other agencies to target limited resources to the highest risk children and to track incidence and risk factors.
 - For example, HUD uses CDC lead surveillance data to identify rental housing properties that have led to multiple children being lead poisoned. HUD, EPA and DOJ then use the CDC data to target their enforcement actions.
- National expertise, guidance and recommendations.
- Collaboration with federal agencies including HUD, CMS, CPSC, and HRSA.
- Resuming the funding of lead poisoning prevention programs and staff in state or local health departments (funding to states and locals was eliminated due to budget cuts in FY 2012 and FY 2013).

In 2014, CDC funded 35 state and local health agencies to support increased surveillance for confirmed blood lead levels. By increasing their surveillance, public health agencies can target specific and focused interventions for children with elevated blood lead levels $\geq$ 5µg/dL. Although California did not apply for a statewide program, Los Angeles County competed successfully for funds. Thirty percent of the elevated blood lead level cases in California reside in LA County. Lead poisoning prevention and surveillance in the county are supported through a \$304,672 agreement with Impact Assessment, Inc., an applied human-environmental research firm that partners with the county health department.

Awards for other evidence-based interventions may be included in future cooperative agreements. Additionally, CDC continues to work with EPA, HUD, and other partners to support and publicize on-going research, implementation and other "best practice" work in elevated blood lead level interventions for children under 5 years old.

Sleep Disorders

In the United States, it is currently estimated that about 50-70 million people suffer from a sleep disorder and consequently insufficient sleep. Insufficient sleep poses a problem in cognitive functioning, performance, and the ability to drive/operate machinery.

1. **Could you please provide us with an update on what the CDC National Healthy Sleep Awareness Project has been able to accomplish to date regarding public awareness of the importance of healthy sleep and the promotion of treatment and prevention of sleep disorders?**

Response: CDC's National Healthy Sleep Awareness Project is focusing on four priority areas: epidemiology and surveillance; partnership and collaboration; strategic communication; and provider education. Accomplishments include:

- CDC's funded partner, The American Academy of Sleep Medicine (ASFM) convened a surveillance workgroup to develop a Behavioral Risk Factor Surveillance System (BRFSS) survey module for 2016 to fill gaps in the surveillance of Healthy People sleep health objectives, particularly for obstructive sleep apnea. The project also identified and recruited 8 partner organizations, including patient advocacy groups, vital for increasing public awareness about general sleep health and obstructive sleep apnea.
- Five sleep health statements were developed on adult sleep duration, child sleep duration, teen sleep duration and school start times, and insomnia in children.
- In February 2015, an expert consensus conference defined the appropriate adult range of sleep duration and the official statement will be released June 2015.
- The project is developing and implementing a multi-faceted public awareness campaign to support Healthy People 2020 sleep health objectives. Six partner organizations are promoting the campaign messages resulting in more than 460 million impressions through print, online and broadcast media.
- Provider education efforts have refined a strategy to target primary care providers such as family practitioners with an assessment tool to assist them in screening for sleep disorders such as obstructive sleep apnea before referral to a sleep specialist. Plans are ongoing for developing online learning modules for educating primary care providers.

2. Can you speak to how effective the project has been in accomplishing the Healthy People 2020 goals for sleep?

Response: All National Healthy Sleep Awareness Project activities fully support one or more of the Healthy People 2020 Sleep Health objectives for: 1) treatment of obstructive sleep apnea; 2) reduce vehicular accidents related to drowsy driving; 3) increase sufficient sleep in high school students; and 4) increase sufficient sleep in adults. The four focus areas detailed in question one work together to advance these HP 2020 goals for sleep. CDC is the middle of year two of a five year funding cycle for these activities and looks forward to continue sharing progress on accomplishments.

Viral Hepatitis

An estimated 3.5-5.3 million Americans live with chronic viral hepatitis – including nearly 453,000 people with hepatitis C (HCV) in California when adjusted for groups excluded in the National Health and Nutrition Examination Survey (NHANES). However, between 65%-75% of these people are unaware of their status. After years of mostly stagnant funding at the CDC's Division of Viral Hepatitis (DVH), it was encouraging to see a proposed increase of \$31.5 million in the President's FY2016 budget request. However, if appropriated, the total DVH budget would be \$62.8million – far less than the \$170.3 million amount the CDC estimated it would need in 2010 to adequately address the viral hepatitis epidemics in the United States.

1. Please tell us more about how the proposed funding would support the Division's response to the hepatitis B (HBV) and hepatitis C (HCV) epidemics?

Response: To address the epidemics of hepatitis B and hepatitis C, efforts are needed to stop disease transmission and to prevent viral hepatitis-related illness and death. CDC has requested an increase of \$31.5 million to:

- Expand adoption of CDC/US Preventive Services Task Force recommendations for hepatitis B and hepatitis C testing and linkage to care by health systems and providers to prevent disease and premature death;
- Develop monitoring systems and prevention strategies to stop the emerging hepatitis C epidemic among young persons and others at risk;
- Enhance vaccination-based strategies to eliminate mother-to-child transmission of hepatitis B; and
- Strengthen state and local capacity to detect new infections, implement prevention activities, provide feedback to providers for quality improvement, and track progress toward prevention goals.

CDC will partner with state and local health departments, universities, medical centers, community-based organizations, and others to achieve prevention priorities, placing the nation on a path toward the elimination of hepatitis B and hepatitis C. CDC will continue to collaborate with the World Health Organization and other partners to advance viral hepatitis epidemiology, prevention, control, and laboratory diagnostics globally.

CDC's primary goal is to assure all hepatitis C infected persons are aware of their status, receive counseling to prevent transmission and protect their liver from further damage, and get referred for appropriate medical care and treatment. CDC estimates that of the approximately 3 million people living with hepatitis C, about 800,000 people already diagnosed with hepatitis C meet 'high' or 'highest' priority for treatment, according to the treatment guidance issued by American Association for the Study of Liver Diseases, Infectious Disease Society of American, and International Antiviral Society-USA. However, many hepatitis C-infected persons have not even received the most basic care, including an assessment of their infection, the health of their liver, and whether they would benefit from treatment.

The increase in funding will allow CDC to expand efforts and reach more people with needed prevention, care and treatment. This expansion would build on current activities to improve the HCV testing, care, treatment, and cure of HCV infected persons (also known as the continuum of care). The CDC-funded community-based programs to Test and Cure Hepatitis C are strengthening health-care capacity to diagnose and cure hepatitis C infection among those most impacted by hepatitis C infection. Key stakeholders—including health departments, primary-care providers, and hepatitis C treatment specialists—have formed a coalition to develop and implement these services. These projects were designed to test at least 10,000 people; increase primary-care provider capacity to diagnose and cure hepatitis C infection; use evaluation data to demonstrate the community impact; and, test, diagnosis, and cure more people unaware of the hepatitis C infection.

Additionally, the increase will enable CDC to improve hepatitis B prevention in multiple ways, including strengthening surveillance and monitoring to better identify communities in need; using data to target and evaluate prevention services for hepatitis B; implementing culturally-appropriate education and outreach to reduce these health disparities; increasing the number of community-based testing and linkage to care projects; and advancing efforts to eliminate perinatal transmission of hepatitis B.

For example, the community-based test and care projects will improve the capacity of health-care providers serving persons born in countries where hepatitis B infection is common. This is especially important for hepatitis B-infected pregnant women who, without proper medical services, can easily pass the virus to their infant.

2. How would funding be used to more accurately estimate the prevalence both hepatitis B and C, two very different disease states?

Response: CDC would use part of the requested increase to assure every state has core surveillance capacity to estimate the burden of viral hepatitis in their jurisdiction and to identify emerging routes of transmission; currently, CDC supports seven jurisdictions for this work to inform prevention planning and evaluation. The current capacity for data collection, analysis, and reporting results in underreporting and variable data quality. For example, a variety of factors affect state and local capacity to conduct adequate surveillance and monitoring:

- The sheer number of persons tested and reported with viral hepatitis;
- Lack of methods and equipment to gather electronic data from laboratories and other health systems;
- Capacity of laboratories to conduct recommended testing for viral hepatitis ;
- Availability of health department staff to investigate reported cases;
- Availability of health department staff to analyze data and release to providers and the public; and
- Capacity of system to maintain ongoing surveillance efforts

In addition, CDC would supplement data from state and local health departments with electronic health data from commercial laboratories and other health systems to estimate the burden of disease, monitor trends in screening and provider practices, and to share data with state and local health departments for prevention planning at the local level.

3. How would funding support a nationally coordinated surveillance initiative and strengthen state and local capacity to do surveillance?

Response: Surveillance data help both CDC and state and local health departments track disease, document the health effects, and inform prevention activities and policies. CDC is evolving from a standalone national viral hepatitis surveillance “system” based only on hepatitis case data reported to health departments to a comprehensive system that collects data from multiple sources. With the requested increase, CDC plans to strengthen the monitoring of viral hepatitis transmission and disease and quality of prevention services; for example, by assuring all states have surveillance systems that can monitor cases of acute (new) and chronic hepatitis C (16 states in 2013). As mentioned previously, several factors affect state and local capacity to conduct adequate surveillance and monitoring:

- Requirements placed upon local public health departments;
- Capacity of labs and sophistication of available equipment;
- Availability of health department staff to follow up on reported cases; and
- Capacity of system to maintain ongoing surveillance efforts.

With increased funding, CDC will strengthen state-level surveillance to have reliable data from all 50 states. States will increase capacity to detect new infections and outbreaks, identify health disparities,

and assess the implementation and impact of CDC recommendations for vaccination, testing, and linkage to care to prevent disease, disability, and death.

Incidence in Youth (under 30 years old)

According to the CDC, since 2010 there has been a 75 percent increase in new cases of HCV, as reported in 35 of the 41 states. These new cases have primarily been concentrated among those under age 30 and seemingly in close correlation to the prescription painkiller and heroin epidemics impacting communities all across the country.

4. How would an increase in funding be used to stop the spread of new HCV cases among our youth?

Response: CDC considers the spread of HCV among youth an urgent health problem for the nation. This epidemic of HCV transmission is primarily from injection of prescription opioids or heroin. To address this epidemic, CDC is working to improve detection of spread among young persons; to understand risk behaviors, drug use patterns, and networks of injection drug users; and, to develop and implement an integrated approach to providing screening, diagnosis, care, treatment, and prevention of HCV.

As part of the proposed budget increase of \$31 million, CDC will invest to strengthen the capacity to detect new HCV infections across the nation. CDC will direct additional surveillance and prevention capacity to the ten states reporting the largest increases in new HCV cases. The enhanced projects will support HCV education and testing in clinical settings providing services for high-risk populations (e.g., emergency departments, rural community health centers, and primary care providers treating drug addiction) to assure HCV- infected persons and their contacts are linked to clinical preventive services. To eliminate the risk of mother-child transmission, the identification of HCV-infected women of child bearing age will be a particular focus.

CDC will also work with partner federal agencies that oversee drug treatment and correctional services to better promote the adoption of HCV education, testing, and prevention. The results of these various activities will guide the development of model community-based projects to eliminate HCV transmission and disease. The integration of HCV treatment with early HCV testing and other prevention services raises the possibility of dramatically reducing and ultimately eliminating HCV transmission.

CDC will also work with partner federal agencies that support drug treatment and correctional services to better promote the adoption of HCV education, testing, and prevention.

Syringe Services/Exchange Programs

Your budget request seeks to modify the federal funding ban on syringe exchange programs, which have a proven role in reducing HIV and hepatitis c (HCV) infections, preventing overdose deaths through education and naloxone distribution, and linking people to drug treatment programs.

As many people – especially youth under 30 – transition from prescription opioid use to injecting drugs, we are observing increasing rates of heroin use across the country, accompanied by an astounding 75% increase in new HCV infections between 2010 and 2012.

It is concerning that a rise in new HIV infections in this population may soon follow.

- 5. In light of your Opioid Initiative and proposed increase in CDC funding to address the hepatitis C epidemic among persons who inject drugs, would you speak to your vision of the role of syringe exchange in confronting America's opioid challenges?**

Response: CDC recommends a comprehensive approach to preventing drug-related HIV and hepatitis transmission, including strategies to prevent and treat substance abuse itself, as well as a range of proven tools to reduce sexual and drug-related risk among those who have not yet stop injecting.

Studies continue to show that comprehensive syringe service programs (SSPs) can reduce the risk of HIV and HCV infection, and do not result in negative consequences such as increases in injection frequency, in injection drug use, or in unsafe disposal of syringes in the community. A recent study from Bramson et al. published on January 15, 2015 in the *Journal of Public Health Policy* (Vol. 36, 2, 212-230) found that, in the states examined where public funding for SSPs was provided, estimated HIV incidence remained low over time or decreased.

Syringe service programs are one of many tools communities have found effective in reducing the spread of HIV and HCV among persons who inject drugs -- by not only providing risk reduction counseling and access to sterile injection equipment, but also providing links to substance abuse treatment, HIV and HCV testing, and other needed prevention and treatment services. CDC's recommendations for Health Departments can be viewed in the April 24, 2015 Health Alert Network message <http://emergency.cdc.gov/han/han00377.asp>.

Due to the current statutory ban, funding from the Departments of Labor, Health, and Human Services, and Education, and Related Agencies Appropriations bills cannot be used for SSPs. States and localities, however, may use other available sources of funding to support such programs, consistent with state and local law. While CDC considers access to sterile injection equipment to be an important part of comprehensive prevention programs for those who are actively injecting drugs, state and local communities ultimately decide how best to provide access as part of their prevention efforts.

Viral Hepatitis Prevention Coordinators

Viral Hepatitis Prevention Coordinators at health departments currently receive less than \$1 in federal funding for every person living with viral hepatitis in the United States. This lack of resources presents a real challenge in their efforts to coordinate an effective, adequate response to the viral hepatitis epidemic(s) in their jurisdiction.

- 6. Should the proposed budget increase be appropriated, how would HHS ensure that state and local agencies receive adequate resources to address hepatitis within their jurisdictions?**

Response: CDC currently provides limited resources to support a Viral Hepatitis Prevention Coordinator in 48 states and 5 major cities. At the present time, funding levels provide for the full or

partial salaries of a dedicated staff person; their activities depend on access to state and local resources. With the proposed budget increase, CDC intends to expand support to states so they can develop comprehensive viral hepatitis prevention plans, establish prevention goals and program performance measures, and implement the plans. The funds will enable the Viral Hepatitis Prevention Coordinators to bring together technical expertise and strategic data from public health surveillance and other sources to identify communities largely affected by viral hepatitis, expand access to and increase the delivery of prevention services in affected communities, monitor standard performance measures, and feedback results to providers and health systems to improve the quality of prevention services.

Perinatal Hepatitis B

It is alarming to note that, in the United States, we still see between 800-1000 cases of perinatal (mother-to-child) transmission of HBV annually. Given our success in essentially eliminating perinatal transmission of HIV in the United States, we know eliminating perinatal transmission of HBV is also possible and we have the tools to do so.

7. How will HHS agencies work together to better address the gaps in maternal health, particularly as it relates to the elimination of HBV perinatal transmission?

Response: CDC supports public health programs to provide case management services to ensure hepatitis B-infected mothers and their infants receive screening and necessary follow-up, including that the infants receive their first dose of vaccine within 12 hours of birth, complete the remaining doses of the vaccine series, and receive post-vaccination testing to ensure they are protected against hepatitis B and are not infected. CDC is currently collaborating with NIH to evaluate the efficacy of treating hepatitis B-infected mothers with antivirals to reduce the risk of mother-to-child transmission. With increased funding, CDC will support improved identification and comprehensive case management of infants born to hepatitis-B infected mothers, as well as linkage to care for the mothers and their infected contacts. CDC will also expand prevention studies and issue updated evidence-based guidelines to prevent mother-to-child transmission of hepatitis B through the collaborations with NIH and other HHS agencies. These guidelines will inform maternal and newborn child health practices, including those in primary care clinics supported by HRSA. Data collected through HRSA-supported clinics could be used to monitor progress toward eliminating perinatal HBV transmission. In addition, HHS agencies will work together to better understand why the U.S. is not identifying all infants born to hepatitis B-infected women and why infants born to hepatitis B-infected mothers are not receiving post-vaccination testing.

Racial and Ethnic Disparities

The viral hepatitis epidemics are particularly alarming given the rising rates of new infections and high rates of chronic infection among disproportionately impacted racial and ethnic populations. American Indian/Alaska Native communities have the highest incidence rates of HCV among all races and ethnicities. Also, HCV is twice as prevalent among African Americans as among Caucasians, and African American and Latino patients are less likely to be tested for HCV in the presence of a known risk factor, less likely to be referred to treatment for subspecialty care and treatment, and less likely to receive antiviral treatment. Additionally, Asian Americans comprise more than half of the known population living with HBV in the United States and, consequently, have the highest rate of liver cancer among all ethnic groups. These statistics document a dramatic public health inequity.

8. How do you plan on ensuring that funding is dedicated towards reducing transmission of hepatitis B and addressing the HBV-related population disparities?

Response: To address hepatitis B as a health disparity for Asian-Americans and other communities, CDC currently supports implementation of CDC and U.S. Preventive Services Task Force (USPSTF) recommendations for HBV testing by providers to increase the identification of foreign-born persons living with hepatitis B and link HBV infected persons to care. Key activities include screening and case finding activities; culturally appropriate community outreach, patient navigation, and other support services; training of primary care staff to enhance screening, management, and referral practices; and implementation of activities to increase community and health professional awareness of hepatitis B. The requested increase will enable CDC to improve HBV prevention in multiple ways, including strengthening surveillance and monitoring to better identify communities in need; using data to target and evaluate prevention services for HBV; implementing culturally appropriate education and outreach to reduce these health disparities; increasing the number of community-based testing and linkage to care projects; and, advancing efforts to eliminate perinatal transmission of HBV.

For example, the community-based test and care projects will improve the capacity of health-care providers serving persons born in countries where HBV infection is common. There is a tremendous health disparity among ethnic populations in the U.S., with certain AI/PI populations comprising 5% of the U.S. population, but 50% of the HBV infection. The test and care projects are designed to identify persons with chronic HBV and link them to high-quality, medical care. This is especially important for HBV-infected pregnant women who, without proper medical services, can easily pass the virus to their infant.

The knowledge gained from these programs would be used to develop additional collaborations with public health programs, private health systems, and community-based organizations to promote and guide adoption of CDC and USPSTF recommendations.

Section 317 Immunization Program and Report

The President's Budget requests a \$50 million cut to the CDC's Section 317 Immunization Program, which monitors the safety of vaccines, educates providers, performs community outreach, and conducts surveillance, laboratory testing and epidemiology to respond to disease outbreaks. It also provides a safety net to uninsured, low-income adults for vaccine purchases. It supports our vaccine infrastructure and the purchase of vaccines among other things.

1. How are health departments using these funds to modernize their immunization systems, and how would a cut to the program be implemented?

Response: The discretionary immunization funding supports the nation's immunization infrastructure at the federal, state and local levels and provides a flexible supply of vaccine to vaccinate uninsured adults and respond to outbreaks. This public health infrastructure provides the foundation for efforts to reduce all vaccine-preventable diseases (VPDs). It is made up of public health experts and systems that promote all routinely recommended vaccines across the lifespan; fosters convenient access for all to recommended vaccinations; provides a safety net for those who cannot otherwise access immunization services; oversees vaccine distribution and management, including vaccine shortages; provides quality assurance to ensure vaccines are properly stored and handled; monitors vaccine coverage and evaluates the safety and effectiveness of vaccines and vaccine policies; develops scientifically based

communication and health education materials to support providers and inform the general public; prevents disease outbreaks and responds early and rapidly should they occur; and prepares to respond quickly and comprehensively to other urgent vaccine emergencies, such as pandemics.

Through the Affordable Care Act, non-grandfathered private health plans are now required to cover recommended immunizations without cost-sharing, which has expanded access to this important service. Therefore, the Budget proposes less funding for the 317 immunization program to reflect coverage expansions that reduce the CDC resources needed for vaccine purchase, while providing the infrastructure and program support to maintain record high immunization rates.

The majority of the reduction to the 317 program reflects reduced vaccine purchase. The Budget also maintains funding to recruit and educate networks of immunization providers; provide continual quality assurance; promote public awareness of new and expanded vaccine recommendations; manage vaccine shortages; and respond to vaccine-preventable disease outbreaks. Since 2009, CDC has invested funding to expand the capacity of public health departments to bill health insurers for immunization services in order to expand access for fully-insured individuals in areas where there is not adequate in-network provider coverage.

CDC made investments in Immunization Information Systems (IIS) that inform and support clinical decision-making and allow interfacing with electronic health records (EHRs) and vaccine ordering systems through a competitive process that provided funds to 56 of the 64 immunization awardees. This helped more than 95 percent of these 56 CDC awardees to reach full compliance with Health Level Seven (HL7) messaging standards for immunization data transactions.

In addition, the Budget increases funding for the Vaccines for Children program, a mandatory program that helps families access vaccines. The investment in the Vaccines for Children Program, taken together with CDC's discretionary 317 activities and coverage expansions through the Affordable Care Act, will provide vaccines and the program support to reach uninsured and underinsured populations.

CDC will work collaboratively with its awardees and partners to establish access points at complementary venues such as schools, pharmacies, and retail-based clinics; expand the network of Vaccines for Children providers through recruitment efforts; purchase and deliver vaccine for at-risk populations; and ensure those with insurance have access to immunization services through an in-network provider.

2. What can public health, the healthcare system, state legislatures and Congress do to ensure all adults receive necessary vaccines?

Response: We know that to reach adults we will need different strategies than we have used with the childhood program. Unlike children who have scheduled routine visits with their pediatrician, adults may see multiple physicians and other healthcare providers for specialty care, many of whom do not offer vaccination services. CDC is working to increase awareness of the need for vaccines for adults among the general population and the provider community. We are also looking at increasing access through non-traditional venues, including pharmacies and retail clinics. CDC has developed new educational materials aimed at increasing the public's awareness about vaccines that adults need. Additionally, CDC partners with a wide range of vaccine providers, including medical, pharmacy and nursing organizations, and state and local health departments to increase awareness of the low rates of adult immunization and to increase implementation of the standards of adult immunization practice.

These standards include assessing adult patients' vaccination needs on a routine basis, recommending needed vaccines, and then either offering vaccines, or if the provider does not stock the vaccine, referring the patient to a vaccine provider in their area. Providers and patients are both able to find vaccine providers in their areas through use of the healthmap.org website. Patients can also take the CDC vaccine quiz to find out which vaccines might be right for them. Taking the quiz generates a list of vaccines a person might need based on their age, medical conditions, prior vaccinations and other factors. Patients can then take this list to their provider to discuss which vaccines they need. The quiz can be accessed at <http://www.cdc.gov/vaccines/adults/index.html>.

3. How will this budget cut impact states abilities to address vaccine hesitancy and under-immunization among adolescents and adults?

Response: CDC knows that maintaining public confidence in immunizations is critical to preventing declines in vaccination coverage rates and outbreaks of vaccine-preventable diseases. CDC supports science-based communication campaigns and other efforts to convey the benefits of vaccines to aid parents in making informed vaccine decisions to protect their children. CDC developed and will maintain a dynamic provider toolkit for conversations with parents about vaccination that includes evidence-based strategies, print materials, and web-based tools: <http://www.cdc.gov/vaccines/hcp/patient-ed/conversations/>.

As seen in the 2015 multistate measles outbreak, the lack of awareness among many adults and their health care providers about recommended vaccines and insufficient data on adult vaccination status in many immunization registries are barriers to improving adult vaccination rates, and ultimately contribute to disease outbreaks. CDC supports the immunization workforce and systems at the local and state levels that assess immunization coverage, identify pockets of under-immunization, and target efforts to reduce barriers to vaccination. This includes building partnerships with complementary venues to provide adolescent and adult vaccines, strengthening public health systems to monitor vaccination status among adolescents and adults, and improving awareness among the public and health care providers about the vaccines recommended for adolescents and adults.

The Immunization Program is responsible for providing federally purchased vaccines to protect uninsured Americans from preventable diseases—and thus protect communities from the dangers of low vaccination rates. CDC estimates that, although it is expected these populations will begin to decrease as implementation of expanded health insurance coverage provisions begin, there will continue to be a need for discretionary vaccines to serve uninsured adults and to provide rapid vaccination response to disease outbreaks and other urgent public health needs. It will be important to maintain a safety net for immunization services. The discretionary Immunization Program is also critical because, unlike the federal VFC Program which has very specific eligibility requirements, discretionary Immunization Program vaccine can be used to vaccinate non-VFC-eligible populations, such as adults or the fully-insured, in a public health emergency.

The majority of the proposed budget cut will be a decrease to the amount of funding available to purchase vaccine, however, CDC will be able to maintain some vaccine purchase funding for these purposes.

For each of the last 6 years, the Congress has included language directing the CDC to submit to Congress an annual Professional Judgment Budget on the funding level required to fully implement the Section 317 immunization program. For fiscal year 2014, the report indicated

CDC would need \$963.4 million to fully implement the functions of the Section 317 immunization program. Included in this is a section which said, "with increased resources, CDC would be able to enhance its web presence and make information available in more formats for more audiences (mobile-ready and Spanish web content), increase the number of public awareness campaigns and partnership activities to raise awareness of vaccine-preventable diseases... and CDC would also be able to conduct additional research to assess public knowledge, attitudes, and beliefs, and as a result, develop, test, and evaluate broad-based and targeted resources, tools and messages." This research is critical to ensure that immunization communications efforts are culturally appropriate and target the right audience.

4. Unfortunately, we have not seen this required CDC report since the 2014 report was sent in 2013. What is the status of the 2015 report?

Response: The Department of Health and Human Services and CDC apologize for the delay in the transmittal of the 2015 report. It was sent to Congress on March 17, 2015.

5. The 2016 report, which was due to this committee 52 days ago, has also not been received. When can we expect to see that report?

Response: The FY 2016 Immunization Report to Congress is under development and we are working diligently to provide this report as soon as possible.

Scaling Evidence-Based Programs

The CDC has been instrumental in establishing appropriate partnerships and identifying innovative mechanisms to scale-up evidence-based programs. Programs such as the National Diabetes Prevention Program, the EnhanceFitness for Arthritis Management Program and the Older Adult Falls Prevention Program help improve quality of life and ensure that individuals are able to enjoy safer and healthier lives while controlling healthcare costs.

1. In what ways is the CDC working with Medicare and/or Medicaid to ensure the sustainability of the evidence-based programs mentioned?

Response: CDC is collaborating with the Centers for Medicare and Medicaid Services on the State Innovation Models and Health Care Innovation Awards programs by providing subject matter expertise and/or project management support. These collaborations across HHS agencies will help to identify and spread innovations in order to improve health care quality while also reducing unnecessary costs. Some specific examples of these collaborations include:

The CDC Arthritis Program, in collaboration with the Self-Management Alliance (<http://selfmanagementalliance.org/>), works with CMS to review the literature on the cost-effectiveness of self-management education programs for those with one or more chronic disease. The CDC Arthritis Program is also working with the Y of the USA to support an expanded dissemination of EnhanceFitness, with the ultimate goal of national dissemination.

CMS-funded demonstration projects currently in progress to inform Medicare and Medicaid reimbursement for the National Diabetes Prevention Program (National DPP) lifestyle change program, which is a critical step toward increasing access. These include:

- CMS Health Care Innovation Awards (HCIA) - Under this project, the Y-USA has been funded to work with 17 local Ys delivering the YMCA's Diabetes Prevention Program (Y-DPP) in 8 states (AZ, DE, FL, IN, MN, NY, OH, TX). Their aim is to enroll 10,000 Medicare beneficiaries with prediabetes in the Y-DPP; the projected cost savings beyond the 3-year grant program is \$4,273,807.
- CMS Medicaid Incentives for the Prevention of Chronic Disease—Five states (HI, MN, MT, NV, NY) awarded funds under this 5-year project are testing the effectiveness of providing incentives to Medicaid beneficiaries to increase participation in the National DPP.

More broadly, CDC is working through CDC funded projects such as the *State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health (1305)* to support collaborations between State Health Departments and their State Medicaid counterparts to support the need for National DPP coverage for Medicaid beneficiaries with prediabetes or at high risk for type 2 diabetes. For example, Montana is providing Medicaid coverage for the National DPP's lifestyle change program, while other states like Washington are working with their Medicaid program on demonstration pilots to make the case for future coverage.

With regard to interventions specific to the clinical setting, CDC is in the initial stages of discussion with CMS regarding the development of innovative payment models to provide reimbursement for falls assessment, screening, medication review and referral to evidence-based programs. Recently, CDC updated two resources for evidence-based programs:

- 1) CDC Compendium of Effective Fall Interventions: What works for Community-Dwelling for Older Adults. This collection of effective fall interventions is designed to help public health practitioners, senior service providers, clinicians, and others who want to address older adult falls in their community.
- 2) Preventing Falls: A Guide to Implementing Effective Community-Based Fall Prevention Programs. This "how-to" guide is designed for community-based organizations who are interested in implementing their own evidence-based fall prevention programs.

Additionally, as part of our work on reducing prescription drug overdoses, CDC's new major state prevention program, *PDO Prevention for States*, will support states to create broad, multi-sector prevention programs, including implementing Medicaid interventions for preventing prescription drug misuse and overdose. This builds on CDC's existing work in states, which includes supporting the creation of an opioid medication management program in West Virginia's Medicaid program, as well as linking Medicaid and prescription drug monitoring program data in Oklahoma. CDC also works to provide technical assistance to state Medicaid programs to share insights and new developments on the most promising interventions.

CDC provides direct assistance in managing population health components of CMS State Innovation Model (SIM) awards and Health Care Innovation Awards (HCIA); both of these awards are testing new models of payment and delivery of health care, with a goal of sustainable improvements in health and health care and reduction in health care costs.

2. What data is the CDC tracking that could be leveraged to demonstrate a sustainable return on investment so that more payers (including CMS) can maintain and prioritize these evidence-based programs?

Response: CDC is actively working to demonstrate a sustainable return on investment to support the adoption of strategies by health care payers including Medicaid. Some examples of CDC's work include:

- CDC's Arthritis Program is working with the Prevention Research Center at the University of North Carolina, Chapel Hill to examine the effectiveness of a chronic disease self-management education program (CDSMP) on work-related outcomes (such as absenteeism, preventing disability, and remaining employed). In addition, CDC collects the following (select) Chronic Disease Indicators (CDI) to help inform and prioritize evidence-based programs:
 - Arthritis among adults who have diabetes
 - Adults with arthritis who have taken a class to learn how to manage arthritis symptoms
 - Adults with diabetes who have taken a class to learn how to manage diabetes symptom
 - Fair or poor self-rated health among adults
 - Recent activity limitations among adults
 - Recent physically unhealthy days among adults
- The National DPP is a one-year, evidence-based lifestyle change program that reduces one's risk of type 2 diabetes by 58 percent and results in significant cost savings. As of April 30, 2015, there are 621 CDC-recognized organizations in the U.S. Of those, 26 are offering the lifestyle change program both on-line and in-person, 4 of which are offering the program exclusively on-line and covering a large geographic area of the U.S. To further support adoption of the program by payers, CDC is working with a contractor (RTI) to develop a toolkit to calculate the potential 5 and 10-year health and economic impacts of implementing the National DPP or similar diabetes prevention programs. The toolkit will include modules for three different audiences: 1. State public health module 2. Health insurance module and 3. Employer module to enable groups to estimate potential cost benefits.
- CDC continually collects data on the national burden of non-fatal fall-related injuries and the national and state burden of fatal falls. CDC is also working with external partners to identify and collect data to track clinical fall prevention efforts and health outcomes. These data will be used to evaluate the success of CDC's fall prevention program and eventually used to inform a return on investment analyses.
- Clinical Screening & Management:
 - CDC is working with state health department partners who are implementing Stopping Elderly Accidents, Deaths and Injuries (STEADI) in New York and Oregon in electronic health records to track the number of fall screenings, provider-conducted assessments, and subsequent falls and fall injuries.
 - CDC is working with the Office of the National Coordinator for Health IT (ONC) to determine effectiveness of incentive program data (e.g., meaningful use and

Physician Quality Reporting System) for tracking fall screening and management in clinical settings.

- Cost:
 - CDC is exploring the use of CMS claims data to track common fall-related injuries and associated costs.
 - CDC is working with data from the Medicare Current Beneficiary Survey to update cost of falls estimates.

Prescription Drug Abuse and Overdose

Your budget request includes a substantial increase in CDC's prescription drug abuse initiative, and the agency appears in large part to be enhancing Prescription Drug Monitoring Programs- or PDMPs- around the country. PDMPs are clearly an important tool in the fight against opioid abuse, but they are only one tool. If a doctor refuses to issue a prescription to a patient based on the information received from a PDMP, due to suspected abuse, we have clearly succeeded for the moment. But that is not the end of the picture.

What happens to the patient identified by the PDMP system? Does any intervention, screening, or referral take place?

Response: PDMP practices vary considerably by state, depending on the specific authorities and capacities of each state's program. Prescribers may learn about a patient's inappropriate controlled substance use from a PDMP in multiple ways. Prescribers may learn about the patient's history through a discretionary check of the PDMP record; they may be required by state law to consult the PDMP prior to writing a controlled substance prescription; or they may receive an automated, proactive report from the PDMP alerting them of suspicious activity by a patient (called "proactive reporting").

CDC is not aware of any states that require specific interventions, screening, or treatment referrals after a PDMP identifies a patient suspected of abuse. CDC is aware, however, of changes that providers in certain states have made based on information obtained from a PDMP. For instance, when Kentucky required that prescribers use a PDMP prior to prescribing some controlled substances, PDMP use increased sharply, and so did prescriptions for buprenorphine, a drug used to treat opioid dependence. Buprenorphine prescriptions increased nearly 90 percent after providers were required to use the PDMP, suggesting that consulting the PDMP resulted in increased efforts to treat opioid dependence. New York State, which passed a mandated use requirement similar to Kentucky's, also saw a 14 percent increase in buprenorphine prescriptions following the requirement.

Based on a 2014 PDMP survey administered by the Brandeis PDMP Center of Excellence, 24 states report engaging in proactive reporting to providers. Some states send letters to prescribers when one of their patients is suspected of misusing or diverting controlled substances. These letters can advise providers about next steps they can take for their patients (e.g., MA, LA, and WA), including increased screening, brief intervention, establishment of a patient treatment agreement, or referrals to specialists or substance abuse treatment.

In addition to CDC's work relating to PDMPs, to help inform prescribing practices, CDC is developing guidelines for the prescribing of opioids for chronic pain. CDC's guidelines will include input from national experts, be responsive to the most recent scientific evidence, and will proceed through a development process carefully tailored to minimize any risk of conflicts of interest. These new

guidelines will articulate best practices around opioid prescribing for chronic pain and make important advances in protecting patients. The audience for these guidelines will be primary care practitioners, who account for the greatest number of opioid prescriptions compared to other specialties. The process of developing these guidelines is comprehensive and CDC is working diligently to publish the guidelines in 2016.

ⁱ <http://www.hhs.gov/asl/testify/2014/11/t20141119c.html>

ⁱⁱ Matt Arduino, <http://www.epa.gov/waste/nonhaz/industrial/medical/programs.htm>

ⁱⁱⁱ <http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/waste-management.html>

TUESDAY, APRIL 14, 2015.

EARLY EDUCATION PANEL

WITNESSES

**WALTER S. GILLIAM, PH.D., DIRECTOR, THE EDWARD ZIGLER CENTER,
YALE SCHOOL OF MEDICINE**

**DIANA MENDLEY RAUNER, PRESIDENT, OUNCE OF PREVENTION
FUND**

DEBRA ANDERSEN, EXECUTIVE DIRECTOR, SMART START OKLAHOMA.

Mr. COLE. Okay. Good morning. We will go ahead and get started. But before we do, I would be remiss not to point out a previous chairman of this subcommittee who is in the audience, my good friend, Mr. Rehberg. So good to see you, Denny. And then he has already told me, he always started on time.

Ms. DELAURO. With or without me.

Mr. COLE. Well, that is what he said. That was actually part of the plot, as I understand it, but anyway. Anyway, good to have you here, my friend.

Good morning. My pleasure to welcome our witnesses today to the Subcommittee on Labor, HHS, and Education to discuss early childhood education. We are looking forward to hearing your testimonies.

Research shows that quality early childhood education improves children's school readiness. Evaluations of Head Start, State pre-K programs, and model early childhood programs have shown positive impacts on cognitive skills for children entering kindergarten through the early elementary years. While the research is limited, there is some evidence of long-term positive academic, economic, and social outcomes for some very high-quality programs. These impacts are greatest among children from low-income families, suggesting the potential for early childhood education programs to help close the achievement gap for disadvantaged children.

The availability of early childhood education programs has expanded in recent years, largely lead by the States. Currently, 40 States and the District of Columbia have at least one publicly-funded State preschool program. About 70 percent of 4-year-olds are enrolled in preschool, including 40 percent in publicly-funded programs. About 50 percent of 3-year-olds are in early-learning programs, and about 14 percent enrolled in publicly-funded programs. However, the quality of these programs varies widely.

The Federal Government has a significant investment in some of these efforts. Head Start program enrolls nearly 1 million children from low-income families. The Department of Education provides early intervention services for children with disabilities under age 5. More recently, the Department of Education has begun to award competitive grants to States to establish or expand universal preschool programs for children from low- and moderate-income fami-

lies. It is critical that we look closely at the results of our Federal investment so that we can make wise choices moving forward about how to maximize the effectiveness of limited taxpayer resources in this area.

Today, we look forward to hearing from our witnesses about what works in early childhood education and what barriers exist to providing quality programs for children. We hope to learn more about how we can improve and better target our Federal investment of funds in this area to help children who can most benefit from these services to receive them.

Today, I am pleased to welcome the following witnesses: Debra Andersen is the executive director of Smart Start Oklahoma and the Oklahoma Partnership for School Readiness Foundations. Smart Start Oklahoma is dedicated to improving early childhood policies that support all children being prepared when they enter school. Prior to joining Smart Start, Ms. Andersen was employed by the Oklahoma State Department of Health, providing State-level leadership for child guidance programs. Ms. Andersen has extensive experience in providing services to young children with communication delays, program planning, and administration, and community coalition building.

Walter Gilliam is the director of the Edward Zigler Center in child development and social policy, and associate professor of child psychiatry and psychology at the Child Study Center, Yale School of Medicine. He is on the Board of Directors of the National Association of Child Care Resource and Referral Agencies, and is a fellow ZERO TO THREE and the National Institute for Early Education Research.

Dr. Gilliam's research involves early childhood education and intervention policy analysis, ways to improve the quality of pre-kindergarten and child care services, the impact of early childhood education programs on children's school readiness, and effective methods for reducing classroom behavior problems and reducing the incidents of preschool expulsion. We may need you for Congress consultation on that.

Diane Rauner is the president of the Ounce of Prevention Fund, a public/private partnership dedicated to advancing program and policy efforts to prepare children for success in school and later in life, among many other initiatives. In partnership with the Buffett Early Childhood Fund, and other national philanthropies, the Ounce has built the Educare Learning Network from one birth-to-five school on the south side of Chicago to a growing network of schools across the country, and launched the First Five Years Fund, a Federally-focused advocacy and communication effort. Ms. Rauner is also the First Lady of Illinois.

I look forward to all of your testimonies.

And now, I would like to go to my distinguished ranking member, the gentlelady from Connecticut, for whatever remarks she would care to make.

Ms. DELAURO. Thank you very much, Mr. Chairman, and I join you in welcoming our colleague, Denny Rehberg. And it is wonderful to see you, we had the opportunity to be the bipartisan Baby Caucus with its focus on infants and toddlers, which was established several years ago, where we did forums that dealt specifi-

cally with early childhood education and some of the issues that we will discuss today about the effect of abuse and neglect and violence against youngsters and what that means. So welcome. It is great to see you.

I also want to say hello to Eleanor Patton, who is with ZERO TO THREE, who has done an outstanding job in that organization, and with its focus on our babies.

And to Katrina, Cat McDonald, who, Mr. Chairman, was a legislative director for me a number of years ago, and now she is with the First Five Years Fund, which was one of the projects announced of prevention funds. So an audience today singularly focused on how we make a difference in the lives of our young people.

I might say, Ms. Andersen, I was speaking to our colleague, Lloyd Doggett, yesterday, and I am telling about this because Libby, his wife, is at HHS and she has talked so highly of the programs that you are engaged and involved in.

So I want to say a thank you to our witnesses, because the work that you do on the front lines of early childhood development is not just critical for our kids, but it is about the future of our country. The Zigler Center carries on the legacy of the father of Head Start, Professor Ed Zigler, who I am proud to count as a mentor, a constituent, and a friend. And we had the opportunity to honor him just a week or so ago.

Ounce of Prevention has pioneered comprehensive early childhood education, including Educare and home visiting, and we know what that means.

And Smart Start Oklahoma has helped to position its State as an acknowledged leader in early childhood programs. So happy to have the opportunity for your views. And it is fitting that we are able to do so in the 50th anniversary year of Head Start.

The chairman mentioned we are here to talk about the importance of early childhood development, the role that government can play in delivering high-quality programs to young children and their families. We will consider the investment made through three crucial Federal programs: The Child Care and Development Block Grant, which helps working parents balance jobs with family life; preschool development grants helps States make strides toward universal pre-K; and Head Start brings together all of the services that matter most to young children and to their families: Education, health, emotional wellbeing, nutrition, social services and more.

Although it is a mandatory program, and therefore not funded under this committee's bill, I would like to mention the maternal, infant, and early childhood home visiting program, which is one of the topics we addressed at the Baby Caucus. This is a program that does an outstanding job of improving the health of at-risk children and their parents. There is a growing momentum of evidence that early childhood interventions like these work. They reduce inequality. They narrow achievement gaps. Economically, they represent an excellent return on investment. We have Nobel laureate Economist James Heckman and former Federal Reserve Chairman Ben Bernanke agreeing on this effort.

Children who benefit from these programs are healthier, less likely to need special education services, to be held back a grade

or to get in trouble with the law. They are more likely to go to college and to have professional careers.

A quick example: I recently spoke at the gala that honored Head Start and Ed Zigler as the father of Head Start. And Professor Zigler at the gala was reunited with an anesthesiologist, Dr. John Paul Kim, who had treated him at Yale-New Haven Hospital. It turned out that Dr. Kim was himself a Head Start alumnus. His parents had been refugees from Cambodia, and he credited his success in life directly to Head Start. Needless to say, he was excited to meet the father of the program even though applying the anesthetic to his hero was a little bit nerve wracking as he described.

So it is not an exaggeration to say that among the kids who are enrolled in early childhood programs are tomorrow's doctors, the scientists, the engineers, the teachers, political leaders. As Professor Zigler himself has put it and I quote, "If every child is a national resource, then every child's welfare is a national responsibility." And I would add, it is a national priority. There is simply no better way to spend our health and education dollars than to fund early childhood development, which is why these programs have long enjoyed support from both sides of the aisle. As I know, as I said from the bipartisan Congressional Baby Caucus, where we do try to keep members up to date on the latest research and information.

Overall, the programs have fared relatively well in recent years. Since 2010, we have grown Head Start's budget by nearly \$1,400,000,000, or 19 percent. Although unfortunately, inflation has swallowed more than half of that increase. Similarly, we have increased the Child Care and Development Block Grant by \$308,000,000, which is \$125,000,000 in real terms. And of course, we have created in funding the preschool development grants and not to be self-serving, but I was very excited to be a part of that effort in developing these development grants.

And in fairness, compared to the ongoing cuts that are devastating other priorities that are funded by this committee, this is good news, and it reflects widespread bipartisan agreement about the importance of early childhood education and development. But the measure of how much we need to invest is now how little we are investing in other areas. That is not the issue. It is the level of need for each program. And there are a lot of disadvantaged children who are not receiving the support that they need in order for them to thrive and succeed.

Dr. Gilliam notes in his testimony, our investment in infants and toddlers has failed to keep pace with population over the past 10 years. Head Start reaches only 41 percent of eligible 3- and 4-year-olds. Less than 1 quarter of low-income families have access to Federally-subsidized child care. As a Nation, we are lagging behind key competitors. We rank 26th in preschool participation among 4-year-olds, 24th among 3-year-olds, and 21st in investment in early childhood interventions relative to the wealth of our country, and while the emerging powerhouses, like China and India, are committing massive increases in their own investments in this area.

The President's budget request is a step in the right direction. A proposal of 18-percent increase for Head Start, 15-percent increase for Child Care and Development Block Grant, and addi-

tional \$500,000,000 for preschool development grants. This is good news for our country. I hope that, given the overwhelming evidence in favor of these programs, we will be able to meet the commitments that the President has proposed. If we are serious about making early childhood programs available to all needy children and maintaining our competitive edge on a global stage, we must be willing to fund even bigger investments.

Thank you all for being here. And many thanks to you, Mr. Chairman.

Mr. COLE. Thank you. So if I plus up this program enough, you will vote for the bill?

Ms. DELAURO. We will take that under advisement, Mr. Chairman.

Mr. COLE. Very good. Very good.

Ms. DELAURO. But it is a good start. It is a good start.

Mr. COLE. Okay. Well, you know, you look for the little clues you can find. Well, it is genuinely good to have all of you here today. And, again, as the ranking member pointed out, this is an area that has brought people together rather than divided them, and so we appreciate that very much. We will deal with each of you in succession.

Ms. Andersen, you are recognized first. Your full statement will be placed in the record, and you are recognized for 5 minutes for whatever comments you care to make.

Ms. ANDERSEN. Well, thank you Chairman Cole, Ranking Member DeLauro, and members of the committee for this invitation to discuss early childhood education in Oklahoma and how Oklahoma and the Federal Government can work together to improve the quality and the availability of early childhood programs.

Oklahoma is fortunate to have had leaders in our State who have long recognized that in order to achieve economic prosperity we must begin with our youngest citizens. During the late 1990s, long before these conversations began at the Federal level so rigorously, simultaneous efforts occurred to pioneer universal pre-kindergarten, State-wide home visiting programs, and quality child care rating systems. Oklahoma is a model for today's Federal early childhood agenda, and we believe strongly in a continuum of services that are needed to be in place to best support the needs of our young children.

Your committee is considering appropriations on early childhood education and care to increase the Child Care and Development Block Grant in order to improve the quality and safety of infant and toddler care and to expand Head Start. In Oklahoma, infants, toddlers, and 3-year-olds comprise 44 percent of all children receiving child care assistance and represent the majority of children who participate in year-round, full-day care in our State.

In 1998, Oklahoma was the first to implement a State-wide quality rating and improvement system. Child care centers and homes that meet the highest quality levels are reimbursed at higher rates. Quality is important, and it is expensive. Effective quality standards need to be identified to ensure the investment in quality yields positive outcomes for children. The Federal Government can support States such as Oklahoma to identify outcomes for children

who participate in high-quality programs and provide adequate funding to provide support to implement high-quality standards.

Pre-kindergarten programs in Oklahoma are considered a grade in the public school system and are allocated funds based on the State Aid Formula. I believe that is a little different than how a lot of States implement their pre-K programs. In fiscal year 2014, the \$313,000,000 that were allocated for pre-kindergarten programs were funded through 47 percent State, 41 percent local, and 12 percent Federal funds. Increases in Title I and Special Education that are being considered by this committee can help support Oklahoma in improving high-quality pre-kindergarten programs due to the nature of our funding.

Oklahoma did not apply for the preschool development grant; however, Federal supports to States for preschool programs in the form of block grants could improve our ability to reach more at-risk 3- and 4-year-olds that may not be participating in universal pre-kindergarten programs in our States. Expanded partnerships are being explored currently in our State between public schools, child care, and Head Start programs. The recent reauthorization of the Child Care and Development Block Grant also creates opportunities for greater flexibility in Oklahoma to expand these partnerships.

Early childhood in Oklahoma represents an array of services provided throughout a child's early years. Here is an example of two children in Oklahoma who are completing their first year of kindergarten, and these are very real examples of differences in experiences that our young children are participating in: Both were born to single mothers who had not completed high school.

The first child's mother received home-visiting services ensuring adequate, prenatal care and delivered a healthy baby. Because this mother received coaching on providing positive parenting skills, the baby was talked to, read to, and mother and child developed a strong attachment. While this mother completed high school and job training, her child was cared for in a safe environment by well-trained providers with opportunities for play and development. The child received regular health and developmental screenings.

At age 4, this child was enrolled in a pre-kindergarten program. She was healthy and ready to participate. Upon kindergarten entry, she was prepared, eager, and excited to begin school.

The second child's mother did not receive adequate prenatal care or support, and her baby was born prematurely. This mother returned to a minimum wage job 2 weeks after her baby was born. She struggled with depression and worked long hours. Her baby was fussy and lagged behind on developmental milestones. This child stayed at a neighbor's apartment while her mother worked. This mother's job made it difficult to get her child to a preschool program, and she lacked information about what programs were available. When this child enters kindergarten, she is scared, withdrawn, starts out behind, and is not able to keep up with her peers. By the end of the kindergarten year, the first child is ready for first grade and the second child will repeat kindergarten.

Unfortunately in Oklahoma, by the end of kindergarten, we are not able to develop connections to understand the different experiences that each child had with their subsequent school success or

challenges. Oklahoma is proud of its accomplishments, but unfortunately, we are not able to brag about our outcomes. Accountability is an important next step on our journey to building a strong early childhood system in Oklahoma.

We know these programs work. We want to establish processes so that we can understand how the program participation has benefited children's outcomes. We are encouraged by efforts at the Federal level to build partnerships across programs and look forward to continued support to ensure that all children have opportunities for the best possible beginning.

Thank you very much.

[The information follows:]

Congressional Statement on Oklahoma's Early Childhood System

Thank you Chairman Cole, Ranking Member DeLauro, and Members of the Committee for the invitation to discuss early childhood education in Oklahoma and how Oklahoma and the federal government can strengthen the quality and availability of early childhood opportunities.

Oklahoma is fortunate to have leaders in our state who have long recognized that in order to achieve economic prosperity we must begin with our youngest citizens. During the late 1990's, simultaneous efforts occurred to pioneer universal pre-kindergarten, state-wide home visiting programs and child care quality rating systems. Oklahoma is a model for today's federal early childhood agenda.

Your committee is considering appropriations on **Early Childhood Education and Care – Administration for Children and Families (ACF)** to increase the Child Care and Development Block Grant in order to improve the quality and safety of infant and toddler care and to expand Early Head Start. In Oklahoma, infants, toddlers, and three-year-olds comprise 44% of all children receiving child care assistance, and represent the majority of children who participate in year round, full-day care. In 1998, Oklahoma was the first to implement a statewide quality rating and improvement system. Child care centers and homes that meet the highest quality levels are reimbursed at higher rates. Quality is important and it is expensive. Effective quality standards need to be identified to ensure the investment in quality yields positive outcomes for children. The federal government can support states such as Oklahoma to identify outcomes for children who participate in

high quality programs, and provide adequate funding to providers to support the implementation of high quality standards.

Pre-kindergarten programs in Oklahoma are considered a grade in the public school system and are allocated funds based on the State Aid Formula, which takes into account disability and financial need. In FY14, the \$313 million allocated for pre-kindergarten programs was comprised of 47% state, 41% local and 12% federal funds. Increases in **Department of Education** funding for **Title I** and **Special Education** being considered by the committee will support Oklahoma in offering high quality pre-kindergarten programs.

Oklahoma did not apply for the Preschool Development Grant, however federal support to states for preschool programs in the form of a block could improve our ability reach at-risk three- and four-year-old children that universal pre-kindergarten may not be serving. Expanded partnerships are being explored between public schools, child care and Head Start programs to expand quality early learning opportunities. The recent reauthorization of the Child Care and Development Block Grant also creates opportunities for greater flexibility in Oklahoma to expand these partnerships.

Early childhood in Oklahoma represents an array of services provided throughout a child's early years. Here is an example of two children who are completing their first year of kindergarten. Both were born to single teenage mothers who had not completed high school. The first child's mother received home visiting services, ensuring adequate prenatal care and delivered a healthy baby. Because this mother received coaching on providing positive parenting skills, the baby was talked to, read to and mother and child

developed a strong attachment. While this mother completed high school and job training, her child was cared for in a safe environment by well-trained providers with opportunities for play and development. The child received regular health and developmental screenings. At age four this child was enrolled in a pre-kindergarten program, and she was healthy and ready to participate. Upon kindergarten entry she was prepared, eager and excited to begin school.

The second child's mother did not receive adequate prenatal care or supports and her baby was born prematurely. This mother returned to a minimum wage job two weeks after her baby was born, she struggled with depression, and worked long hours. Her baby was fussy and lagged behind on developmental milestones. This child stayed at a neighbor's apartment while her mother worked. The mother's job made it difficult to get her child to a preschool program and she lacked information about what programs were available. When this child enters kindergarten, she's scared, withdrawn, starts out behind, and is not able to keep up with her peers. By the end of the kindergarten year, the first child is ready for first grade, and the second child will repeat kindergarten.

Unfortunately, by the end of kindergarten, we are not able to connect the different experiences each child had with her subsequent school success or challenges. Oklahoma is proud of its accomplishments, but unfortunately, we are not able to brag about our outcomes. Accountability is an important next step on our journey to building a strong early childhood system in Oklahoma. We are encouraged by efforts at the federal level to build partnership across programs and look forward to continued support to ensure that all children have opportunities for the best possible beginning.

Mr. COLE. Thank you.

Professor Gilliam, again, you are recognized for 5 minutes. Your full statement will be placed in the record so whatever remarks you care to make.

Mr. GILLIAM. Thank you. Mr. Chairman, Ranking Member DeLauro, members of the subcommittee, it is an honor to be invited to provide this testimony regarding our Nation's investment in our youngest citizens and their families and their communities. I appreciate the increased investment Congress has made over the past several years in early childhood programs such as Early Head Start and child care during these tight budgetary times.

As this subcommittee makes decisions about where to devote admittedly scarce resources, I urge you to increase funding to key programs for our youngest children. Babies are born with an amazing capacity to learn, and that learning happens within the context of meaningful human relationships. During the first 2 years or 3 years of life, neurons are being connected at a rate that far surpasses any other age period. At about 2 to 3 years of age something else is happening: The brain connections that are not being reinforced through human interaction and exploration are pruned away. They die off. Rebuilding these connections requires years of neurological rehabilitation, and it is often not fully successful.

This neurological rehabilitation is known by various names: Special education, therapy, remedial education. It is very expensive, and, in many case cases, its need is preventable.

Early care and learning programs should be an integral component of our Nation's educational strategy. In order to avoid more costly fixes during the K-through-12 period and beyond, our strategy for keeping children on a positive learning trajectory needs to begin as early as possible, even before birth. Research shows that the positive impacts of Early Head Start are greater when supports are provided to families during the prenatal months, especially when the supports are carried through to the preschool years.

Both educational and economic research confirm common wisdom: Supporting and intervening early is far more effective and cost beneficial than waiting for problems to become more intractable and costly. Research by James Heckman has shown the greatest return on educational investment occurs during the first 5 years of life, especially the first 3. Although preschool programs certainly support school readiness, their impacts and return on investment are greatly enhanced by access to high-quality infant toddler supports. In other words, when it comes to maximizing our Nation's educational investment returns, the infant-toddler years should not be our afterthought, they should be our forethought.

Although my written testimony addresses several areas of early care and education such as home visiting, early intervention for infants and toddlers and disabilities, and early childhood mental health consultation, I focus my verbal remarks on the crucial areas of Early Head Start in child care. Early Head Start is one of the few supports directed specifically at the one quarter of our infants and toddlers living in poverty. Unfortunately, it only reaches about 4 percent of the eligible children, 5 percent with more recent increases.

Last year, appropriators provided funding for an exciting new direction for Early Head Start, forming partnerships with child care programs to increase access to and promote the spread of quality services in communities.

The Early Head Start-Child Care partnerships are a crucial effort to create cost-saving efficiencies in our overall system of early care and education. These programs are just getting started and will help infuse quality into child care programs from the ground up while increasing the percentage served. Yet, a full 95 percent, 95 percent of our infants and toddlers in poverty are still left out of this highly-effective support. I urge you to provide additional resources to Early Head Start Expansion and Child Care partnerships to reach these most vulnerable children.

One of our largest supports for our youngest children and families is the Child Care Development Block Grant. CCDBG serves a very disadvantaged population of families of which 52 percent are below the poverty line, and an additional 26 percent are below the 150 percent Federal poverty threshold. Over 1 quarter of these children are infants and toddlers. When implemented at high quality, child care can have a meaningful impact on children's development, especially those from very low-income families.

Last November, the 2014 CCDBG reauthorization passed Congress with strong bipartisan support, was signed into law marking its first reauthorization since 1996. The 2014 CCDBG includes many highly-essential fixes to our Nation's child care system. It helps keep our young children safe by requiring comprehensive background checks and safety inspections. It dramatically improves quality, especially in infant-toddler care where the quality is typically at its lowest; it then provides consumer information so parents can make informed choices. These are all extremely needed fixes to help make sure child care is beneficial to both the working parents and their children.

Our child care is facing a crisis. Funding has stagnated over the past decade, and CCDBG has never served more than one in six eligible children. Since 2003, funding levels have not kept pace with the rising cost of child care, decreasing the real value by about 20 percent over the past 12 years. As a result, since 2016, the number of children served by CCDBG has dropped by more than 300,000, enough children to fill every single seat in the massive University of Oklahoma football stadium nearly four times over.

Infant care is more expensive than typical public college tuition in some States, including Connecticut and Oklahoma, and far beyond the means of many working families, yet subsidies in most States are below Federally-recommended levels, limiting parents' options for safe, good quality care for their babies. Although the fixes to CCDBG are extremely important for improving safety and quality of child care, these now mandated fixes do come at a cost. Without adequate funding to these improvements, States will be forced to further cut the number of children served. Working families most in need of child care will have even less access to it, negatively impacting their ability to enter or sustain employment as the economy recovers.

In sum, our system of early care and education provides meaningful benefits to children and families and reaps a significant economic return. And with the recent passage of the 2014 CCDBG reauthorization, several much-needed fixes will greatly improve our system. But the overall effort is woefully underfunded, and the fixes themselves may result in even more children and families losing access unless funding levels are improved.

Early care and education provides meaningful short-, mid-, and long-term economic benefits. In the short- and mid-term one, they help provide an opportunity for parents to maintain employment by making child care more affordable; plus the early care and education system itself employs many providers and teachers. That is the number two. Underpaid workers who are likely to spend their wages immediately and locally to support area businesses.

In the mid- and long-term range, early care and education programs help close the school readiness gap and place children on a path towards greater economic success and subsequent employability, reducing later educational costs in remedial education and grade retention, increasing their own potential life earnings. Early care and education is one of the few Federal investments that has been shown to yield these kinds of short-, mid-, and long-term economic benefits and public benefits. I urge you to continue to grow this wise investment. Thank you.

[The information follows:]

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**U.S. House Committee on Appropriations
Subcommittee on Labor, Health & Human Services, Education and Related Services
Budget Hearing – Early Education Panel
April 14, 2015**

**Testimony of Walter S. Gilliam, PhD
Director, The Edward Zigler Center in Child Development and Social Policy
Associate Professor of Child Psychiatry and Psychology
Yale School of Medicine**

Mr. Chairman, Ranking Member DeLauro, and Members of the Subcommittee, it is an honor to be invited to provide this testimony regarding our nation's investment in our youngest citizens and their families and communities. I appreciate the increased investments Congress has made over the past few years in early childhood programs such as Early Head Start and child care, during tight budgetary times. I will speak on the latest research regarding early learning and the effects of early intervention, care and education; the impact and value of our early education investment; the most efficient ways to target these investments; and where our investment are reaping the greatest returns. My comments will span services provided in both the Department of Health and Human Services and the Department of Education, but will focus most specifically on the important first three years. At Yale University, I direct The Edward Zigler Center in Child Development and Social Policy. The Zigler Center's mission is to improve the well-being of children and families by bringing objective child development research into the policy and public arenas. I also serve on the board of ZERO TO THREE: the National Center for Infants, Toddlers, and Families, an organization whose mission is to ensure that all babies have a strong start in life, as well as Child Care Aware of America. My testimony is based on the available scientific research, as well as twenty-five years of working closely with early education, prekindergarten, preschool special education and early intervention, child care, Head Start and Early Head Start.

What do we know about children and how they learn and develop? Babies are born with an amazing capacity to learn, and the learning happens within the context of meaningful human relationships. They come into this world actively exploring their environments and seeking human interaction. Their behaviors are literally designed to draw adults into their world, to interact with them. It is through this exploration and these interactions that babies learn to read social cues, regulate their own emotions, develop language, learn to solve problems, and figure out how to interact with others – and, in fact, teach their families how to care for them. During the first two to three years of life neurons are being connected at a rate that far surpasses any other age period, and the baby's brain reaches about 80% of adult volume. It is during this time that the basic brain architecture is being formed. At about two to three years of age, something else is happening – the brain connections that are not being reinforced through human interactions and exploration are being pruned away, they die off. In other words, learning begins immediately, but it is only sustained and nurtured when a caring and capable adult is on the other side of those interactions. Rebuilding these connections requires years of neurological

rehabilitation and it is often not fully successful. In educational terms, this neurological rehabilitation is often known by various names – special education, therapy, and remedial education – and it is very expensive, yet in many cases its need is preventable.

Unfortunately, too many of our babies live in circumstances that undermine their natural development. Almost half live in families that are poor or near poor. Of the one quarter of American infants and toddlers who live in poverty, more than half experience at least one adverse experience (maltreatment, domestic violence, parental substance abuse or mental health issues) that can have lifelong negative health and educational consequences. By age five, one third of children in poverty have two or more such experiences. And as the risk factors increase, the likelihood of developmental delays and disabilities rise, as well as the subsequent costs associated with treating those delays and disabilities. This happens early – well before they arrive at the schoolhouse door – placing many of our children on a trajectory toward school failure, delinquency, and lost human potential.

What do we know about the impact of early care and education? Fortunately, we have over five decades of rigorous research on the effectiveness of early care and education and care to help guide public decision making. This includes research from model early education programs, as well as Head Start and Early Head Start, child care, prekindergarten, home visiting programs for infants and families, and early intervention and preschool special education. Across these many studies, what is clear is that investing in our young children as early as possible through the provision of high-quality early care and education programs significantly decreases the school readiness gap, places children on a positive educational trajectory, and provides a sizable return on our public investment. For examples, home visiting programs for infants and families, depending on the model, have shown a range of benefits from improving children's health, development, and school readiness; enhancing parents' ability to support their children's development; and improving family economic self-sufficiency—resulting in savings from \$1.80ⁱ up to \$9.50 for every dollar invested.ⁱⁱ Similarly, child care, Head Start, and prekindergarten have all been shown to promote cognitive, linguistic, and social-emotional development, providing that the level of quality is high, with the relationship between the provider and the child and family being integral. For Early Head Start, serving children prenatally to age three, a Congressionally-mandated rigorous evaluation showed significant impacts by age three in language skills, social skills and interactions, and behavior, with parents being more engaged with their children, more likely to read to them, and displaying more appropriate and safe disciplinary practices. Many of these positive outcomes persisted to school entry and beyond, with the greatest impacts found for African-America children and those at highest socioeconomic risk. When Early Head Start was followed by center-based child care, prekindergarten or Head Start, even greater gains were found in academic school readiness skills.ⁱⁱⁱ One thing that is clear is that the U.S. continues to require a broad and complementary array of programming to meet the varied needs of American families through both home-based and child care options, with supports aimed at both the needs of the child and the parents.

What do we know about our current federal investment in our infants and toddlers?

Depending on which services are counted, the current federal investment in our infants and toddlers is about \$4-5 Billion. The most recent data suggests that these federal resources account for nearly 80% of all public investments in our nation's children under three, highlighting the essential nature of this support.^{iv} Indeed, our federal investment in our youngest and most

vulnerable infants and toddlers has been the catalyst for important advances in states and communities, by creating a framework by which state and local resources can be added. Unfortunately, the value of the federal investment has not kept pace. Even with the recent addition of the Early Learning Challenge Fund, Preschool Development Grants, and Early Head Start-Child Care Partnerships, the value of federal investment in constant dollars is about the same now as it was ten years ago.

Where should our federal investments be targeted? Early care and learning programs should be integral components of our nation's educational strategy. In order to avoid more costly fixes during the K-12 period and beyond, our strategy for keeping children on a positive learning trajectory needs to begin as early as possible, even before birth. Research shows that the positive impacts of Early Head Start are greater when supports are provided to the family during the prenatal months, especially when the supports are carried through the preschool years. Both educational and economic research confirm common wisdom – supporting and intervening early is far more effective and cost-beneficial than waiting for problems to become more intractable and costly. Research by Nobel Laureate economist, James Heckman, has shown that the greatest return on educational investment occurs during the first five years of life, especially the first three. In fact, earlier supports actually augment the economic return on investment yielded from later supports – high-quality preschool supports augment the economic value of the K-12 experience and, similarly, high-quality infant-toddler supports augment the economic value of preschool and later K-12.^v A recent study of the effects of Educare, a high-quality birth-to-five program, shows that children who receive the supports early in life and have a longer duration in the program do better on school readiness assessments when heading to kindergarten, and this is particularly true for dual language learners.^{vi, vii} In brief, although preschool programs certainly support school readiness, their impacts and return on investment are greatly enhanced by access to high-quality infant-toddler supports. In other words, when it comes to maximizing our nation's educational investment returns, the infant-toddler years should not be our afterthought, they should be our forethought.

Which supports hold the most promise for infants and toddlers? While outside of the purview of this Committee, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program helps pregnant women and families develop the skills they need to support the development and later school readiness of their young children and is an important part of an overall strategy to reach vulnerable families. Using evidence-based models of home visiting supports, the MIECHV program is a stellar example of how federal resources are used to bring highly effective supports to young children and families. In Connecticut, for example, one home visiting model, *Minding the Baby*, recently has achieved evidence-based status. In rigorous evaluations conducted at Yale, participation in the program was directly responsible for higher rates of on-time pediatric immunization, significantly lower rates of rapid pregnancy, better parent-child interactions and attachments, and significantly lower rates of child protection referrals for neglect or abuse.

As this Subcommittee makes decisions about where to devote admittedly scarce resources, I urge you to direct increased funding to key programs for our youngest children. Early Head Start is one of the few supports directed specifically at the one quarter of our infants and toddlers living in poverty. Unfortunately, it only reaches about 4% of the eligible children.^{viii} Last year, appropriators provided funding for an exciting new direction for EHS, forming

partnerships with child care programs to increase access to and promote the spread of quality services in communities. The Early Head Start – Child Care Partnerships are a critical effort to create cost-saving efficiencies in our overall system of early care and education. These projects are just getting started, but could help infuse quality into child care from the ground up, while increasing the percentage served to 5%. Yet, a full 95% of our infants and toddlers in poverty are still left out of this highly effective support. I urge you to provide additional resources for Early Head Start expansion and the Child Care Partnerships to reach more of these vulnerable children.

One of our largest supports for our young children and families is the Child Care and Development Block Grant (CCDBG). CCDBG serves a very disadvantaged population of families, of which 52% are below the poverty line and an additional 26% are below the 150% poverty threshold, and 27% of these children are infants and toddlers.^x When implemented at high-quality, child care can have a meaningful impact on young children's development, especially those from very low-income families. Last November, the 2014 CCDBG reauthorization passed Congress with strong bipartisan support and was signed into law, marking its first reauthorization since 1996. The 2014 CCDBG includes many highly essential fixes to our nation's child care system. It helps keep our young children safe by requiring comprehensive background checks and safety inspections prior to licensing and annually; it raises the quality set-aside, used to improve quality to reasonable standards, from the previously tokenistic 4% to 9% plus an additional 3% for infant-toddler programs (where quality is typically at its lowest); keeps young children from losing their services mid-year when their parents work extra hours or get a raise; and provides consumer information to parents so they can make informed choices. These are all extremely needed fixes to help make child care beneficial to both working parents and their young children. But this program is facing a crisis. Funding has stagnated over the past decade. It has never served more than 1 in 6 eligible children. Since 2003, CCDBG funding levels have not kept pace with the rising cost of child care, decreasing in real value by about 20% during the past 12 years. As a result, since 2006, the number of children served by CCDBG has dropped by more than 300,000 – enough young children to fill every seat in the massive University of Oklahoma football stadium nearly four times over.^x Infant care is more expensive than typical public college tuition in some states, including Connecticut and Oklahoma,^{xi} and far beyond the means of many working families, yet subsidies in most states are below federally recommended levels,^{xii} limiting parents' options for safe, good quality care for their babies. Furthermore, although the fixes to CCDBG are extremely important for improving the safety and quality of child care, and therefore its beneficial impacts on children, these now mandated fixes come at a cost to the system. Without adequate funding for these improvements, states will be forced to further cut the number of children served, struggling parents who can barely afford child care in order to work would be forced to pay more, or child care providers (many barely able to keep their businesses open) would be paid even less to serve our neediest working families. Working families most in need of child care will have even less access to it, negatively impacting their ability to enter or sustain employment as the economy recovers. Significantly increasing funding for CCDBG is a major priority for our children and our working families.

Part C (Early Intervention) provides services for infants and toddlers with developmental delays and disabilities or conditions that lead to delays and disabilities. But the services are woefully underfunded leading to state eligibility criteria often excluding many children who could benefit. In 2013, 333,982 were served – 2.8% of the infant-toddler population, based on the Department of Education's point-in-time data,^{xiii} although a cumulative count of children served throughout the year could be as much as double that number.^{xiv} This means only about a

quarter to one half of the estimated number of infants and toddlers with a diagnosable developmental disability are served through the program.^{xv} And current funding levels do not allow for many of the currently served infants and toddlers to be provided a reasonably adequate level of special educational services. These children are in grave need of early intervention services to mitigate the adverse impact of their delays and help establish a course for better school-age outcomes and lessen the need for later special educational supports.

Infant-Early Childhood Mental Health Consultation is a support service designed to provide early care and education providers the skills they need to avoid expelling young children from our early care and education programs. As many as 10% of all prekindergarten teachers report having expelled at least one preschooler in the past year (a rate of expulsion more than three times that of grades K-12 combined), and for child care providers that rate is as high as 39%. A March 2014 report from the U.S. Department of Education's Office of Civil Rights indicated that African-American preschoolers and boys are at far greater risk of expulsion. The children most at risk of expulsion from our early care and education programs are the ones that tend to show the greater benefit from attending them, which means that preschool expulsions sabotage the economic benefit of these programs by undercutting the rate of return on investment. With support, early childhood educators can address or even prevent these behaviors, promoting positive social-emotional development starting with infants. In Connecticut, I have conducted three separate statewide random-controlled evaluations of a state-funded early childhood mental health consultation program called *Early Childhood Consultation Partnership* (ECCP), two evaluations with preschool programs and one with infant-toddler programs. The results were impressive, with significant reductions in challenging behaviors noted in as little as three months of consultation services, making this program very cost efficient. Unfortunately, Connecticut is one of only a few states that have such a service. Supports such as this are a worthy investment because they protect the economic value of our early care and education efforts by helping to maximize the return on investment.

In sum, our system of early care provides meaningful benefits to children and families and reaps a significant economic return, and with the recent passage of the 2014 CCDBG reauthorization several much-needed fixes will greatly improve our system. But the overall effort is woefully underfunded, and the fixes themselves may result in even more children and families losing access unless funding levels are improved. The compelling national interest in ensuring that children get off to a good start should figure into larger conversations about constraints on overall domestic discretionary funding. Early care and education programs provide meaningful short-, mid-, and long-term economic benefits. In the short- and mid-term, they help provide an opportunity for parents to maintain employment by making child care more affordable, plus the early care and education system itself employs many providers and teachers – underpaid workers who are likely to spend their wages immediately and locally to support area businesses. In the mid- and long-term, they help close the school readiness gap and help place children on a path toward greater academic success and subsequent employability, reducing later education costs in remedial education and grade retention and increasing their own potential life earnings. Early care and education is one of the few federal investments that have been shown to yield these kinds of short-, mid-, and long-term economic and public benefits, and I urge you to continue to grow these wise investments.

¹ Karoly, L.A., Kilburn, M.R. & J.S. Cannon. (2005) *Early childhood interventions: proven results, future promise*. Santa Monica, CA: RAND.

ⁱⁱ *The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?* Hearing before the Committee on Energy and Commerce, House of Representatives. 113th Cong. (2014) (Testimony of Michael Lu, M.D., M.S., M.P.H.)

ⁱⁱⁱ U.S. Department of Health and Human Services, Administration for Children and Families. (2006) *Research to Practice: Preliminary Findings from the Early Head Start Prekindergarten Follow-up*. http://www.acf.hhs.gov/sites/default/files/opre/prekindergarten_followup.pdf.

^{iv} Edelstein, S., Isaacs, J., Hahn, H. & Toran, K. (2012). *How Do Public Investments in Children Vary with Age?* Washington, DC: Urban Institute.

^v Heckman, J. (2008) "The case for investing in disadvantaged young children." In *Big Ideas for Children: Investing in our Nation's Future*. Washington, DC: First Focus.

^{vi} Frank Porter Graham Child Development Institute (2012). *Educare Implementation Study Findings—August 2012*. University of North Carolina. <http://fpg.unc.edu/resources/educare-implementation-study-findings%E2%80%99August-2012>.

^{vii} Yazejian, N., Bryant, D., Freel, K., Burchinal, M., & the Educare Learning Network (ELN) Investigative Team. (2015). High-quality early education: Age of entry and time in care differences in student outcomes for English-only and dual language learners. *Early Childhood Research Quarterly*, 32, 23-39.

^{viii} Calculation based on U.S. Department of Health and Human Services (2015) *2013-2014 Head Start Program Information Report*.

^{ix} U.S. Department of Health and Human Services (2014). *Characteristics of Families Served by Child Care and Development Fund (CCDF) Based on Preliminary FY 2013 Data*. <http://www.acf.hhs.gov/programs/occ/resource/characteristics-of-families-served-by-child-care-and-development-fund-ccdf>

^x Matthews, H. (2014). *Child Care and Development Block Grant Participation at a 15-Year Low*. Center for the Study of Social Policy. <http://www.clasp.org/issues/child-care-and-early-education/in-focus/child-care-and-development-block-grant-participation-at-a-15-year-low>

^{xi} Child Care Aware of America, Parents and the High Cost of Child Care 2013, http://usa.childcareaware.org/sites/default/files/cost_of_care_2013_103113_0.pdf

^{xii} Schulman, K. & Blank, H. (2014). *Turning the Corner: State Child Care Assistance Policies 2014*. National Women's Law Center. http://www.nwlc.org/sites/default/files/pdfs/nwlc_2014statechildcareassistance-report-final.pdf

^{xiii} The Early Childhood Technical Assistance Center. *Annual Appropriations and Number of Children Served Under Part C of IDEA Federal Fiscal Years 1987-2012*. <http://ectacenter.org/partc/partcdata.asp>

^{xiv} Data Accountability Center (October 2011). Part C Child Count Comparison of Cumulative and Point-in-Time Counts Using State-Reported 618 Data, Westat, Rockville, MD, Amy Bitterman and Joy Markowitz.

^{xv} Calculation derived from data in Boyle, C.A., Boulet, S., Schieve, L.A., Cohen, R.A., Blumberg, S.J., Yeargin-Allsopp, M., Visser, S., & Kogan, M.D. (2011) Trends in the prevalence of developmental disabilities in US children, 1997-2008. *Pediatrics* 127(6), 1034-1042. <http://pediatrics.aappublications.org/content/early/2011/05/19/peds.2010-2989.full.pdf>

Mr. COLE. Thank you very much.

Ms. Rauner, you are recognized for 5 minutes. Your full statement will be placed in the record.

Ms. RAUNER. Chairman Cole, Ranking Member DeLauro, and members of the subcommittee, thank you for inviting me here today to testify as part of this important panel, and thank you very much for holding this hearing. In addition to serving as a practitioner, I have a business background, and I would like to take this opportunity to speak with a business approach to investing in early childhood development. And again, for us all, that is birth to five, or prenatal through age five.

I spent a decade of my career in investment banking and private equity investing, so I do know a little bit about return on investment. And I came to the field of early childhood because of concerns about the huge social and economic cost of educational inequities. I chose to focus on early childhood development because we know, as my esteemed colleagues have described, investments in the first years of life are simply the most efficient and effective ways to develop human capital. With the right investments, human capital development can provide great economic and social gains for individuals and society.

I congratulate the bipartisan effort to understand early childhood in this Congress, and I can tell you that there is nothing partisan nor political in investing in new parents, in infants, toddlers and preschoolers to achieve better education, health, and economic outcomes. A wide body of developmental and economic research shows these investments make sense, and dollars, far above their original cost when put into programs and systems targeted to disadvantaged children.

Data from a wide body of researchers give credence to this investment strategy. None is more solid than the empirical research by Nobel laureate economist James Heckman, who shows the economic value of investing in the early childhood development of disadvantaged children from birth to age five. Heckman's work has shown the power quality preschool has to change lives, increase productivity, and reduce the need for social spending. His Perry Preschool findings show that every dollar invested in high-quality early learning for disadvantaged children provides a 7- to 10 percent return on investment in better education, health, and social outcomes, and reductions in remedial spending.

In addition, Heckman's most recent analysis of the health effects of the Abecedarian early childhood program in North Carolina illuminates the power of investing in comprehensive birth-to-five programs to permanently increase IQ, contribute toward greater academic and personal achievement, and prevent expensive chronic diseases such as obesity, hypertension, heart disease, and diabetes. These hard returns are based on rock solid research. With Heckman accounting for all the variables that could create doubt, he adjusts for small sample sizes, control group pollution, and the incidents of chance. Few analyses of social programs have been subjected to this level of rigor.

At our own network of Educare schools across the country, we have seen firsthand how high-quality early education drives better student outcomes. The Ounce developed the first Educare school in

2000 in Chicago. Soon after, we partnered with the Buffett Early Childhood Fund to create the Educare Learning Network, and there are now 20 Educare schools operating across the country.

We rigorously evaluate our programs to collect information that we can use to improve our models. The language and school readiness scores of Educare children far exceed typical achievement levels for children living in low-income households. In follow-up studies in Chicago and Omaha, we have seen these effects persist through third grade and beyond, and we see powerful effects on parenting.

The outcomes I have cited are found not only in small demonstration programs; they are also apparent in Early Head Start, Head Start, New Jersey's Abbott Program, North Carolina's Smart Start, North Carolina Pre-K, and State investments in Georgia, Alabama, Michigan, Oklahoma, and my own State of Illinois. But the key determinant in these programs is quality.

As president of an organization that has served as a State and Federal intermediary for over 30 years, I can attest that delivering high-quality programs at scale using public dollars is both possible and necessary. It requires a commitment to professional development, data systems, innovation, and continuous quality improvement. We don't need to reinvent the wheel. What we need is more Federal investment in State and local innovation, and more coordination between current investments in early learning, maternal and child health and nutrition for disadvantaged families and children. And we don't need to wait 20 years to see immediate returns. Investing in birth-to-five programs pays regular dividends in milestone outcomes.

Governors and legislators from red and blue States alike are investing more in high-quality early child care programs and systems. The Federal Government should follow their lead to achieve significant returns. States and private investors and philanthropy cannot do it alone. There is an appropriate role for the Federal Government that is not intrusive, but highly catalytic and collaborative.

One of the most important roles for the Federal Government is ensuring funds are directed at supporting and increasing quality. Consider home visiting programs, which increase the potential of two generations. Young parents learn to invest more in their children and more in themselves, with many learning how to navigate a return to school and the workforce while providing a home environment that prepares their child for school and success in life.

The Federal Maternal Infant Early Childhood Home Visiting, MIECHV program, is designed with a high degree of accountability. Funding is allocated only to evidence-based programs, and States are required to report improvement on a range of benchmarks. Your recent support to extend this critical program is much appreciated.

Recent reauthorization of the Child Care Development Block Grant will help parents work while their children receive higher quality care that stimulates their physical, emotional, and cognitive growth. Specifically, a \$370 million increase in discretionary funding for CCDBG will help ensure that the goals of increasing quality

in the new act become a reality, and that parents receive the support they need to meet their child's early education needs.

The case for increasing Federal support for Head Start and Early Head Start could not be more evident than when noting that less than half of eligible preschool-age children are able to participate in Head Start, and only 5 percent of eligible infants and toddlers receive Early Head Start services. And the additional increase of \$150,000,000 for the Early Head Start-Child Care partnerships will spur even greater partnerships between child care providers and States, local governments, and public and private entities committed to meeting elevated quality.

Finally, preschool development grants build on State-driven momentum to expand quality preschool opportunities for 4-year-olds from low- and moderate-income families, including children with disabilities. Support for this program at \$750,000,000 will allow for currently-funded States and new States to partner with the Federal Government to develop and expand the quality State-based preschool programs that help prepare children for school and reduce the need for expensive special education and remediation. Investing in quality early childhood developments clearly makes dollars, and sense.

Thank you very much. I am happy to answer any questions.
[The information follows:]



**House Appropriations Subcommittee on Labor,
Health and Human Services and Education
U.S. House of Representatives
Testimony of Diana Mendley Rauner
President, the Ounce of Prevention Fund**

April 14, 2015

Chairman Cole, Ranking Member DeLauro and Members of the Subcommittee, thank you for inviting me here today to testify as part of this wonderful panel. I also want to thank you for holding the hearing. As you will hear it's an issue dear to my heart.

I would like to use this opportunity to offer a business approach to investing in early childhood development programs from birth to age five. I spent a decade of my professional career in investment banking and private equity investing. I came to the field of early childhood because of concerns about the huge social and economic cost of educational inequities. And I chose to focus on early childhood development because investments in the first years of life are simply the most efficient and effective ways to develop human capital.

With the right investments, human capital development can provide great economic and social gains for individuals and society.

A little bit about my background: I left the financial world to earn a Ph.D. in Developmental Psychology from the University of Chicago, and was a senior researcher at Chapin Hall Center for Children at the University of Chicago. I'm currently the president of the Ounce of Prevention Fund, which seeks to ensure that all children—particularly those born into poverty—have quality early childhood experiences in the crucial first five years of life. Most recently, I've also become the First Lady of Illinois.

I can tell you that there is nothing partisan or political in investing in new parents, infants, toddlers and preschoolers to achieve better education, health and economic outcomes. A wide body of developmental and economic research shows these investments make sense—and dollars far above their original costs when put into programs and systems targeted to disadvantaged children.

Data from a wide body of researchers give credence to this investment strategy. None is more solid than the empirical research by Nobel Laureate economist James Heckman who shows the economic value of investing in the early childhood development of disadvantaged children from birth to age five.

Heckman's work has shown the power quality preschool has to change lives, increase productivity and reduce the need for social spending. His Perry Preschool findings show that every dollar invested in high quality early learning for disadvantaged children provides a 7-10% return on investment in

better education, health and social outcomes and reductions in remedial spending.

In addition, Heckman's most recent analysis of the health effects of the Abecedarian early childhood program in North Carolina illuminates the power of investing in comprehensive, birth-to-five programs to permanently increase IQ, contribute toward greater academic and personal achievement—and prevent expensive chronic diseases such as obesity, hypertension, heart disease and diabetes.

Abecedarian achieved these outcomes by combining parent education with early health, nutrition and learning for disadvantaged children. At age 35, those treated as children in the Abecedarian program are doing dramatically better in employment, wages, family life and health than those in the control group. Most astounding is the effect on male health. Treated males at age 35 had zero incidence of metabolic syndrome—the precursor to heart disease, stroke and diabetes—while 25% of males in the control group had metabolic syndrome. Quality early childhood development programs for disadvantaged children are an effective upstream strategy for reducing health care costs. This is a significant finding for a committee that appropriates millions each year to treat chronic disease.

These hard returns are based on rock solid research, with Heckman accounting for all the variables that could create doubt. He adjusts for small sample sizes, control group pollution and the incidence of chance. Few analyses of social programs have been subjected to this level of rigor.

At our own Educare network of schools across the country, we've seen first-hand how high-quality early education drives better student outcomes. The Ounce developed the first Educare in 2000 in Chicago. Later, we partnered with the Buffett Early Childhood Fund to create the Educare Learning Network to launch Educare Centers across the country. We rigorously evaluate our programs to collect information that we can use to improve our models. The language and school readiness scores of Educare children far exceed typical achievement levels for children living in low-income households. And we see powerful effects on parenting.

The outcomes cited by Heckman and other researchers are not only found in small, demonstration programs: they are also apparent in Early Head Start, Head Start, New Jersey's Abbott Program, North Carolina's Smart Start, North Carolina Pre-K and state investments in Georgia, Alabama, Michigan, and my home state of Illinois. As President of an organization that has served as a state and federal intermediary for over 30 years, I can attest that delivering quality programs, at scale, using public dollars is both possible and necessary. It requires a commitment to professional development, data systems, innovation and continuous quality improvement. We don't need to recreate the wheel. What we need is more federal investment in state and local innovation—and more coordination between current investments in early learning, maternal and child health and nutrition for disadvantaged families and children.

And, we don't need to wait 20 years to see immediate returns. Investing in human capital is a long term investment that pays regular dividends in milestone outcomes.

Investments in home visiting increase the potential of two generations. Young parents learn to invest more in their children and more in themselves, with many learning how to navigate a return to school and the workforce while providing a home environment that prepares their child for school and success in life.

The federal Maternal Infant Early Childhood Home Visiting (MIECHV) program is designed with a high degree of accountability. Each home visiting program that is eligible to apply for MIECHV funds must demonstrate improvement among eligible families participating in the program in six benchmark areas: maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports. By all accounts the program has been successful in giving states flexibility to reach families who benefit from these voluntary services.

Recent reauthorization of the Child Care Development Block Grant (CCDBG) funding will help parents work while their children receive higher quality care that stimulates their physical, emotional and cognitive growth.

Investments in state preschool systems and preschool development grants help finish these birth-to-five investments, preparing children for school and reducing the need for expensive special education.

Governors and legislatures from red and blue states alike are investing more in high quality early childhood education programs and systems. The federal government should follow their lead to achieve significant returns. States, philanthropists and private investors cannot do it alone. There is an appropriate role for the federal government that is not intrusive but highly catalytic and collaborative.

Federal-State partnerships should be expanded and the federal government should provide additional funding to help states and communities do their part. The federal government through greater investments in CCDBG, Head Start, Early Head Start, Early Head Start-Child Care Partnerships and Preschool Development grants can help to ensure that high-quality, comprehensive early education services reach young children in their local communities.

The implementation of the newly reauthorized CCDBG Act is one example of where a renewed commitment at the federal and state level will be needed to help support low-income families as they seek the highest quality care for their young children. A \$370 million increase in discretionary funding for CCDBG will help ensure that the goals of the new Act become a reality and that parents receive the support that they need to meet their children's early education needs.

An increase in funding for Early Head Start-Child Care Partnerships represents another opportunity to strengthen federal, state and local efforts to drive investment to high-quality early childhood development services. Specifically, an increase of \$150 million for this initiative will increase quality and spur even greater partnerships between child care providers and states,

local governments, and public and private entities committed to meeting both Early Head Start standards and the needs of working families.

We also must recognize that the federal government could not only increase the quality of early childhood programs, but also access by providing, on top of funding of Early Head Start-Childcare Partnerships, a total of \$9.467 billion for Head Start and Early Head Start. The case for federal funding could not be more evident than when noting that less than half of eligible preschool-aged children are able to participate in Head Start and only five percent of eligible infants and toddlers receive Early Head Start services.

There is great hope though now at the federal, state and local level that we will be able to do more to improve the quality of early childhood services and level of opportunity for our nation's most disadvantaged children. Preschool development grants build on this hope and state-driven momentum to expand quality preschool opportunities for four year-olds from low- and moderate-income families, including children with disabilities. An increase in funding to a total of \$750 million for this program will allow for currently funded states and new states to partner with the federal government to develop and expand quality state-based preschool programs.

Investing in early childhood development programs clearly makes dollars and sense. Timing is everything and the time is clearly now. Thank you and I will be happy to answer any questions the Committee may have.

FADEOUT

Mr. COLE. Thank you. Appreciate, again, all of your testimony. If I can, Dr. Gilliam, I will start with you. And as I mentioned to you in our conversation before we began this session, and one of the concerns that we hear when we talk about these programs is a lot of the gains that appear early seem to disappear sometime around the third grade. So, as I told you, that sometimes raises more questions to me about what we are doing in K through 5 than what we had done before children were coming and going through early childhood education. But I would like to get your thoughts on that.

I mean, how do you make sure that whatever gains do occur actually continue to occur?

Mr. GILLIAM. That is a great question. That is one that I get a lot of. In terms of the fadeout and what the fadeout actually means, when I am asked this question, I am trying to find a way to sometimes describe it to folks. I remind them that most things in life do have a fadeout. Things do fade over time if you do not sustain the effort that you have originally put into it.

One good example of that is dinner. Every time I eat dinner, the next morning I find myself hungry again. Dinner has a fadeout effect, but it doesn't mean I am not going to eat dinner tonight. You know, I am going to eat dinner. Then I am going to make sure that the next morning I am going to get my breakfast too.

When it comes to thinking about sustaining the impacts, one of the things that we have learned from a lot of research is that the efforts that you put into early childhood tends to reap benefits for the later educational experiences because it makes the later educational experiences more efficient. However, if the later educational experiences that are following are of extremely poor quality, then it is possible that you could actually wipe out a lot of the benefits that you had made before.

It is not possible to ever take care of a seedling well enough that that seedling will be able to survive drought conditions later on, you know. And in many of our young children, unfortunately, when they were growing up in poverty, are being sent to school programs that are not going to be able to sustain those. Now, that doesn't mean that the early intervention program failed; it just means that we failed them, those children, to be able to sustain those impacts later on by making sure that we are matching those with adequate supports later.

Ms. RAUNER. May I also?

Mr. COLE. Oh, yes. Please do.

Ms. RAUNER. I would also like to add that while we see fadeout in academic skills, reading, and math skills, what we see as well over the long haul is that children who have attended Head Start and Early Head Start perform better than their peers in life outcomes, in long-term life outcomes. And we suspect that this is due to the long-term effects of the building of self-regulation and executive function skills that persist over lifetime.

What we know, and we have seen that as well in larger studies like the Tennessee STAR study, which Raj Chetty and his colleagues performed at Harvard of the Tennessee kindergarten

study, is that while academic effects fade out over time, over time, high-quality experiences early in life continue to pay dividends. So it may be a question really of what are we measuring and what kinds of effects are we expecting? We know that most important effects have to do with approaches to learning, self-regulation, and self-control, persistence, and motivation. These are skills which we all draw on throughout life.

And it turns out that children who have had Head Start perform better in the long term in ways that suggest that those are the most important things that we are doing in the first years of life.

Mr. COLE. Thank you.

CHILD CARE WORKFORCE

Ms. Andersen, one of the challenges, obviously, if we are talking about increasing access and increasing the number of people that achieve these services is simply the workforce that will be required to handle them. Where do you find the workers? What are the programs that you would favor that would make sure that we had, you know, if we were able to, you know, ramp this program up, actually have people in place that could be beneficial to young people?

Ms. ANDERSEN. That is always a challenge, finding enough workers that have adequate training to provide the kind of daily interaction with children to make sure that we do have high-quality programs. So it is a combination of ensuring that those that provide services are adequately paid. That is one advantage to Oklahoma's pre-K program through the public schools. Those providers are compensated similar to a public school teacher, and that definitely has been a recruitment tool to get individuals to provide those pre-K programs.

Sometimes that has been a detriment to our Head Start programs because providers tend to sometimes move from Head Start once they get a bachelor's degree, and then move into a public school program. Oklahoma does have four Educare Centers in the State, and those also attract and pay adequately for providers.

And if we could look at providers across all programs, having the right kinds of qualifications and appropriate pay, I think that makes the job more attractive. There is a number of individuals who want to go into early childhood, but don't see that as economically viable for them, for their profession.

And I think we are seeing a decreasing number in our universities right now with individuals who are enrolling in early childhood education, and it is something we definitely need to think about as the workforce overall in our State.

Mr. COLE. Thank you very much.

Mr. GILLIAM. May I add to that also? I guess we are starting a culture here of adding to each other.

Mr. COLE. That is okay.

Mr. GILLIAM. But in terms of how to really sustain a high-quality workforce, one of the things that we really haven't been paying attention to is coaching and consultation for our teachers. And this is not just a point for early education. This is K through 12, this is higher education. This is anywhere where we have teachers. We teach teaching, and we think of teaching as if teaching were an academic subject, as if teaching were like math or history.

Teaching is not an academic subject. Teaching is a performing art. And we really need to be training our teachers the way you would train a performing artist, by getting on the stage with them and coaching through the actual motions of it.

And some research has been conducted that suggest that if you put a coach in the early care and education program with the teacher, the amount of gains that it provides in terms of that teacher's ability to be able to do a good job is far better than anything that we can provide in pre-service training, and so it is really one of the things we should be looking into.

Mr. COLE. Thank you. And I move next to the gentlelady from Connecticut. Thank you for being generous and allowing me to run a little over on my time.

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

Just to add to that point, there was just a recent article in the New Haven Register early in March, a mental health report. Special training support can be key to infants' mental health. In terms of what you are talking about, and high quality of individual that is needed in order to be able to interact with our youngsters, this is an additional layer of training that has surfaced as being critical.

Just here, tens of thousands of Connecticut infants and toddlers are at risk for social and emotional problems and the professionals who interact with them most need mental health training in order to help them. That is a report that was just issued. So the training of those teachers, the compensation of those teachers, of utilizing a coach in these processes are really critical.

EARLY CHILDHOOD TRAUMA

Dr. Gilliam, let me just focus on a couple of things which involve both what you and Ms. Rauner have talked about. Almost half of the babies and toddlers in this country live in families that are poor or near poor. Dr. Pam Cantor—who I was dealing with the Turnaround program in New York—talked about the grinding effect of poverty and what that means to youngsters.

I am interested in a couple of pieces here about the comprehensive services that are offered by Early Head Start, in two ways: Those youngsters who are vulnerable to trauma in the home; abuse, neglect, poverty, homelessness, parental depression, other mental health difficulties. What does the research and what does the impact of early childhood have on a those youngsters?

Coupled with that is the noncognitive skills which you made reference, Ms. Rauner—that growing up in poverty, et cetera, reinforcing that. What are we doing through early preschool programs to deal with those comprehensive services for which early childhood is famous for to provide the noncognitive skills that youngsters need in order for them to succeed in probably not getting fired from school in terms of preschoolers, Dr. Gilliam? So let's talk about the abuse, the neglect, et cetera, and early childhood, and then the noncognitive skills portion of this.

Ms. RAUNER. Do you want to start?

Mr. GILLIAM. Either one.

Many of our children are being raised in poverty or in near-poverty circumstances where their parents are staying out of poverty because they are working very long, nontraditional hours. Either

they are in a single-family home where the parent is working or they are in a dual-family home where both of the parents are working.

It is not as much as the poverty, it is the stuff that goes along with the poverty that hurts. It is the domestic violence. It is the drug and alcohol abuse. It is the community violence. These are not things that every impoverished child faces, but it is something that a lot of impoverished children face.

When we think about comprehensive services in Head Start, people refer to that as a thinking of the whole child, whole child services. But I would say that it is really not just the whole child. It is the whole child; it is the whole family; it is the whole community.

And that is one of the things that Head Start has been doing brilliantly for 50 years is realizing that when we are talking about really young children, it is not about providing them math tutoring at 3-years-old. We are talking about making sure that all the supports are in place that are able to ameliorate, or at least mitigate to some degree all these negative life impacts that are going to happen as a result of that child being exposed to poverty. A lot of that is directed to the child. A lot of it is directed to the family.

COACHING PARENTS

Ms. RAUNER. And I will just add, Early Head Start programs and Head Start programs, when we talk about comprehensive services, these are really 2-generation programs. And at their best, they are programs where, of course, the focus is on the child's development, but also on the parents' development. And we know that most of our parents are becoming adults as they are becoming parents. They themselves have not had the kinds of experiences and had the kinds of homes where they understand intuitively what they should be doing with their own children.

So part of what we do a lot of in our programs is coaching and mentoring. We build relationships with parents in which it is possible to talk about things like discipline, nutrition, the stresses that they as a family are under, and frankly, very basic things, including math.

You know, one of the things that we started in our program was family math night for infants and toddlers. And you might be asking what that is. Well, if you think about singing songs, that is pattern recognition. That is the foundation of algebra. If you think about setting the table, that is one-to-one correspondence.

Teaching parents that they are their child's most important teacher is one of the most important things that we do in high-quality early programs like Early Head Start and Head Start. And it is the thing that sustains the intervention going beyond the fifth year.

I mentioned that in Educare, we do not see the kinds of academic fadeout that we have seen in other studies, and we know that that is because of our parents. We know our parents are sustaining the intervention. They have internalized the values of education and of their own capability to advocate for their children and to be their child's leader and coach and nag throughout their lives, which is what we all do with our kids, and that is why those children con-

tinue to succeed. We have seen that in our data, and we have seen that from comments that the teachers tell us about those kids.

Ms. DELAURO. Thank you, Mr. Chairman.

Mr. COLE. Thank you.

We will next go to the distinguished vice chairman of the committee, my good friend from Arkansas, Mr. Womack.

Mr. WOMACK. Thank you, Mr. Chairman.

My thanks to all. I am a proud grandparent of a nearly 22-month old and an 8-year-old, and I recognize the value of early childhood education. You know, and I think that everybody up here on this dais probably will agree on the merits of investing in our children very, very early.

PROGRAM EFFECTIVENESS

For the director in Oklahoma, as mentioned in your testimony, evidence shows that the investments made early have a great impact on long-term achievement, even despite the fadeout that was talked about earlier. I will come back to that. There are a couple of studies that we commonly tout when discussing the virtues of expanding access to preschool and the value of early intervention, the Perry Preschool and the Abecedarian projects.

But since the 1960s and 1970s, when these studies were conducted, Federal investment has grown dramatically. In fact, a 2012 GAO report says that there are actually 45 programs that provide or support services for children 0 to 5.

So here is my question: What work has been done to identify key programs that create the greatest difference in a child's life at the most reasonable value-added cost? And how do we draw the line between fruitful necessary programs and duplicative ones?

Ms. ANDERSEN. Thank you, Mr. Vice Chairman. That is a question that we get frequently, especially from our business leaders in the State. We have a network of about 60 business leaders that are interested in investments in early childhood and want to know what are those that we need to highlight as the strongest investment. That is a very, very difficult question to identify.

Every family is different. Every child's circumstance is different in that family. There are a number of well-researched programs that we implement in Oklahoma. We value evidence-base. We value research. We value high quality with the services that we provide.

The menu that every family needs is a little bit different based on their individual needs. The two teen moms that I talked about who gave birth before they had completed high school have a very different path that they need as supports for parents and the kinds of things that are going to help their child be successful in school, versus a child who may be born into a two-parent, college-educated, working, one or both parents in the workforce.

While we have several programs that are universal, such as our pre-K program, we have not enough programs that target families with higher need to make sure that we can best meet the needs for that family based on what we have available.

We have just launched in Oklahoma what we are calling parentPRO, and we are putting all of the home-based services under one umbrella. So if a family says, yeah, I really could use

some home-based supports, I am interested in somebody coming and visiting me, we are trying to do a better job of coordinating those different models of home-based services to make sure that we can match the right level of intensity with the need of the family. Some families need more intense services; other families don't.

I would hate to say that there is any one or two things in early childhood that are the only things where we should invest our dollars. I do believe strongly that kids having a good start, those infant-toddler years, parents being equipped with capacity to be their child's nurturer and good teacher are very, very important investments that we are not probably investing in as much in.

But I wouldn't do that in lieu of having a 4-year-old program where children have that opportunity to develop those noncognitive skills, those kinds of skills that prepare you to be able to be successful.

RURAL ACCESS

Mr. WOMACK. And I am about out of time. I have one final question. And I will just throw it out on the table for anybody. And that is, how can we be sure that we are giving the same opportunities in early childhood education for rural kids? And, you know, I come from a State that has got a lot of rural kids—Oklahoma, a lot of rural kids—as opposed to those in the more built-up areas and the more urban areas. How can we be confident that the opportunities are the same given the difference in circumstance?

Ms. RAUNER. I will try to take that, because of course in Illinois, we have very rural communities as well as, of course, large cities. And that is one of the places where a strong State system can make all the difference. Having a strong State system that can do asset mapping, can bring coaching and professional development to programs across the State, and can provide adequate funding to programs in rural areas that will not have the economies of scale or the capacity of a large city.

Again, that is the province of a strong State, and that is where something like the preschool development grants have great potential, because they are given to States to build their infrastructure and their capacity.

Mr. WOMACK. I appreciate the testimony. I have got to move to another hearing, but I am glad to hear that better State control, that is something that I think a lot of us would agree with is giving the opportunity for our States to make these decisions based on what the needs of those particular States are. And I thank the panel. Thank you so much.

Mr. COLE. Thank you.

We will go next to the gentlelady from California, Ms. Lee.

HEAD START

Ms. LEE. Thank you very much. Good to see all of you. And really do appreciate your testimony and all of the work that you do each and every day to make sure that our young people have a future, and that is what this is about.

I guess, you know, I am concerned first of all, we are talking about now Head Start—this is 50 years later. Head Start was one of the Great Society programs which President Johnson actually

initiated. And one of the concerns I have, and I think Ms. Rauner—Rauner, is it? You mentioned the numbers in terms of only 4 percent of eligible children right now today are enrolled in Head Start, yet we have all talked about and know what the benefits are of Head Start.

So my former district director was a graduate of Head Start. Children of color, low-income children have benefited tremendously from Head Start. One of the concerns I have now, of course, is a result of the Draconian budget cuts over the last several years, and if we are only at 4 percent now of children enrolled, how do we get to reach the numbers of children that should be enrolled, and how do we address that within the context of this budget? Because 4 percent, I mean, 50 years later, only 4 percent?

So how do we get there? Because we all know that early childhood education is a key to ensuring the children do not fall into poverty as adults, and it is a way of lifting children and families out of poverty.

Ms. RAUNER. Well, thank you for raising that. I think we would say that while the investments that are proposed before you are large, they are not that large relative to the size of the challenge. And certainly in the case of infants and toddlers, when we know, again, the returns on these investments, we believe very strongly that the investments that are proposed in Early Head Start are but a starting point, really, for the need that we need as a country.

Ms. LEE. Starting point, but how do we move past the starting 50 years later?

Ms. ANDERSEN. That is definitely a challenge and something we grapple with quite a bit in Oklahoma. We currently serve, in our 4-year-old program, 74 percent of the 4-year-olds in public school pre-K programs. We serve about 12 percent of our 4-year-olds in Head Start. Some of those, the 74 percent and the 12 percent, are being served currently in what we call a collaborative classroom.

So we have had many, many school districts, because of our rigorous 4-year-old programs, join forces with Head Start programs and they are co-locating services in a public school or in another community setting, predominantly in public schools, where they are sharing resources, sharing teachers.

And that has allowed as us to do two things: One, expand access; but also, there are some things that Head Start brings to the table that the public schools don't always incorporate, and much of that is the family support and the encouragement that Head Start can provide in outreach to families.

So we have found that to be a successful model. It is a difficult model to maintain and sustain, but it certainly has helped us get a number of our 4-year-olds into that kind of a setting.

Mr. GILLIAM. Along those lines, a few years ago, I finished a report, I released a report where I was looking nationwide at all the State-funded pre-kindergarten programs and Head Start and child care programs, because in many cases, these fundings are braided together. And about 17 percent at the time of all Head Start grantees were a public school. This is building on the point that you are making.

INTEGRATION

And when we looked at the strengths of Head Start, you basically got what you would expect, a lot of focus on comprehensive services that these low-income children absolutely needed. Lots of focus on parent involvement. But the program struggled in terms of access to the kinds of supports that are typically found in a public school building, such as access to guidance counselors and school psychologists and things like that, special education services. And the teachers were undereducated and undercompensated in comparison to the public schools. And the public schools were the absolute opposite. But when a Head Start grantee was a public school, you tended to have the best of both worlds, and the weaknesses of neither.

And in terms of the question that Mr. Womack was asking before about how do we find redundancies, to some degree, the redundancies are inherent and built into the system by keeping these as separate silos. What we really need to be doing is finding better ways to be able to integrate these programs together.

But the integration can't just simply happen by having funding that can equally be tapped. There has to be some real cautious effort placed into it, because what we basically have at this point is a difficult-to-navigate siloed system at the Federal level that gets reiterated at the State level, and then it relies on very courageous local people who are willing to do things sometimes that they are not quite sure are legal in order to collaborate. Or else you end up with a hallway where you have the program for the poor kids on one side and the program for the really poor kids on the other side, which is certainly not something that any of us would want.

Mr. COLE. Going next to gentleman from Tennessee, Mr. Fleischmann.

UNIVERSAL PRESCHOOL

Mr. FLEISCHMANN. Thank you, Mr. Chairman.

And I want to thank all of you all for being here today on this very important topic. I am a very strong supporter of early learning, and the tremendous positive impact that it has on children's lives.

As you know, some studies indicate that a person with preschool education is less likely to drop out of high school, get arrested, repeat grades or require special education services. I think we all can agree that these are all good things.

I have a few questions, though, for anyone who wants to answer this or cooperate on the issue of universal preschool. Concerns have been raised that universal preschool would unnecessarily subsidize people who can already afford to pay for it and place the burden on other taxpayers.

My first question, could you please tell the committee what you see as the major risks and downsides of pursuing an across-the-board approach to preschool?

Ms. RAUNER. Well, I will start. I think the biggest risk is that we under-invest in the infant-toddler years. And certainly, it is really important to create a prenatal-through-age-five system that targets the most at-risk children first.

We have to be sure that we don't expect preschool, 1 year of preschool to address all of the challenges of being born into poverty. We know that the brain is built from the bottom up, and that the first 1,000 days of life are the most critical for building a foundation on which to build great learning skills.

Mr. FLEISCHMANN. And I appreciate that, but on the issue of subsidizing those folks who can afford to pay. Obviously, we have a lot of folks who can't afford to pay but subsidizing those who perhaps could afford to pay.

Mr. GILLIAM. More specifically to the question that you are asking, I mean, there is nothing inherent within the concept of universal preschool education that would suggest that it means that you couldn't have a sliding fee scale; and that some families could pay when they are able to pay, and then other families wouldn't pay as much. And indeed, some systems are set up that way.

There is a benefit to having universal access to preschool programs, and that is a benefit that has been shown in a few studies where it suggests that the low-income children who are in classrooms when there are more advantage children in the classrooms tend to have better language gains. And the reason why is that if you spend any time in a preschool program, you can tell it for yourself, the majority of the words that children hear are not from the teacher, they are from the other children.

And so, if you can mix in middle-class children, it is probably good not only for the middle-class children's families in terms of their own child care, but it is also good for the program itself in terms of the benefits you are going to get from it. But it doesn't necessarily mean that those middle class children, or the upper middle class children would it get it for free. They could pay on a sliding fee scale.

UNIVERSAL PRESCHOOL AND SCHOOL-READY

Mr. FLEISCHMANN. Okay. Thank you.

Also, could you please provide the committee with further detail on how universal preschool would make children school-ready? What are the lesson plans? What are the skills they are learning? And what are the teacher qualifications?

And so—I know with our time, I see the green light—but my final question for you all will be: And then finally, how would the success of universal preschool programs be measured?

Ms. ANDERSEN. I will take a stab at that. We have long recognized the need in Oklahoma to improve our measurements around our pre-K programs, and better understand the preparedness level of children when they enter kindergarten. Many States are implementing measures. Oklahoma has not yet. That is one of our largest priorities is better understanding what children are gaining in pre-K, and how that impacts their kindergarten readiness.

Ms. RAUNER. I can add that many States have begun kindergarten-readiness assessments, which, in the best of all worlds, will be multi-domain assessments. They will look at things like language development and math skills. They will also look at social, emotional development, physical development, approaches to learning.

These measurements, when done State-wide, can really begin to benchmark differences between low-income and middle-income children in terms of school readiness. They can look at the differences between rural and nonrural children, between races, and really hold States accountable for improvements in closing those achievement gaps, again, before children enter school.

Mr. GILLIAM. And that is when it is done sensitively. Although, there is a danger to all of this. And the danger to this that I have seen in some States is that they may be using kindergarten entrance exams with the intent that they are going to then figure out which preschool that child went to before and identify which ones are doing a good job and which ones are doing a bad job.

The problem with that is that the benefit that you will get from that is nowhere near as strong as the likely problems that you will get from it in terms of the negative side effect. The negative side effect is the predictable one.

The director who is struggling for resources will only want to serve the children who are likely to do well on tests, which basically means that the children who are most in need of the preschool programs won't be able to find one, especially a high-quality one, because those programs will want to look good on the test next year in the kindergarten level.

And so any time we think of these policies, we have to think about what is the intended impact that we want, and then what is the way in which this policy is likely going to become gamed, and which one is stronger, our intended hoped-for impact, or this negative side effect that you could potentially end up with?

Mr. FLEISCHMANN. Thank you all very much.

Mr. Chairman, I will yield back.

Mr. COLE. Thank you.

We will go next to the gentleman from Pennsylvania, Mr. Fattah.

Mr. FATTAH. I thank you, Mr. Chairman. And I thank the chairman for hosting this hearing and the ranking member. It brings back some memories. Rosa and I had an event that we put together with George Miller a few years ago. And we had one of the leading experts on pediatric brain development, a young man from Vanderbilt, was saying that actually in the third trimester, about 700 times a second these neuronal connections are taking place.

And it is critically important that we understand the brain in its development as an architectural circumstance. And the more that is done early, the more, obviously, it will be able to be done later. And this pruning that you speak of and the kind of 2-to-4 frame is important to note.

So I would start in—you know, the Pew Trust is based in my district. They have been really involved in a lot of the States that have been mentioned. At a point, Mr. Chairman, they weren't really involved in Pennsylvania because our State wouldn't take the decisions like Oklahoma and some other States took to prioritize early childhood education. And then when Governor Rendell came in, we got headed off in the right direction.

But our country has got some challenges. So we have fallen in terms of the nations with college-educated adults, even though through the work of this committee and this administration, we have got 1 million more young people in college now today, and we

have kind of got the needle headed in a different direction. But we have more job openings than we have ever had in 14 years, but we have some skill deficits in terms of filling them.

We have got a lot of challenges as we face 1 billion-plus populated countries economically, like China and India. So these discussions that used to be about, you know, what are we going to do to help children really are now really about what are we going to do to make sure that America can retain its leadership position in the world? We cannot afford to leave these children behind no matter what their circumstances of birth. Every possible thing that needs to be done needs to be done if America is going to hold its position in terms of world leadership.

And so this really is a discussion about investment, and it is about common good. My colleague asked about, you know, what would it mean if we did something universal. We do a lot of things as a universal base. We have got common defense. We do public highways and airports. We could do a lot of things that benefit the society. And I think that we have to see this impulse in terms of early childhood education as something that is a public good.

It is really not about the family and their ability to see the value in early childhood education. The country has got to see the value, and we have to make sure that the utility of it is better understood by parents, and then, I think, they will take advantage of it, but it also has to be available.

So, you know, nationally-certified child care centers are scarce. There is a dearth of them. So there are plenty of places where you can drop a kid off. Doesn't necessarily mean that they are going to get the best services that they should get. And we need to figure out how to improve quality and improve access.

So I think that the chairman in terms of holding this hearing, it is a great place. Really, there should be, and there is a lot of common ground that we need to take the work we have done over 50 years with Head Start and see it as a kind of floor for what we should be doing, and we need to improve upon it.

So I just want to thank all of you for the work that you are doing. And as we are thinking about as appropriators, we have to make some choices here, you know, in terms of the budget request from the President. I know through your comments that you didn't really lean in on the question of money.

PRESIDENT'S BUDGET

This is an appropriations subcommittee. And we have to make some choices, and it would be wonderful to hear from you about what you think vis—vis the work we have to do in terms of marking up this bill, and where you think the balance, the trade equities are in terms of the numbers that we should be looking at vis—vis the President's request.

And all of you can jump in.

Ms. RAUNER. Well, I will just say that we are firmly in support of the President's proposals. And, again, these are—while they are large numbers, relative to the need and to the challenge that is before us, they are not that large. In fact, they are just the beginning, and they are just a drop in the bucket.

So I think it is really important to acknowledge that while the proposed investments in the President's budget are large, they are nowhere near as large as the need for these services.

Mr. GILLIAM. I would like to say how much I appreciate your comment about global competitiveness. I do a fair amount of work not only in the United States, but also in China and in the United Arab Emirates and some other countries.

And I can tell you this: We spend a fair amount—and this is probably going to sound like heresy coming from an academic—but we spend a fair amount of money in the United States studying children, and many other countries don't spend so much money studying children. What they do is they read the American research, and they spend their money implementing what the research says.

And it is amazing how much we are exporting our know-how on early childhood to other countries. We are basically manufacturing our own Sputnik moment right before our eyes when it comes to early childhood.

When it comes to appropriations, I would echo what Diana just so eloquently stated. But I would also add to it that one of my concerns that I have right now is that CCDBG in specific has some amazing, terrific fixes in place that needed to have been in there for a long time. But the concern that we all have to keep in mind is that the fixes and quality will come at a cost, and if we don't fund that up to the adequate level, then the quality costs are going to cause massive amounts of access difficulties.

You know, and so one of the things that I would really focus on is making sure that the tremendous work that was done on CCDBG, when it achieved just massive amounts of bilateral support in Congress in both Chambers, is really being able to be appropriated so that the successes that we got with CCDBG aren't going to ultimately end up with access failures.

Ms. ANDERSEN. I would just like to build on that. I definitely agree that we need to adequately fund CCDBG so that we can have the quality, the availability. It is tough on child care providers in our State to meet quality standards. We have very rigorous quality standards in Oklahoma, and as I said earlier, quality is expensive. And they need to be able to have the supports to be able to maintain that quality and run a business. And that helps ensure that our children who are being supported through child care subsidies do have access to, you know, high-quality centers.

Talking about the rural issues, we have so many small towns in Oklahoma that it is very difficult for a center to operate at the quality expectations that we want to see for our children in subsidy. Along with that, the reauthorization does help us think about forming those partnerships with Early Head Start. And that is incredibly important that we have the availability of the regulations between the programs that allow for that collaboration to occur.

Mr. FATTAH. Thank you, Mr. Chairman.

Mr. COLE. You are welcome.

The ever-patient Mr. Rigell from Virginia.

Mr. RIGELL. I will work my way up, Mr. Chairman, over time.

This is a fascinating discussion. I thank the chairman, and I thank you all for being here.

Let me just first say very quickly that indeed this is a shared value. Just this past Saturday night, I had the privilege of roasting the fellow that I ran against a couple years ago. But we were co-chairs of Horizons Hampton Roads for many years, and it is an early childhood intervention, really an educational program. And Paul and I just have this bond of really trying to help young people and especially kids at risk. So it truly is a shared value.

A few things that were said that were very intriguing—I would like to hit on these very quickly and then come back to something really of substance here—is that, Dr. Gilliam, when you said teaching is a performing art and not an academic subject, that is intriguing to me. It is not a question, but I am going to hold onto that because I think you are right, and I think there is a lot of potential there. You also mentioned—I think I am quoting you correctly—redundancy is built in and difficult to navigate the silos at the Federal level. At least that is a rough paraphrase.

STREAMLINING PROGRAMS

And what I am going to do is start with Ms. Rauner. Ms. Rauner, I knew it. Thank you for being here. And I am a businessman turned public servant here. And if I had to look at this, I would say, you know, public education, this isn't some radical proposal here, but it is almost ready for like a leverage buyout. There is a lot of efficiencies I think we could gain, which I think is a shared value.

So could you at least comment on this notion that we can improve even what we have, maybe through streamlining or making the silos more logical or easier to navigate, because this must be, I am sure, common ground.

Ms. RAUNER. Well, again, I will speak as a practitioner and we do blend and braid funding streams, Federal Head Start and Early Head Start programs, child care dollars and State pre-K dollars, and it is an enormous effort when it happens at the program level. Everything that the Federal Government can do to support more efficient blending and braiding of funding streams is of great value to the people who actually have to put those programs out on the ground.

And I would cite particularly the Early Head Start-Child Care partnerships as an example of an innovation that is blending and braiding funding at the Federal level instead of at the program level. That is of great value to all of us on the ground doing the work.

Mr. RIGELL. Thank you.

Dr. Gilliam.

Mr. GILLIAM. I would like to throw in maybe a concrete example of what Diana is talking about. We have some programs that are funded through CCDBG child care dollars, and that same program is a Head Start program, and that same program is in a public school that is participating in the State-funded pre-K system, which, in many cases, means that that program is going to be undergoing child care licensing, Head Start monitoring, public school—whatever happens in the public school level.

Perhaps that State even has a QRIS system, quality rating and improvement system, and they are undergoing rating from that too.

And on top of that, if they want to be accredited, then they are also subjecting themselves voluntarily to any last-year accreditation.

I don't know when they have time to actually work with the children and families, because they are spending so much time in the monitoring because every single funding stream has its own monitoring systems attached to it, and its own administrative systems attached to it. The redundancies are not really redundancies that are non-planned redundancies. The problem that we really have is that most of our redundancies are actually planned redundancies.

They are created redundancies that are in the system because every way in which these funding streams get braided in order to be able to create the programs in the way that the two panelists flanking me are talking about create their own monitoring structures that then create extra weight and extra cost burdens on the system. If we could find a way to be able to reduce that, we would be able to fund a lot more quality and a lot more access.

Mr. RIGELL. Ms. Rauner, did you want to—

Ms. RAUNER. No, I was simply going to reiterate that in our own programs we would have an enormous amount of what we would describe as indirect staff. Those are people that are not working with children, are not working with teachers; they are working on paperwork. And particularly when we prepare for our Head Start, our now annual Head Start reviews, even though we were one of the exemplary providers that were supposed to get a 5-year pass, it turns out what you get is a review every year.

Mr. RIGELL. I see that my yellow light is on, but Ms. Andersen, there are some areas where you, I would think, would agree that efficiencies could be made, right?

Ms. ANDERSEN. Definitely. And I was thinking, I agree 100 percent. In addition to that, our focus is really to think a lot about how are we understanding the outcomes that kids are achieving and benefiting from this blended quality. And to me, when we are able to understand and celebrate those outcomes, we have a better idea that these were investments that were wisely made.

Mr. RIGELL. Thank you. My time is up.

Chairman Rogers charged us when we first started with trying to find redundancy and things like this, and this is common ground. I thank the chairman very much, and thank you all for being here today and your testimony.

Mr. COLE. All right. You always get extra time when you cite the big chairman.

It strikes me, just listening to the discussion and thinking through all the challenges associated with different funding streams—oh, I am sorry. I am sorry. I was getting ready to move ahead, and I hadn't realized, Lucille, you had come. Please forgive me.

Gentlelady from California is recognized.

Ms. ROYBAL-ALLARD. Thank God for staff.

Mr. COLE. Always smarter than members.

ACHIEVEMENT GAP AND LATINO CHILDREN

Ms. ROYBAL-ALLARD. Ms. Andersen, 2 weeks ago, UC Berkeley released a study that found that Mexican-American toddlers with similar language comprehension skills to their white peers at 9

months old falls significantly behind by the time they are 2. And studies show that this early gap only continues to widen throughout childhood, which to Mr. Fattah's point, is really a concern to the future of this country, not just to the children, as we look to them to be our future leaders, doctors, teachers, and so on.

I know that Smart Start Oklahoma has focused heavily upon closing the achievement gap for Latino babies and toddlers. My question is, what specific intervention and supports do you find most effective for closing the achievement gap in language acquisition skills and early childhood education for Latino children and other English language learners?

Ms. ANDERSEN. I will give you one specific example in Oklahoma City of collaboration that is occurring with our Latino clinic, and the home-based MIECHV-funded programs in that clinic. While some of our home-visiting services are seeing some challenges with enrollment, we cannot put enough providers at the Latino clinic to meet the needs of the families that are seeking the services.

So providing culturally-appropriate home-based supports to parents that while you are coaching them on strategies to talk to their children, to read to their children. We have an initiative we call Reading Begins At Home, and we provide books for children who are receiving home visits.

We get feedback from Latino families that I didn't know it was important for me to start reading to my child when they are a baby. I thought they learned to read when they got into school. Dad is now reading with the baby because we have developmentally-appropriate books. We buy books that are bilingual so that both families, no matter what their language is, can read.

So implementing programs like that and making sure that they are meeting the culturally-appropriate needs of Latino families, we have found to be most successful. Providers that are able to understand and relate to parenting styles of their culture has proven to be incredibly successful.

Ms. RAUNER. May I add to that? We have found in research of our Educare schools, the Frank Porter Graham Institute at the University of North Carolina has found that children, English-language learners, are particularly benefiting from early programs that begin at an early age. So we see in our network that English-language learners who begin before age 1 by the age of 3 are performing in English as well as in Spanish as well as at national norms.

So what we find is that if we begin early, those children catch up and learn English much more quickly and enter kindergarten with language skills at national norms.

Mr. GILLIAM. There is a lot of research to support that.

EXPULSIONS AND MINORITIES

Ms. ROYBAL-ALLARD. Okay. Dr. Gilliam, you have authored research showing that a significant number of young children are denied the opportunities preschool affords for one reason: That they have been expelled. In fact, you found that preschoolers are three times more likely to be expelled than children in kindergarten through twelfth grade.

Even more troubling, according to a March 2014 Department of Education report, expulsions and suspensions are greatly disproportionate to boys and African-American children. Since research shows that low-income children who are more likely to be children of color gain the most from high-quality preschool, what impact do these expulsions have on our Federal investments in early education? Why are young children being expelled at such a high rate? And what policies can we pursue to reduce the number of children being expelled?

Ms. DELAURO. Would the gentlelady—can I just add to that, why are these kids getting fired? What is it about the kids? Is it the teachers? Is it the system? There it is. I just wanted to add that.

Mr. GILLIAM. This is a great question. I am very happy that you raised this, and that Ms. DeLauro added to the question. We could have a whole hearing on this topic alone. I will try to summarize it in just a few words.

They are more than three times as likely in State-funded preschool programs. When you are talking about child care programs, now it is about 13 times as likely as K through 12. 39 percent of child care classrooms have experienced at least one expulsion in the past 12 months. That is a lot. That means if your child is in a child care program, your child has got about a 40 percent chance of being in a classroom with a child who has been expelled. That is a lot of expulsion happening.

As to why it happens, we have looked at a wide variety of factors and many of them really don't have much to do with the child at all. Teacher/child ratios. When teacher/child ratios increase, you have more children per adult in the classroom, it is a real clear relationship. Group size.

Teacher depression. Teachers who screen positive for depression expel at twice the rate of teachers who screen negative for depression, and job stress seems to matter even more. And if a teacher is depressed and has inadequate amounts of supports available to that teacher in terms of consultants or other people who can come into the classroom and work with the teacher, then the depression tends to convert into job stress. And as soon as the job stress happens, then somebody gets expelled from the classroom. It is a way to mitigate the amount of stress.

Now, that doesn't mean that the child's behaviors doesn't have anything to do with it, but it means it is also balanced against whether the teacher feels that the teacher has the resources in order to be able to deal adequately with the challenging behavior in the classroom.

But positively, when we are able to provide a support in the classroom, and many of these are fairly low-cost supports, they are basically taking advantage of mental health providers that already work in the field, giving them a little bit of extra training, and then putting them in the classroom that has consultants. The expulsion rates drop dramatically, and behavior problems improve not just in a way that impacts that one child, but changes the way in which that teacher is going to be teaching all the other subsequent children that that teacher will ever have access to.

In terms of the race issue and the gender issue, it is very disturbing that that was found. But to be honest with you, that is

what we found about 10 years ago when we first released these reports in 2005 that African American children were expelled about twice the rate of non-African American children; boys, about four times the rate.

What concerns me the most about this is this: We talked in this one hearing here about the Perry Preschool project. Abecedarian. We didn't talk about the Chicago Child-Parent Centers, but that is the other cost benefit analysis report that people use to justify early care in education programs.

In many presentations, I have asked people what they know about the Perry Preschool project sample. And it is amazing, people know the year, they know how many children, they know what city it was, Ypsilanti, Michigan. But consistently, I never get the answer that, "and they were all Black." And that is true. Every one of them.

Abecedarian, 98 percent African American. Chicago Child-Parent Centers, overwhelmingly African American. We have, in this country, purchased early care and education for all of our children on data that belonged to African American children, and then when nobody's looking, we disproportionately expel them out the back door.

And that creates two major problems: One is that it basically undercuts the investment potential in early care and education because you are expelling from and removing from the program the children most likely to give you your return on investment; and two, it is just simply not fair and it is not American to use their data to create a program for all of us and then disproportionately expel them out the back door.

Thank you for asking the question.

Ms. ANDERSEN. May I just mention that in Oklahoma, we do use some quality funds from our CCDBG grant to support mental health consultation in child care centers. We have a State-wide system network for that.

FEDERAL GOVERNMENT ROLE VS. STATES

Mr. COLE. Finally, my turn. Thanks. Great questions. Great response. Thank you.

You know, as I struggle with the sheer number of programs we have and the different funding sources, and you mentioned the different monitoring methods, you know, I am struck that in part, I would assume this is because when we think about the Federal role on K through 12, those systems already existed. I mean, we didn't start them. We have been there to supplement them, to add, you know, value added. We are not the main proponent.

Early childhood we were much more there at the beginning, so to speak, with Head Start. So, you know, we are not used to, as Mr. Fattah said, creating universal systems from up here. We are used to doing value added. And we have almost created a system here where we are becoming, I would assume, the largest single provider of early childhood education. That may not be the case.

But we all know, given budget realities, we are certainly not in a position to do what we would all like to do and expand these programs to the degree we were hitting significantly higher percentages of young people.

So given that hard reality, a lot of this, it seems to me, gets back to encouraging other people to participate, particularly State governments, you know, who, as you have all pointed out, increasingly see the value of this.

And so how do we take the resources we have and use that to encourage and leverage, if you will, more State dollars, so we are not the only provider here? If we could do more, we would be more than happy to do more, but in the short-term we have to encourage other people to make these kind of investments with us, particularly at the State level.

Anybody want to take a shot?

Ms. RAUNER. Well, I will try. I think the most important thing that the Federal Government does is it sets standards and expectations and accountability. Many States have invested over years and have been cobbling together State systems with State QRIS systems, kindergarten readiness assessments, training, and mental health infrastructures, training infrastructures in professional development.

Other States are really just at the beginning of that process. And so one of the most important things that the Federal Government can do is use both its funding power but also its accountability power and investments to support the development of strong State systems that can serve prenatal through age 5 in a multitude of ways, because we are never going to have a system like K-12 where there is one size that fits all. We know that some families need different kinds of things.

So it seems as though the most important investments are those that really promote quality, promote accountability, and support the infrastructure that will drive quality over the long haul in the States.

Mr. GILLIAM. What I would add to that is that there have been a few developments recently that I think are very promising. One of them, not too long ago, was that the person who is in charge primarily of Head Start and child care became interdepartmental liaison to the person who is primarily in charge of early childhood in the U.S. Department of Education. So that is Department of Health and Human Services, U.S. Department of Education, at least admitting that they need to have their early childhood people working together.

Early Head Start-Child Care partnerships, an effort to take Early Head Start and child care programs and get them to actually coordinate and work together so that the quality efforts that exist in Early Head Start can actually be applied to the child care world where the vast majority of the children actually are.

These, along with other efforts that we have had, at the Federal level, as well as in some States, to try to create a more cohesive system, I think, gives us the greatest promise to be able to find our redundancies. Because when we create cohesion, that is where you will locate your redundancies. But we have to also then be willing to then take a bit of a surgical knife and remove some of these redundancies. I am not saying that we shouldn't have monitoring structures. We absolutely have to have monitoring. I am just not so sure that we need to have six different monitoring structures that some of these programs are all subjected to individually so

that they have to go through every one of them. That is a level of redundancy that just doesn't seem very wise to me.

But through the efforts to create greater cohesion among these programs, which is really something I think at the Federal and State level we should be encouraging more of, that is where we are going to find the redundancies.

Ms. ANDERSEN. In Oklahoma, we have a strong history of not only pioneering early childhood programs, we also have a strong history of really working together with each other as a State. I staff a 32-member public/private partnership board that is comprised of half State agencies and half governor-appointed members to the board.

And in the 5 years that I have tried to get 32 members to a board, I have never—one time we didn't have a quorum, and we moved out of the Oklahoma City area. So we are interested in working together. We are encouraged by the partnerships that are occurring at the Federal level, because sometimes it felt as though that was a difficult task for us to coordinate across the State when we had silos that were occurring at the Federal level.

Continued support to help States both collaborate with the Federal Government and collaborate with each program—early childhood services are across a wide variety of agencies—we are probably going to continue to be that way. That could change some day. But irregardless, if everything is under one umbrella or a different agency, it is important that all those programs work together to best meet those needs of different families.

Mr. COLE. Thank you. Gentlelady from Connecticut is recognized.

TRAUMA-INFORMED SERVICES

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

Just a couple of points. I want to say thank you to Ms. Andersen, because I think you have described the use of these extended—and you all have mentioned the expanded partnerships and the value of doing that, and I think that that is helpful to us as we think about how we are able to, in the programming that we do, encourage that kind of partnership effort.

I just want to make one comment on this testing regime that was mentioned. I don't want it to go by because not too long ago, we had a school of thought that believed accountability in Head Start centers should be measured by standardized tests. That was debunked by researchers and questioned the practicality of testing young children. It was squashed by the Congress in the 2007 Head Start reauthorization. It has the unintended consequences that you have reflected.

I want to just—two pieces, and it is yes or no: Are you incorporating trauma-informed services into your practices?

Ms. RAUNER. Yes.

Mr. GILLIAM. How can you not?

Ms. DELAURO. Okay. Thank you. I need to know that, and at some other point I really would like to focus on what you can share with us in terms of what we ought to be doing in that regard.

STATE FUNDING DIFFERENCES

Let me—we have talked a lot about States committing resources. State investments are unequal. They are very unequal. National Institute of Early Education Research 2013 Preschool Yearbook reports 10 States provide no support for public preschool. Recent Department of Education, nearly 60 percent of 4-year-olds are not enrolled in public preschool.

So when we listen to all of you today, that we have got like a Swiss-cheese approach to what we are doing in providing high-quality early education. The unmet need is great and so we have to fill the holes. So if we are serious—and this is an Appropriations Committee—if we are serious about that development of human potential, what do we do to bring our efforts to scale?

States, I note that, are making the case for more Federal investments. Thirty-six States applied for the preschool development grants. I think we were able to do 18.

Mr. GILLIAM. Uh-huh.

Ms. DELAURO. But there is a need from the State. So each application identifies a need for an increased Federal role. So what do we do about ensuring that it is not a scattershot approach, and that we are looking at this as a national need and not State by State, and then trying to piece together what we think is the right direction to go on?

I will just add this quick addendum. If we did something about special education funds in that we were dealing with that, that would take a hell of a lot of pressure off the States to deal with special ed. Federal Government has never met its 40-percent commitment on that effort. We are about 16 or 17 or 18 percent at the moment.

I want to talk about how we address this as bringing this program—the cities' programs to scale, Federal level, what your thoughts are? How do we do it? And what can this committee do?

Mr. GILLIAM. Well, I think I would start with making sure that we keep the pressure on the system to create more cohesiveness. The Early Head Start-Child Care partnerships is incredibly brilliant in its thought. Early Head Start or Head Start has about 20, 25 percent of its allocations devoted to quality efforts and improving quality of the programs. Child care, on the other hand, much, much less, but that is where the vast majority of the children are.

By creating those kind of cohesions where they can actually utilize funding across the system and to be able to build partnerships in there, that is probably where we are going to get some of the bigger bang for our bucks.

Other things that we could be potentially doing is finding ways to encourage school districts to partner with Head Start. Schools are notoriously not good at comprehensive services, or at least many schools are. And many schools are not very good at parent involvement services, but these are hallmarks of Head Start.

Why it is that we need to be trying to think about ways to make Head Start look more like the public schools and the public schools look more like Head Start, when, in fact, what we really should probably be doing is finding ways to get these two programs to actually cooperate and work together. Ultimately, I think, that is a

big part of the answer to your question. We have a lot of the building blocks already in place. We just haven't assembled them.

Ms. DELAURO. Ms. Rauner.

Ms. RAUNER. I would add that the preschool development grants are an excellent way to bring States up to some higher level of engagement in early childhood education and capacity. So those are really capacity-building grants that give States the opportunity, depending on their own stages of development, to move towards a more comprehensive system.

They provide services, but they are also—in our State, there are also opportunities for us to bring early childhood mental health consultation into all of the programs that we work with. It is an opportunity to have the school districts begin to do full-day, full-year programming, which we know is important.

Ms. DELAURO. Right.

Ms. RAUNER. And all of those things, again, that is where the Federal Government can really push States to become more engaged and to build their own systems.

Ms. ANDERSEN. I think, just to build on that, giving each State, kind of meeting each State where they are, as you said, we are all at a different place. We all have a different amount of State investment. In Oklahoma, we have a tremendous amount of philanthropic investment into our early childhood programs as well. And so providing us that flexibility to fund where we have gaps is probably most beneficial to our State.

Ms. DELAURO. Okay. Thank you.

Mr. Chairman, I have to dash because today is Equal Pay Day, and I have a commitment to the Department of Labor to be there.

But if I could just say, thank you to all of you. We didn't get the full day. We didn't get to some other things. This has been a most enlightening effort today, and we will look forward to just tapping your brains to help us to come up with the kind of systems approach that will help to make a difference for our youngsters today. You really are doing the Lord's work. Thank you so much.

Mr. COLE. Thank you.

Gentlelady from California is recognized.

Oh, Mr. Fattah is recognized.

Mr. FATTAH. Thank you, Mr. Chairman.

Dr. Gilliam, I want to thank you for your comments about the circumstances when we factor in the question about race. But I want to put it in a different perspective. When Rosa and I had this gathering a few years ago, Mr. Chairman, the father of Head Start was there, Mr. Zigler, he put up a chart, and he showed something. He said that America would be surprised to see which is that holding constant for everything else, the most the child would do exactly what we would want them to do, graduate from high school, go to college and go on to graduate school, was an African American male.

That is not the picture we often think about in terms of expected outcomes in our country, but I do think that it adds to your point about what is happening in terms of the data, and it adds to the chairman's insistence that we spend some time as appropriators kind of grappling with the broader implications of what we are doing. So I want to thank the chairman.

Thank you for your comments.
Mr. COLE. All right.

AFRICAN-AMERICAN BOYS AND EXPULSION

Ms. LEE. Thank you very much. I, too, want to follow up on this issue with regard to the expulsion of young people, primarily African American boys in preschool, which when I read some of the studies, I was shocked and outraged. And I think this really, once again, sweeps race from under the rug and have to really deal with race head on.

Oftentimes, we are accused as of playing the race card when we want to talk about race. And I think if we are going to crack this school-to-prison pipeline, we have got to talk about institutional and systemic racism and bias, and I think this is a clear example of what we are talking about.

And so I want to ask, how do you propose that we address this from a policy point of view and a systemic point of view when there is some who say race is not a problem, and racism does not exist, when it is very clear that this is much of the unfinished business of our country, and I think that expulsion of African American young boys, preschool, is probably one of the most glaring examples of racism in our country.

Mr. GILLIAM. Yeah, and I certainly can't state whether or not this is conscious racism versus it is just——

Ms. LEE. No, no, it may not be conscious.

Mr. GILLIAM. Right.

Ms. LEE. It could be benign. It could be subconscious. It could be—but the impact and the result is——

Mr. GILLIAM. Absolutely.

Ms. LEE [continuing]. Racial bias.

Mr. GILLIAM. Absolutely. It creates disparate results in outcomes at the end. And so as a result, we certainly have to think about it and treat it as a huge blight and problem that we have within our system. What we don't have is a lot of good data on exactly why that is. We are starting right now.

We just received some funding just recently, private money, to start looking specifically at why exactly is it that African American children and boys are more likely to be expelled. The challenge for a long time has been finding a funder who is willing to touch the topic. But it is something that I felt really strongly for a long time that we needed to be able to get a better handle on and be able to understand better. It is just not an easy one to study. You can't just go to a bunch of teachers and say, you know, do you think that you treat children differently depending on the color of their skin?

You can't possibly get a decent answer out of that. And so as a result, you have to really think about ways that you can do these studies at a much more nuanced level if you are going to be able to ultimately end up with the kind of results that you would want.

I am not even sure in the end what the intervention is going to be. I don't know if it is going to be another coursework on cultural sensitivity. I am not so sure that we have had a whole lot of mileage on that in the past. What it might boil down to is helping people be able to see their own behaviors and look at their own behaviors in a way that causes them to have to reflect. And that is ulti-

mately, I think, the direction that we are heading towards. But, I mean, we are just starting to—the sad truth of this is we are just starting to go down this path.

Ms. RAUNER. But I would say that one of the things we do know is that programs and teachers need support. They need support for mental health consultation and behavior management. They need coaching, and they need adequate ratios so that all children can succeed in classrooms, even children who are either victims of trauma or children who are just spirited naturally, which is challenging for parents and teachers at times. And we know that many of the programs where these young children are are the most under-resourced programs.

Mr. GILLIAM. Yeah. We could try to equalize expulsion rates by getting all the children be expelled at the same number, and I suppose that is how you get rid of disparities. And if that is the case, then the number that I would choose is zero. That really we should not be expelling any of the children from our preschool programs because—I can tell you this—the child that is being expelled is the child that is most in need of the program. That is the child that is going to give you the return on the investment.

You are basically undercutting the value of your investment by expelling children. It is like kicking sick people out of hospitals. You are not going to cure very many people if all the sick people get kicked out.

Ms. ANDERSEN. I would just like to add that in Oklahoma, due to the way that we collect information on children in our child care programs or in Head Start or in the pre-K program, I don't have the data that I could tell you if African American males or females or Latino males or females are being expelled at higher rates than children who are Caucasian. We don't have that information.

Ms. LEE. Okay. But I think many States have that information, and I think many studies have borne this out.

Mr. GILLIAM. Yeah, actually many, many States unfortunately don't have the information. The first time that it was collected was in 2005 when I did a study, and it was a study that wasn't even about preschool expulsion. It was a study about State-funded pre-K programs and the way in which they are implemented, and whether they look like the State policies, and what things give rise to better policy adherences per child, spending and things like that.

And I just threw in some questions about expulsion. That was the first time anybody had ever collected this, and it wasn't until 9 years later that the U.S. Department of Education started collecting it, in large part, because of some pressure that was placed by a Member of Congress to start collecting that.

Ms. LEE. Well, Mr. Chairman, I think it is really very important that this committee somehow weigh into this issue. Because when you have this disparity, you know, these racial gaps existing in our country with young preschool children, our national Federal Government has a responsibility to these children to make sure that they are treated fairly and tax dollars should go to insist that there is some equity and justice in this.

And so, Mr. Chairman, I would hope that this committee could kind of discuss what we would want to do as suggestions and rec-

ommendations as a committee to begin to address this. Thank you very much.

Mr. COLE. Gentelady makes a really good point, which she has made in other context before, and I couldn't agree with you more. I want to turn to Mr. Harris in a second, but just I would like to work with you on that. And certainly, you know, pushing more money toward research. Pretty shocking to me what you just told us, that nobody had really looked at this. That you almost stumbled on them, I mean, that happens, but one would have thought there would be a greater level of sensitivity just given the history of the country.

And, you know, I also see these things with Native American kids, frankly, particularly on reservation settings, and it is another population that tends to be overlooked and forgotten. Pretty substantial obviously in our home State, but not in many very States.

But the same, if you look at educational attainment, or success in school, very low statistics, very poor in terms of graduation rates, you know, going on to college. Lots of trauma, lots of alcoholism, drug abuse. So same thing, we have probably overlooked those kids as well.

But the gentelady's point is well taken. I would be happy to find ways we can work together on that and encourage our government, which I think wants to do the right thing to actually focus and start getting it done.

With that, Mr. Harris has done a valued effort to get here before the end of the committee. We are all juggling multiple hearings, so please forgive us as members come in and out. But I appreciate very much that my friend made time to come, and I want to recognize him for any questions that he may have.

HEAD START IMPACT OVER TIME

Mr. HARRIS. Thank you, Mr. Chairman. I will be brief.

You know, a concern of mine has always been that if we are going to undertake this kind of expenditure and, you know, the President's recommendation for \$75,000,000,000, I mean, up until now, my understanding is Head Start—total Federal contribution of Head Start is \$180,000,000,000 since Lyndon Johnson. So this is a tremendous increase in funding.

And yet, you know, the evidence that there are long-lasting effects the way in the few studies that have been done really is pretty lacking. I mean, look, just honestly, I mean, I don't know why. I mean, it kind of would make intuitive sense that if you start education earlier, or give a child an early pre-K education versus a child who doesn't that, you know, by third grade, the one who got the earlier education should be better, but it has just never been borne out rigorously.

Which makes me think that based on just the last couple of observations made, that, you know, maybe the President's attempt is to expand it, make it available to kind of everyone, instead of focusing really on the children in whom it makes a difference. Is there an indication—are we getting smarter in figuring out in which child it really makes a difference whether or not you have an early education? Any of you. I mean, do we know?

Mr. GILLIAM. I am happy—

Mr. HARRIS. Is there good data to show us? Because, again, instead of expanding it to everyone, you know, it seems to be more efficient to say, okay, these are the children whom we have demonstrated that it actually makes a difference. And some children, whether you are low or middle income, you know, my personal feeling, if you come from a good family background, you are low income, it probably makes a lot less difference than if you come from a different family background. Is there data?

Mr. GILLIAM. Yep, there is a lot. There is a lot of data. It is not data that a lot of people talk about an awful lot because it involves people, therefore, it is nuanced. You know, so it is a bit of a nuanced answer to the question.

We know that the children who benefit the most from early care and education programs are the children who are most at risk, and it is a clear relationship. The more at risk you are, the more you actually benefit from it. And in large part, that is because the child stands more to benefit from it.

And it is also due in part, we think, to the fact that the early education stimulation that is being provided in the program is replacing more. It has more of a replacement option than for more advantaged children. So more advantaged children are able to have parents who read to them, take them to the zoo, take them to the museum.

Many disadvantaged children don't have anything like that at all. And so whatever level of stimulation they are going to get from their program is going to be displacing a lot of lack of stimulation within those children. That is what we really think is causing that.

But the part that makes it nuanced is this: We also know that when low-income children are in a preschool program with children who are not low-income, middle-income children, upper middle-income children, those low-income children in comparison to other programs where it is all low-income children, the low-income children in the mix SCS groups tend to gain more on language skills.

And if you spend any time in preschool programs, the reason why seems pretty clear: It is because the majority of the language that the children are hearing is not from the teacher. It is from the other children.

And so if you want to augment the effectiveness for the early education program on young children's development, segregating and creating a program just for the poor isn't typically your best way to do it. And in many cases, when we create programs just for the poor they end up being poor quality programs.

Mr. HARRIS. Well, let me just interrupt you for a second, because it is not about poverty. It is not about how much money you bring home. It is about whether your family at home will spend time—you know, it doesn't cost to read a book to a child. And so, you know, we use low-income as some proxy. It is not a proxy.

You know, what we are really talking about is identifying those houses. I am sorry. I just had to interrupt you, because we say low income as though low income is a pox on a child. Yes, it is associated with worse outcome. But I know many people of very modest income whose parent will read to a child, whose child will read second grade or read by third grade and who will go on to do great things.

But just to wind up on the point you specifically make, it makes sense that there would be some incremental benefit of having that disadvantaged child in with—and I will use the word “disadvantaged” instead of “low income,” because that is really what we mean, disadvantaged educationally—I can see where that would help in a class with less-disadvantaged children or non-disadvantaged children, but that is—to expand it to that group is expensive to bring in those folks.

Those children don’t get the same benefit, and then the question is, you know, how much of an incremental benefit is there to that? And you are right; it is very nuanced. So I appreciate your answer, and I thank the chairman for your indulgence in letting me come in at the last hour, late last minute and ask a question.

It is a very complicated situation, and we really do need to take care of the children who unfortunately don’t get the care they need at home that would, you know—and that is what we are trying to do. We are trying to replace, I think—you know, let’s just be honest—we are trying to replace the education at home.

Mr. GILLIAM. Yes.

Ms. RAUNER. Can I just step in there for just one second, because we are trying to replace education at home only to the extent that the environments in which children whose parents are working all the time tend to be pretty disadvantaged environments.

And I have to speak personally here from my own research of going into family child care homes, which is where most low-income children are, and those are really, in many cases, that is environmentally-induced mental retardation. Those are kids who are sitting in environments where no one is talking to them, the television is on all day, and that is an environment in which we see their achievement gaps opening up over time.

So we are not really replacing parenting. We are actually thinking about creating stimulating environments for those children as opposed to those warehousing environments. But we are also, in Head Start and other programs, thinking about coaching the parents and supporting the parents to be better parents, to understand the importance of reading and talking and cuddling with their child. And those are things that we know these programs are very effective at doing.

Mr. HARRIS. Well, thank you very much, Mr. Chairman.

Mr. GILLIAM. Earlier when we were talking about poverty, I made the point that, and very similar to what you were saying, Dr. Harris, it is not the poverty; it is the things that often go with the poverty that causes the challenges. And effective early care and education programs find ways to be able to ameliorate those things that often go along with the poverty.

But regarding creating universal access to programs, there is nothing in any rule book that says that the children who are middle class or upper middle class would have to go to these programs for free. They could be on a sliding-fee scale, maybe even on a full-fee scale, because the families would need it and value it for child care. But their participation in the program would save us from having a segregated program.

One of the last things that we want to do right now in 2016—2015—what year is it?—2015 is to create a new segregated child

care program, segregated early education system by having a program just for poor kids. You know, so if we can find a way to be able to open up the enrollment but at a way that doesn't cost the system through having sliding-fee scales, I think that would be the way to go.

Mr. HARRIS. Thank you very much.

And thank you, Mr. Chairman.

Mr. COLE. Thank you. And thanks for making the effort to get here.

Just in conclusion, first of all, thank all three of you for your testimony and for the discussions. It has been very helpful. To these last points that were made, I think one of you have made—it may well have been you, Ms. Andersen—but one of you used a wonderful phrase. Think of this as a two-generation program.

So it really is about not just the children themselves but changing parenting behavior too, and the contrast you drew between the two parents and the two outcomes was pretty eye opening. And I think it is something we have to think about when we look at these things.

But it is a complex problem. It is hard to know exactly what to do, and limited resources. So thank you for sharing your expertise to educate the committee a little bit. We will probably be calling on you for additional ideas and thoughts as we go forward.

We never have enough money on this committee to do all the things everybody wants us to do and that we would like to do ourselves, so we really need to help in terms of deciding when we know what the numbers are what makes the difference, you know, where can we actually leverage those dollars, encourage other people to participate and get the most out of them we possibly can.

But, again, thank you for your work. Collectively, you have changed and are changing—I am sure will continue to change—thousands of lives, all for the better. And all that, as Mr. Fattah said, benefit this country globally as well as obviously helping the individuals involved. So again, we are very grateful for your participation. And we are adjourned.

WEDNESDAY, APRIL 15, 2015.

EBOLA

WITNESSES

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CHAIRMAN COLE OPENING STATEMENT

Mr. COLE. We are going to go ahead with the hearing, so we will be joined by members coming and going throughout the morning. There is a lot of markups going on. As I mentioned, there is a conference going on the minority side, and I know they will be arriving shortly, but they want us to go ahead in respect for your time and get moving.

So good morning. It is my pleasure to welcome you to the Subcommittee on Labor, Health and Human Services, and Education to discuss the Ebola supplemental funding provided in fiscal year 2015. Looking forward to hearing the testimony from Assistant Secretary for Preparedness and Response, Dr. Lurie, who I understand will provide an overview of the Ebola response; followed by Dr. Frieden, old friend here at the CDC; another old friend in Dr. Fauci at the NIH; and Dr. Robinson of BARDA, who will each describe the specific actions of their organizations related to Ebola.

These organizations make up the Health and Human Services portion of the Public Health Emergency Medical Countermeasure Enterprise that addresses the medical countermeasures needed to protect our Nation's people against threats as determined by the Secretary of Homeland Security.

This past September, United States experienced its first domestic case of Ebola. To date, we have had 11 cases in the U.S., and unfortunately, two individuals have succumbed to the disease while under treatment in the United States. Unfortunately, our global friends in West Africa have experienced a much more tragic result. There, they have seen nearly 25,000 confirmed Ebola cases, and over 10,000 deaths. Fortunately, the work of these countries, the global community, and the efforts from our witness' organizations, along with the \$2,700,000,000 of supplemental Ebola funding provided by Congress, is resulting in positive signs and developments

over the past few months in West Africa. We certainly hope these positive trends continue and that we are finally turning the corner on this truly terrifying disease.

Before we get started with the hearing, I want to publicly thank all the frontline workers who have done so much to help stop this disease, relieve human suffering, and protect others from Ebola. Everyone from local nurses and doctors, ambulance crews, State labs, and public health officials, our military overseas, and countless Federal employees who have assisted with the Ebola effort deserve our tireless gratitude for their efforts. So first of all, thank you.

I happened to notice, as I was reading the testimony last night, that 853 healthcare workers had contracted the disease. 494 of those have died. That is an extraordinary sacrifice by those people and by the folks that you represent and work with across international boundaries. And it is certainly not lost on this committee and on Congress in general, how much frontline healthcare workers put themselves at risk to protect everybody else. So, again, indeed, thank you.

I look forward to discussing with you this morning the lessons learned from this outbreak and how the funding Congress provided will support longer-term public health capacity. I also hope to increase our understanding on how the vaccine therapeutics, advanced development, and strategic national stockpile have supported the U.S. Ebola preparedness and response activities.

Today, we welcome, again, Dr. Lurie, Assistant Secretary for Preparedness and Response, also a rear admiral. So we didn't know if you were going to be in uniform or not today. But we are happy to have you, and we certainly appreciate your service; Dr. Thomas Frieden, Director of the Centers for Disease Control and Prevention; Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases and the National Institutes of Health; and Dr. Robin Robinson, Director of the Biomedical Advanced Research and Development Authority, Deputy Assistant Secretary for Preparedness and Response.

And with that, I would like to yield to my good friend and distinguished ranking member, the gentlelady from Connecticut, for any opening comments she cares to make.

RANKING MEMBER DELAURO OPENING STATEMENT

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

And I want to say a thank you to Dr. Robinson, Dr. Fauci, Dr. Frieden, and Dr. Lurie. Thank you for your commitment and for your service to this country and for helping to make a difference in one of the most important efforts that we have, and that is to save people's lives. So thank you very much and God bless you all for that effort.

This is an important effort in a hearing this morning, and I might say that at a time when ill-informed pundits and policy-makers were calling for quarantines and for travel bans, your agencies provided expert advice. You helped to craft a measured science-based response that is proving effective in saving lives.

I want to particularly recognize, as the chairman to the staff who have deployed to West Africa, they responded to this human trag-

edy by going directly at its source. As Dr. Frieden has noted, some traveled by jeep, by canoe or even on foot to reach the remotest regions of West Africa. These are brave individuals who put themselves in harm's way to keep us safe, and they deserve our deepest gratitude.

Domestically, however, our response has not been perfect, as two of the nurses who treated the first Ebola patient became infected with the disease. Fortunately, they received world-class treatment and they are healthy today. Our public health leaders deserve credit for learning from early mistakes, moving quickly to strengthen infection-control protocols across the country.

At the same time, as I have said on so many occasions, there is no doubt that ongoing budget cuts in recent years have damaged our ability to respond to public health threats. As our witnesses can attest, NIH, CDC, and ASPR have also suffered substantial real-term cuts over the last 5 years.

When members of this committee visited the National Institutes of Health in January, we met Dr. Nancy Sullivan, who leads the team that has been working on vaccines for Ebola and similar viruses. Dr. Sullivan first published her promising work in 2000, and yet it took a decade and a half and the worst Ebola outbreak in history to move forward with the clinical trial.

Why did it take so long? One reason is that over the past 5 years, Congress has underfunded NIAID's budget for biodefense and emerging infectious diseases by more than \$250,000,000, in comparison to NIAID's budget request in those years.

No one knows how a clinical trial would turn out; if we did, we would not need it. But there is a reasonable chance that if Congress had fully funded NIH over the past 5 years, maybe we could have had a vaccine in time to respond to the Ebola outbreak.

So yes, it is true that Congress eventually provided \$5,400,000,000 in emergency funding to respond to the Ebola outbreak, but simply responding to crises after they arise is not good enough. We must do all that we can to prevent outbreaks and other public health emergencies from happening in the first place.

That requires consistent annual funding to support scientific research as well as prevention, detection, and emergency response programs. These are core government functions. When we cut funding for these activities, we jeopardize our Nation's security no less than when we cut funding for the military. Which is why I support the President's proposal to eliminate the harmful policy of sequestration, boost investment in these critical areas.

The President's budget requests additional funds for NIH, CDC, ASPR, and BARDA. It includes investment in research to develop a universal flu vaccine and to combat antibiotic-resistant super bugs. It boosts funding to purchase medical countermeasures for the strategic national stockpile as well as to expand the global health security initiative.

The President's budget also proposes \$110,000,000 for a new public health emergency response initiative to give HHS the flexibility to respond quickly to a public health crisis, either domestically or internationally. I strongly support that idea. Other components of the Federal Government have flexible funds available to fight threats, such as forest fires and hurricanes. We should do the

same for public health emergencies. But \$110,000,000 is not nearly enough. For comparison, the emergency funding we provided for Ebola in 2015 in the omnibus is nearly 50 times that amount.

I introduced a bill in the last Congress to provide HHS with a similar flexible fund worth \$5,000,000,000. That is the order of magnitude that we should be considering. In the meantime, it is important for members of this subcommittee to understand how HHS is using its emergency funds. Congress provided those funds for two reasons: First, to respond immediately to the Ebola crisis; and second, to better fortify the country against future threats.

I expect our witnesses to report on the progress that has been made to eliminate Ebola at its source in West Africa, and to discuss the initial results of our investments in vaccines and therapeutics to prevent and to treat this horrific disease. I also expect today's witnesses to outline our progress in equipping our Nation's hospitals and public health professionals with the tools to prevent, detect, and respond to a future outbreak, and that includes the establishment of treatment sites across the country with the capacity to handle the world's most deadly infectious diseases.

The next public health emergency will probably not be another Ebola outbreak. It could be another naturally-occurring pathogen, like Middle East Respiratory Syndrome or pandemic flu, or God forbid, it could be a deliberate attack. Either way, if any lasting good is to come from the Ebola outbreak, we must be sure that we are learning the lessons that will help us to deal with future threats before they become crises.

I thank you very much for this hearing, Mr. Chairman. And a thanks again to all our witnesses, and I look forward to the discussion.

Mr. COLE. Thank you.

If we can, we will go to our witnesses now. Again, I think probably most of us read your testimony last night. Some of it was more than 5 minutes. That is okay. It is all entered into the record. But if you could hold your remarks to 5 minutes, that would let us get to the questions a little bit quicker.

So if we can, then, Dr. Lurie, we will begin with you.

DR. LURIE OPENING STATEMENT

Dr. LURIE. Sure. Good morning, Chairman Cole, Ranking Member DeLauro, and distinguished members of the committee. I am Dr. Nicole Lurie, the Assistant Secretary for Preparedness and Response, or ASPR. ASPR leads the nation in preparing for, responding to, and recovering from public health and medical disasters and emergencies. I appreciate this opportunity to talk to you today about our actions to address Ebola, and how the emergency funding you provided is positioning us to address gaps in Ebola and infectious disease preparedness.

Our first priority is, of course, to eliminate Ebola from West Africa; at the same time, we must also fulfill another critical responsibility: Protecting our country from this and another serious infectious diseases by addressing the challenges revealed by this disease.

While we don't know what it will be, we are nearly certain that the world and the U.S. will face another deadly infectious disease

crisis. The most important lesson here is that there is no end point to preparedness. It is forever. Our Nation's health security requires a posture of continuous improvement and constant vigilance.

I would like to briefly highlight three areas in which ASPR is addressing the Ebola issues: First are the medical countermeasures. Early on in this outbreak, I convened the departments and agencies that make up the Public Health Emergency Medical Countermeasure Enterprise, and together, we identified opportunities to rapidly accelerate the development of Ebola diagnostics, vaccines, and therapeutics that were in the pipeline.

Within ASPR, BARDA has been at the center of our medical countermeasure response, but in truth, this has required a coordinated interagency effort. The result is that two vaccines and a very promising therapeutic now are being tested in clinical trials in affected countries. This was possible largely because of the preparedness investments over the last several years, which Dr. Robinson will discuss in detail.

Second, since the beginning of this outbreak, our hospital preparedness program has been pivotal in preparing hospitals and their health system partners to identify potential patients with Ebola, isolate and evaluate them safely, and treat confirmed patients when necessary. The funding will provide awardees with a total of \$194,500,000 to further prepare Ebola treatment centers, assessment hospitals, and healthcare coalitions for their Ebola responsibilities.

The funding will also be used to develop a regional approach for the care of patients with Ebola and to provide technical assistance and training to ensure the ongoing readiness of the treatment hospitals. In addition to compensating institutions for costs incurred with getting ready, it will most importantly support future preparedness efforts for Ebola and other serious pathogens.

Third, we are now accepting claims from healthcare providers for reimbursement related to the direct care of Ebola patients, following through on the commitment we made to hospitals who treated them. We have come a long way since last fall when I mostly heard that hospitals and State health departments did not feel comfortable, or ready to accept an Ebola patient.

More recently, with the repatriation of exposed volunteers, I called the number of hospitals and health departments to be sure we were ready to treat all of those patients simultaneously in the very unlikely event they were to become ill. This time I heard that they were confident, felt ready, and, in fact, wanted to help by treating an Ebola patient.

Ebola has given us the opportunity to learn important new lessons: First, protecting the safety of healthcare workers from clinicians and laboratory workers to ancillary staff is essential to health system preparedness; second, caring for Ebola patients is clinically complex and demanding, and the early case recognition is critical for preventing spread and improving outcomes.

But perhaps most importantly, having available funds at the start, responding to the beginning of an emergency is critical. That is why we are seeking a reserve fund to be used in the event of an unanticipated future crisis. We have got to get out of the blocks quickly.

While we would have preferred that this crisis had never happened, it has truly enhanced our preparedness for this and other infectious diseases. In fact, since Ebola cases of last fall, we have also been focused on other infectious diseases of concern, notably, measles and MERS-CoV. While they are spread very differently than Ebola, it is clear that improvements we are making in hospital preparedness and infection control will serve us well if these diseases or others become significant challenges.

I want to thank this committee and Congress for its support of our Ebola response. My goal has been to use the bulk of this funding to increase the Nation's preparedness against the Ebola virus while continuing to build preparedness in our healthcare system and our Countermeasure Enterprise, with the aim of an ever faster and more nimble response.

Chairman Cole, the support of your committee has been critical to this success. I look forward to working with you and your staff in the future as we work to protect our country and its people from all hazards, whether naturally occurring or manmade. There is still a lot of work to do. Thank you.

[The information follows:]



Written Testimony
House Committee on Appropriations,
Subcommittee on Labor, Health and
Human Services, Education, and Related
Agencies

The U.S. government's response to the
Ebola outbreak in West Africa and
domestic cases of Ebola.

Statement of

Nicole Lurie, MD, MSPH

Assistant Secretary For Preparedness and Response



For Release on Delivery
Expected at 10:00 a.m.
Wednesday, April 15, 2015

Good morning Chairman Cole, Ranking Member DeLauro, and distinguished Members of the Committee. My name is Dr. Nicole Lurie, the Assistant Secretary for Preparedness and Response (ASPR) at the Department of Health and Human Services. ASPR leads the nation in preparing for, responding to, and recovering from public health and medical disasters and emergencies.

I appreciate the opportunity to talk to you today specifically about ASPR's actions to address Ebola and how the emergency funding you provided helped us respond to Ebola and position us to address important gaps in infectious disease preparedness. As we have seen recently, with the increased number of cases in Guinea and the staggering caseload in Liberia and Sierra Leone in the past few weeks, we cannot let down our guard. We must continue our focus on eliminating Ebola from West Africa. But we have another critical responsibility-- protecting our country from this, and other serious infectious diseases such as MERS-CoV, SARS, antimicrobial resistant pathogens, pandemic influenza, and the next unknown threat. We may not know when, where, or how, but we do know that in our increasingly global society that the next threat is inevitable. We are no longer immunized via long borders and vast oceans. ASPR is suited to address this problem. We are working daily to ensure that we have the right medical countermeasures and that we are pushing manufacturing to produce more, better, and faster. We are working with our health care system partners to ensure that hospitals can identify, isolate, and treat Ebola patients, and we are making sure that these investments today will be beneficial to our response to future outbreaks later. Finally, we are working with those providers who stepped up to treat Ebola patients, by making sure they do not have to bear a financial burden for their leadership.

Now let me focus on our primary activities with regard to the emergency appropriation. Early on in this outbreak I convened the departments and agencies that make up the Public Health Emergency Medical Countermeasure Enterprise (PHEMCE). Together we identified opportunities to rapidly accelerate the development of diagnostics, vaccines, and therapeutics for Ebola. I am proud to say the PHEMCE process has worked superbly. It is a fine example of the strong day-to-day, whole of government system that ASPR leads in order to meet our mission. This collaboration has allowed the Biomedical Advanced Research and Development Authority (BARDA) to position themselves to accelerate candidates through the medical countermeasure development pipeline.

Together with industry and U.S. government partners, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Food and Drug Administration (FDA), and the Department of Defense (DoD), BARDA has quickly built and implemented a strategy to combat Ebola by developing, manufacturing, and testing multiple promising Ebola vaccine and therapeutic drug candidates. Those agencies are also working to ensure these countermeasures are safe, work effectively, and can be manufactured to scale if the epidemic worsens. Also key to the response was our National Medical Countermeasure Response Infrastructure, including our Centers for Innovation in Advanced Development and Manufacturing, the Fill-Finish Network and the Clinical Studies Network. These tools were established as a result of lessons learned from the H1N1 epidemic. Each of these components has been vital to our countermeasure response. Last year, BARDA successfully transitioned several Ebola monoclonal antibody candidates (like ZMapp) that were in early development at the National Institute of Allergy and Infectious Diseases (NIAID), the DoD, and industry, into accelerated development and manufacturing. Using funds included in the \$215 million provided

by Congress for the development of Ebola medical countermeasures, BARDA supported manufacturing of clinical investigational lots of ZMapp, which are currently in clinical trials in West Africa and the U.S. to verify safety and efficacy. Other newly developed Ebola monoclonal antibody candidates have shown protection similar to ZMapp in nonhuman primate challenge studies and may soon enter clinical trials. BARDA is also supporting the advanced development of an Ebola antiviral drug candidate transitioned from NIH's NIAID, called BCX 001. That drug is currently undergoing safety trials. Should the epidemic get worse in West Africa, it would likely be ready for efficacy testing. Similarly, BARDA is supporting the advanced development and scaled-up manufacturing of three Ebola vaccine candidates, two of which are presently in clinical trials for safety and efficacy in West Africa. BARDA's support of these two Ebola vaccine candidates could help ensure that millions of vaccine doses can be available later this year if needed for a mass vaccination campaign. Equally important is our partnership with FDA. Their impressive speed and flexibility in making products available for emergency use and in assessing and approving designs for clinical trials has been key to moving products forward. Dr. Robinson's testimony will provide additional details both about the progress being made to develop medical countermeasures for Ebola and about how we have used our newly built infrastructure in this response.

Complementing our successes in medical countermeasure development, ASPR has made great strides in U.S. health care system preparedness. Since the beginning of the program's inception in 2002, our Hospital Preparedness Program (HPP) has been fundamental in preparing hospitals and their community health partners for all hazards that impact the public's health, including infectious diseases. In fact, in a recent survey to understand the impact of HPP, 98 percent of the program's awardees say that HPP has been critical to health care system

preparedness. In the last several years, HPP awardees have demonstrated their ability to respond to and quickly recover from disasters—from natural disasters like tornados, floods and hurricanes to the Boston Marathon bombing and diseases like fungal meningitis caused by contaminated steroids. Specifically for Ebola, HPP’s efforts focused on enhancing the health care system’s capabilities to identify potential patients with Ebola; isolate and evaluate them safely; and treat confirmed patients.

In order to make sure that the U.S. health care system could safely and successfully confront Ebola, HPP provided guidance and updated information to communities about how best to be prepared for Ebola. With input from the public health and hospital communities, as well as our partners at CDC, we developed a framework for a tiered approach for the U.S. health care system, which outlines the different roles facilities can play in preparing to identify, isolate, and evaluate patients with possible Ebola and / or treat patients with confirmed Ebola. Building upon that framework and in response to input from experts and public health and health care stakeholder groups, as well as meeting the Congress’—specifically this Committee’s—regional directive, HPP established a nationwide, regional treatment network for Ebola and other infectious diseases. This network will balance geographic need, differences in institutional capabilities, and account for the potential risk of needing to care for an Ebola patient. It will consist of:

- Up to ten regional Ebola and other special pathogen treatment centers (one in each of the ten HHS regions) that can be ready within a few hours to receive a confirmed Ebola patient from their region, across the U.S., or medically-evacuated from outside of the U.S., as necessary. These hospitals will also have enhanced capacity to care for other highly infectious diseases.

- State or jurisdiction Ebola treatment centers that can safely care for patients with Ebola if necessary.
- Assessment hospitals that can safely receive and isolate a person under investigation for Ebola and care for the person until an Ebola diagnosis can be confirmed or ruled out and until discharge or transfer are completed.
- Frontline health care facilities that can rapidly identify and triage patients with relevant exposure history and signs or symptoms compatible with Ebola and coordinate patient transfer to an Ebola assessment hospital.

The “Hospital Preparedness Program Ebola Preparedness and Response Activities” Funding Opportunity Announcement (FOA), released on February 20, 2015, will provide awardees with a total of \$194.5 million to support this regional approach. In addition, it will support future preparedness efforts for Ebola and other special pathogens, as well support facilities and health care coalitions’ preparedness activities undertaken since July 2014. In developing the HPP Ebola FOA, we incorporated input from a number of data sources, including: modelling results, information about where travelers from affected countries ultimately went within the U.S., diaspora population centers within the U.S., and input from state and local health departments, hospitals, and health care professional organizations. Applications are due on April 22 and we expect to make awards by May 20.

A key lesson learned from the early health care system response to Ebola is the critical importance of protecting the safety of health care workers -from clinicians and laboratory workers to ancillary staff. Protecting these workers is essential to health care system preparedness and response activities. Other lessons involve understanding that care for Ebola

patients is clinically complex and demanding, and that early case recognition is critical for preventing spread and improving outcomes. Recognizing these important lessons, on March 19, 2015 ASPR and CDC announced a \$12 million funding opportunity, from supplemental funds, to support a National Ebola Training and Education Center (NETEC). The NETEC will offer expertise, training, technical assistance, peer review, monitoring, recognition, and if feasible, certification to regional Ebola and special pathogen treatment centers, state- and jurisdiction-based Ebola treatment centers, assessment hospitals, and state health departments. This approach leverages the expertise we have seen in the United States in addressing Ebola to further support our domestic health care system to be better prepared for future patients, and expand our nation's health security. Applications are due May 20, and an award is expected by June 22.

Whether from Ebola or the next infectious disease threat, our Hospital Preparedness Program is committed to ensuring that patients receive safe and effective care. Moreover, HPP ensures that frontline providers – including emergency medical services personnel - are trained to recognize and isolate a person with suspected Ebola or other emerging infectious diseases.

While making sure that Ebola patients are safely and well treated, we also recognize that the level of constant care required for Ebola patients creates a substantial financial burden for treatment hospitals. For costs not covered by insurance, reimbursing hospitals and other providers that have taken the initiative to take care of these patients is crucial. They should not have to bear financial burden because they stepped up to treat patients. As I mentioned earlier, we have set up a mechanism to do this, and are now able to accept claims from health care providers.

Let me now turn to where we are today. We recently needed to test some of the nuts and bolts of the system we have been building. As you may know, NIH is treating an Ebola patient who was repatriated to the U.S. Other individuals who were in contact with this individual were also repatriated to the U.S. for observation. We tested our medevac system and procedures with the Department of State and they worked. I want to be sure hospitals are truly ready and willing to take care of each and every one if they had developed Ebola. When I called hospitals and state health departments to check, I heard that they were confident, felt ready, and in fact wanted to help by taking care of someone with Ebola. This was a far cry from the situation last fall when I mostly heard they were not comfortable or ready to accept an Ebola patient. We have come a long way and are incorporating lessons learned from this Ebola outbreak. While the partnership with Congress leading to the emergency funding request was excellent, we know we need to continue to be looking ahead to future potential threats and be prepared. Time is of the essence when it comes to biothreats or public health emergencies. To that end, the President's FY 2016 Budget request includes \$110 million to be held in reserve as a response fund, to enable rapid response when it is needed. Second, it is very important to accelerate the development, manufacture, and testing of medical countermeasures. As a result of the Ebola epidemic in 2014, BARDA transformed its core service assistance programs that help MCM developers routinely into its National Medical Countermeasure Response Infrastructure to make these programs capable of providing a full suite of MCM activities for emergency response. The Infrastructure is comprised of BARDA's Nonclinical Studies Network, the Centers for Innovation in Advanced Development and Manufacturing (CIADM), Fill-Finish Manufacturing Network, and the Clinical Studies Network in addition to technical and regulatory assistance provided directly by BARDA including in Sierra Leone for Ebola. Together, these mechanisms

accelerate the nation's response to an outbreak. Based on successful rapid monoclonal antibody development during the Ebola response, BARDA is expanding its new Infrastructure's capabilities to include MCM research and development in an emergency to known and unknown threats. In addition, we need flexible and nimble contracting options that allow us to expedite the procurement of goods and services that are needed during a high priority public health crisis or during a response to a public health emergency. Furthermore, planning and consideration for transporting waste will continue to improve our national preparedness. ASPR and our partners are looking at ways to expedite review and approval for permits to transport biocontainment materials. While we would have preferred that this Ebola crisis had never happened, it has truly enhanced our preparedness for Ebola and for other infectious diseases. In fact, as we have seen in both measles and MERS-CoV over the past few weeks, the improvements we helped make in hospital preparedness and infection control will serve us well going forward.

At the same time, we are not done and our mission continues. The regional HPP system must be built and the preparedness of each hospital, each healthcare coalition, and the entire health care system, needs to be exercised and tested regularly. It needs to be ready for when we need it. Preparedness must be continuous; it never stops. HHS is prepared, as needed, to handle unexpected changes in this epidemic by maintaining a healthy reserve of emergency funding to address any unanticipated future needs. This could include anything from medical evacuation of the Department's health care workers abroad, additional reimbursement for uncompensated care for Ebola patients, additional international response efforts, or any other activities necessary to respond appropriately to unforeseen changes in the epidemic.

In closing, I want to reiterate that none of what has been achieved would have been possible without the strong collaboration we have built with the PHEMCE, industry, State and

local health departments, and the healthcare system as part of our preparedness efforts.

Chairman Cole, the support of your committee has been critical to this success. I look forward to working with you and your staff in the future as we work together to protect our country and its people from all hazards, whether naturally occurring or manmade. There is still a lot of work to do. I thank you again for this opportunity to address these issues and welcome your questions.

Thank you.

Mr. COLE. Thank you very much, Dr. Lurie.
If we can, Dr. Frieden, we will move to you next.

DR. FRIEDEN OPENING STATEMENT

Dr. FRIEDEN. Thank you very much, Chairman Cole, Ranking Member DeLauro, for your support of CDC and of the fight against Ebola and for this opportunity to appear before you this morning.

CDC works 24/7 to protect the American people from health threats, whether these are from the U.S. or from anywhere in the world. And I would like to start with the bottom line: The West Africa Ebola epidemic is not over, and until it is over, the American people are potentially at risk. We are all connected by the air we breathe, the water we drink, the planes we travel on, and Ebola demonstrates powerfully that diseases know no borders.

The Ebola epidemic has been and continues to be unprecedented. It is actually the world's first epidemic of Ebola. The first spread of Ebola at the same time among multiple countries. The first extensive urban spread of Ebola. More than 15 times as many cases in this epidemic as in all prior outbreaks combined.

In other parts of Africa, where CDC, WHO, and other partners have worked with national authorities, we have been able to establish systems, people, laboratories, infection control, that can contain Ebola outbreaks and outbreaks of other conditions like Ebola, such as the Marburg virus.

And in countries, such as Nigeria, where CDC has a presence, we were able, when there was a single Ebola case, to surge in many CDC staff and CDC-trained staff to have an intensive response that was able to contain the outbreak. But these three countries are places where CDC did not have a presence previously, and that has made our challenge much more challenging.

A single case of Ebola can lead to dozens of secondary cases, and each one of those secondary cases can potentially lead to dozens more. At present, our goal is to get to zero and stay at zero, and we are not finished with either of those efforts. The solution to the outbreak is core public health services, quickly finding, stopping, and preventing spread in every single community at risk.

We have made substantial progress to date. On the home front, we have provided more than \$250,000,000 to States to track every traveler, to establish laboratories, to strengthen hospital systems, to establish a system whereby every person who returns is tracked, such that they are monitored, and if they develop fever or other symptoms, they would be rapidly assessed at a facility that has been prepared to care for them.

We have responded to more than 1,000 clinical inquiries, and tested more than 100 returning travelers for Ebola. The monitoring system has tracked travelers in every single State of the country. In West Africa, nearly 1,000 CDC professionals have spent more than 40,000 workdays doing more than 12,000 laboratory tests, training 25,000 healthcare workers, helping to screen 150,000 travelers leaving. And many people are alive today and Americans are safer today because of the very difficult and challenging work done by our staff and our partners in West Africa.

It is intensive, hard work to find and track every patient and every contact, and we have done that traveling by canoe, by heli-

copter, hiking, but working fundamentally with the national and local public health and healthcare communities to more rapidly find and stop Ebola. We were able to establish a new strategy to rapidly isolate and treat Ebola that cut the length and the fatality rate of Ebola outbreaks in half in West Africa, improve burial practices and implement innovations.

A month ago, we had a single case in Liberia. That was a case that came a month after the last prior case. And while we were very disappointed, and tragically the patient died, a lot of the care of that individual demonstrates what has to happen to stay at zero. That individual came in, didn't identify a risk factor, but was immediately triaged and cared for safely. Their contacts were elicited. They were monitored. If they developed symptoms, they were rapidly tested. And that rapid health and public healthcare may well have prevented an outbreak.

What works here is prevention, through things like trained epidemiologists, detection systems for laboratory networks, and response to capacity through things like emergency operation centers. This has been the largest response in CDC history, and our efforts are paying off but the outbreak is not yet over. We are in it for the long haul and we won't stop until we both get the risk to zero and have the readiness in the areas at risk to stay at zero.

Thank you for your support, and I look forward to answering your questions.

[The information follows:]

House Appropriations Committee
Subcommittee on Labor, Health and Human Services
Update on the U.S. Public Health Response to the Ebola Outbreak

April 15, 2015

Statement of Dr. Thomas R. Frieden, M.D., M.P.H.
Director, Centers for Disease Control and Prevention

Good afternoon Chairman Cole, Ranking Member DeLauro, and members of the Subcommittee. Thank you for the opportunity to testify before you today and for your ongoing support for the Centers for Disease Control and Prevention's (CDC) work protecting Americans. I am Dr. Thomas R. Frieden, Director of the CDC. I look forward to providing you with an update on the Ebola epidemic: the important steps we are taking to protect Americans here at home and our work to eliminate threats overseas. I thank Congress and this Subcommittee in particular for your support through investment in the Emergency Funding Request for Ebola to end the epidemic in West Africa, enhance preparedness capabilities in the United States and advance global health security capacity to prevent, detect, and respond to infectious disease outbreaks.

Status of the Epidemic

The response to the world's first documented epidemic of the disease has required an unprecedented public health intervention both in West Africa and the United States. The epidemic has emphasized the need for stronger global public health detection, response, and prevention capacity. Within a week of the initial disease report, CDC had an expert response team on the ground in Guinea. Since July 9, 2014, when CDC activated its Emergency Operations Center (EOC) for the Ebola response, CDC has sent more than 800 staff to West Africa on more than 1,500 missions, taking more than 40,000 work-days on the front lines to help stop spread of disease. While CDC has focused efforts

in the heavily affected nations of Guinea, Sierra Leone and Liberia, CDC also responded promptly to help Nigeria, Senegal, Mali, and other neighboring countries prevent travelers from further spreading Ebola. CDC continues to coordinate with and help mobilize multiple other governmental and non-governmental partners in the United States and globally, and to develop new diagnostics and support vaccine evaluation.

We are seeing promising outcomes from these efforts and the generous support of the American people, and our continued vigilance to end the epidemic is critical. Notwithstanding one recent case (after 29 consecutive days with no new cases), the epidemic in Liberia is clearly under control, and we hope to be able to get to zero in the coming months. In Sierra Leone, where CDC has had our largest team of epidemiologists, disease control experts, and others, the peak of the epidemic was about two months after that in Liberia. We are now seeing a similar reduction in cases, and believe that we are likely to see further progress as long as we continue to intensify the work. Guinea's challenges are greater: it has a larger population and area than the other two countries combined. Guinea has made progress, essentially eliminating Ebola from the forest area – a region about the size of Sierra Leone. But we have much more to do there, and we continue to intensify our response. Our health security depends on health security around the world – making getting to zero in West Africa an imperative.

Protecting Americans

To help hospitals prepare for possible additional cases of Ebola, CDC experts in infection control, occupational health, and diagnostic laboratory practices have visited 81 facilities in 21 states plus Washington, D.C.; 55 of them were identified by states as facilities prepared to care for a patient with suspected Ebola. In August 2014, 13 LRN laboratories in 13 states were qualified to test for Ebola. CDC has qualified 56 state, county, and local public health laboratories to perform Ebola testing using a DoD assay which the FDA approved.

CDC has established Ebola Response Teams consisting of CDC experts in epidemiology, clinical care, infection control, laboratory, and communications. These teams stand ready to deploy to any hospital in the United States with a probable or confirmed Ebola case.

CDC worked closely with the United States Customs and Border Protection and state and local public health departments to establish a system to track more than 10,000 travelers who returned from Ebola-affected countries since August 2014. Travelers are monitored for 21 days by local public health authorities and health departments are prepared to facilitate safe transport to a hospital ready to assess them for Ebola if they develop fever or other concerning symptoms. In coordination with these partners, 101 individuals were ultimately tested for Ebola infection after travel from the affected countries and none have been diagnosed with Ebola.

Eliminating Ebola in West Africa

Close coordination with partners has allowed CDC to quickly enhance existing efforts and implement a comprehensive, coordinated public health response to contain and end the Ebola epidemic in West Africa through the following strategies.

Incident management. CDC's first priority when Ebola reached epidemic status in West Africa was establishment of incident management systems, including EOCs, to be run by national leaders in each of the 3 heavily affected countries.

Epidemiology and surveillance. Working with national governments and the World Health Organization (WHO), CDC epidemiologists supported national and district-level staff in each country to better track and respond to the epidemic.

Laboratory testing. Global collaboration with laboratories from an EU consortium made real-time genetic testing available in each of the countries. CDC laboratory experts helped coordinate with the laboratory section of the incident management system. CDC supported laboratories throughout

Liberia and operated a field laboratory in Sierra Leone, which has now processed more than 12,000 samples.

Contact tracing. Working with national counterparts and WHO, CDC improved the quality of contact identification and follow-up, including isolation of symptomatic contacts for laboratory testing. This is critical to controlling Ebola.

Rapid response outbreak control. Starting in late September, CDC worked with partners to implement a rapid response approach to new cases of Ebola in Liberia, an intervention known as Rapid Isolation and Treatment of Ebola (RITE). RITE teams cut the length of outbreaks in half and improved survival outcomes, and the approach is now being implemented in Sierra Leone and Guinea.

Infection control. CDC trained more than 23,000 health care workers in the 3 countries in infection control, including guidance on personal protective equipment. CDC also has provided a 3-day, hands-on training course on approaches to clinical care and infection control for Ebola, originally designed by Doctors Without Borders (Médecins Sans Frontières or MSF), for nearly 500 United States based health care workers and other international staff planning to work in West Africa.

Communications. All of CDC's staff deployments included health risk communication specialists essential to generate and disseminate accurate audience-appropriate information, address rumors, reduce stigma and decrease unsafe burial practices (which has proved critical to the response, since it was such a considerable means of transmittal). Our health communicators have worked with partners in the 3 countries to identify and implement strategies to ensure respectful response efforts that are sensitive to community needs and perceptions.

Technical guidance. CDC issued more than 150 technical guidance documents covering many aspects of the response, both in the United States and globally.

Mobilization of partners. During the summer, CDC recognized that even with superb work by MSF, commitment by the countries themselves, and a response from other international partners, the

epidemic was moving faster than the response and was spiraling out of control. CDC therefore worked to increase involvement throughout the United States Government and the global community.

Exit screening. CDC staff worked with ministries of health and airport authorities in all 3 heavily affected countries, as well as in other affected countries, to establish screening of every traveler leaving affected countries by air to prevent sick travelers from boarding planes.

Innovation. CDC laboratory scientists have worked with private industry and others to implement high-throughput laboratory capacity using robotics, and to promote the development of a rapid test for Ebola designed for use in the field. This innovation may enable us to diagnose most cases within 30 minutes using a simple finger stick or oral swab. In addition, CDC staff are working with Sierra Leonean authorities to implement a vaccine candidate trial among health workers in that country, in parallel with an NIH trial of a vaccine in Liberia.

Global Health Security Agenda (GHSA)

The West Africa Ebola outbreak is unprecedented. In contrast to previous outbreaks, it is larger, more widely distributed, affects multiple countries, new geographical areas, and in large urban areas for the first time ever. The outbreak, which grew quickly to an epidemic, could have been detected and fought more swiftly if the three affected countries had effective surveillance and containment systems in place before 2014. Our funding to advance the Global Health Security Agenda prioritizes countries that are particularly susceptible to Ebola virus disease importation and other high impact infectious diseases, as well as nations that are high-priority due to poor infrastructure, countries serving as major transport hubs, and high population density centers. CDC is working to enhance global health security capacity in vulnerable countries to prevent, detect, and rapidly respond to outbreaks before they become epidemics by standing up emergency operations centers; providing equipment and training needed to test patients and report data in real-time; providing safe and secure laboratory capacity; and developing a trained workforce to track and end outbreaks before they become epidemics.

In Uganda, for example, where CDC and other partners have provided global health security assistance and broader health-related support for years, cases of Ebola and Marburg are now rapidly diagnosed, infection control and contact tracing is quickly implemented, and outbreaks are either stopped rapidly or prevented altogether.

With FY 2015 Emergency Funds, CDC is working in partnership with other United States Government partners and other host governments to apply these best practices and our lessons learned from the Ebola response to achieve specific, measurable capacity working with countries that do not yet have the capacity to prevent, detect and rapidly respond to infectious disease threats, whether naturally occurring, deliberate or accidental. . Specifically, CDC is working with partners to implement all of the Global Health Security Agenda targets to establish the capability required to contain and stop the Ebola epidemic in West Africa, including incident management – the ability to establish emergency operations centers; surveillance – the foundation for making decisions about how to respond to outbreaks; laboratory networks; biosafety and biosecurity systems, immunization, zoonotic disease surveillance, antimicrobial resistance, real-time biosurveillance systems, medical and non-medical countermeasures and personnel deployment, multi-sectoral response capacity, and workforce training. Investing in these health capacities will help countries prevent, detect, and respond to outbreaks of other dangerous pathogens - man-made or naturally occurring.

Conclusion

CDC's response to the Ebola epidemic has been the largest emergency mobilization in the agency's history, and will continue until we have reached and remain at zero cases. The epidemic initially spread faster than CDC and national and international counterparts could mount an effective response.

Stronger national and international systems for prevention, detection, and response to infectious disease threats are needed urgently. Paradoxically, the world may be better prepared to find and stop

emerging health threats than at any time in history, yet the world also is at greater risk for rapid spread of infectious diseases in our increasingly interconnected world. Global health security systems can prepare for large-scale emergencies if they are in place around the world, and if we use them on a daily basis to respond to routine health problems and can ensure that they can be rapidly scaled up when needed. With a focused global effort, and vigilance at home, we can stop this epidemic, protect Americans, and leave behind a system in West Africa and elsewhere to find, stop, and prevent Ebola and other biological threats in the future.

Thank you again for the opportunity to appear before you today. I appreciate this Committee's support and I look forward to answering your questions.

DR. FAUCI OPENING STATEMENT

Mr. COLE. Next, if we could, Dr. Fauci, we will go to you.

Dr. FAUCI. Thank you very much, Chairman Cole, Ranking Member DeLauro, members of the committee. I appreciate the opportunity to talk to you this morning about the role of the National Institute of Allergy and Infectious Diseases in the research response addressing the Ebola virus disease outbreak.

As many of you know, the work on addressing these types of diseases actually began in earnest with an acceleration of our effort following the 9/11/2001 attacks on the World Trade Center. These attacks were followed immediately by the anthrax attacks, which triggered a government-wide effort, including HHS, as well as all of its components represented here today, to respond to the possibility of having to address a deliberate terror attack, using infectious pathogens or the threat from naturally emerging ones.

Our research on category A agents, such as anthrax, botulism, plague, smallpox, and also including the hemorrhagic fever viruses, including Ebola, has brought us to where we are right now. Over the past several years, we have been working in basic and clinical research on these issues. The NIH approach is to conduct fundamental basic research on the microbe and on the host, clinical research and the provision of resources for academia as well as for industry, with the goal in mind of providing countermeasures in the form of diagnostics, therapeutics, and vaccines. And, in fact, very briefly, this is what we have done in addressing the Ebola outbreak.

With regard to diagnostics, we have conducted and supported some of the basic research that has led to the development, and right now, field use, of a number of point-of-care, rapid, sensitive, and specific diagnostics in collaboration with several pharmaceutical and biotech companies.

With regard to vaccines, we have been quite successful. As many of you know, and as Ms. DeLauro has mentioned, the Ebola vaccine that is currently in clinical trials was developed at the NIH more than 15 years ago with the work of Nancy Sullivan in the NIAID Vaccine Research Center.

That particular vaccine, together with another candidate, a VSV candidate, made by NewLink Genetics in collaboration with Merck, is currently in a clinical trial in Liberia in follow up to a Phase I trial that was started at the National Institutes of Health, and was successfully completed. Additional Phase I trials led to what we are supporting right now, a Phase II trial in Liberia that as of last night, has enrolled 1,175 people. This vaccine is safe and it is inducing a response that one would predict would be protective, although obviously we will need to have the field proof of that.

With regard to therapeutics, there have been a number of candidates that have been tested in a preclinical setting. The NIH has focused on one of these, which is most promising in an animal model: ZMapp, a cocktail of antibodies directed against a particular protein on the Ebola virus.

We have started a trial, a randomized trial, which is comparing standard accelerated treatment of intravenous fluid replenishment and electrolyte replenishment against the standard accelerated

treatment plus ZMapp. It began enrolling in late February. We now have six patients who have been randomized into the trial: One at the NIH, one in Liberia, and four in Sierra Leone.

And, finally, the NIH is proud to be one of the three designated high-containment acute-care facilities capable of taking care of Ebola patients. And in October of this past year, we took care of Nina Pham, the first United States citizen who was infected in this country while she was taking care of Thomas Duncan.

On March 13, we admitted a healthcare worker who volunteered for Partners in Health to serve in Sierra Leone. He became infected while taking care of Ebola patients and was Air Evac'd at our unit at NIH. He turned out to be one of the sickest patients that I have ever taken care of. But thankfully, calling upon the skill of a core group of volunteer NIH physicians, nurses, and healthcare providers, the patient has done very well and he walked out of the hospital on April 9 with the patient's parents to go home.

In summary, through an intensive investment in basic and clinical research involving the development of diagnostics, vaccines, and therapeutics, as well as our specialized clinical capabilities, the NIH has played a role, together with our sister agencies at HHS and throughout the U.S. Government, in successfully addressing the challenge of this historic Ebola outbreak. Thank you very much.

[The information follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH

The Role of the National Institute of Allergy and Infectious Diseases in Research Addressing
Ebola Virus Disease

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

Anthony S. Fauci, M.D.
Director
National Institute of Allergy and Infectious Diseases
April 15, 2015

Mr. Chairman, Ranking Member DeLauro, and Members of the Subcommittee: Thank you for the opportunity to discuss the National Institutes of Health (NIH) response to the global health emergency of Ebola virus disease. I direct the National Institute of Allergy and Infectious Diseases (NIAID), the lead institute of the NIH for conducting and supporting research on infectious diseases, including viral hemorrhagic fevers such as those caused by Ebola. In fiscal year (FY) 2014, NIH funding for Ebola was approximately \$77 million. In FY 2015, the President requested and Congress appropriated \$238 million to NIAID to prevent, prepare for, and respond to Ebola domestically and internationally.

For more than six decades, NIAID has made important contributions to advancing our understanding of infectious, immunologic, and allergic diseases, from basic research on mechanisms of disease to applied research to develop diagnostics, therapeutics, and vaccines. NIAID has a dual mandate that balances research addressing current biomedical challenges with the capacity to respond quickly to newly emerging and re-emerging infectious diseases, including bioterror threats. Critical to these efforts are NIAID's collaborations with other Federal

entities, particularly the Centers for Disease Control and Prevention (CDC); the Food and Drug Administration (FDA); the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response, including the Biomedical Advanced Research and Development Authority (BARDA); the HHS Office of Global Affairs; and the Department of Defense (DOD); as well as with academia, industry, and international organizations. NIAID has a longstanding commitment to advancing research to combat Ebola virus disease while ensuring that potential medical countermeasures are rigorously tested for safety and efficacy.

OVERVIEW OF EBOLA VIRUS DISEASE

Ebola virus disease presents typically with fever, vomiting, and severe diarrhea. It can progress to profound fluid loss; weakness; electrolyte loss; impaired kidney, liver, and other organ function; and in some cases internal and external bleeding. The current Ebola outbreak in West Africa is by far the most severe ever recorded and remains an ongoing public health crisis. There is a critical need to develop improved diagnostics, as well as safe and effective treatments and vaccines for Ebola virus disease. In addition, it is becoming increasingly apparent that the consequences of Ebola virus infection on the infected individual do not end when the virus is cleared from the blood. Survivors report a variety of complications, including eye and joint problems. A study is being launched by the Liberia–U.S. Clinical Research Partnership to better characterize these potential long-term complications of Ebola virus infection.

DEVELOPMENT AND TESTING OF EBOLA MEDICAL COUNTERMEASURES

Since the 2001 terrorist attacks on the United States, NIAID has markedly enhanced its biodefense research portfolio and supported the development and testing of candidate products to

prevent or treat viral hemorrhagic fevers, including those caused by Ebola. NIAID was well-positioned to respond rapidly to the crisis in West Africa because of its longstanding investment in biodefense and emerging infections research. NIAID research on Ebola focuses on understanding how Ebola virus causes illness and on developing and testing new diagnostics, vaccines, and therapeutics.

Diagnostics

Symptoms of Ebola can easily be mistaken for other common causes of fever in affected areas, such as malaria. A rapid diagnostic for Ebola is critical so that isolation and treatment strategies can be implemented without delay. With NIAID support, Corgenix Medical Corporation developed the ReEBOV™ Antigen Rapid Test, which detects the presence of an Ebola virus protein in about 15 to 25 minutes. FDA recently authorized the test for emergency use in the presumptive detection of the Ebola Zaire virus in symptomatic individuals in appropriate circumstances; it was the first rapid diagnostic test for the Ebola virus to receive such a designation. The test represents a new tool allowing rapid isolation of Ebola patients to limit spread of the disease. NIAID also is advancing the development of other rapid point-of-care diagnostics that use novel technologies to detect multiple pathogens, including Ebola.

Rapid and accurate Ebola diagnostics are critical to monitor the outbreak, rapidly diagnose patients, and provide appropriate patient care. NIAID scientists, in coordination with CDC and DOD, have established and staffed laboratory sites to identify the presence or absence of Ebola virus in clinical samples in Monrovia, Liberia. In addition, NIAID scientists and grantees are analyzing genomic sequences of Ebola virus isolated from patients in West Africa to better understand the origin and transmission of the virus. NIAID scientists recently reported that the currently circulating Ebola virus has undergone relatively few mutations, none of which

suggest that it is becoming more severe or transmissible. Moreover, the researchers suggest that these genetic changes are unlikely to affect the efficacy of available diagnostics or candidate vaccines and treatments.

Therapeutics

NIAID supports the development of novel therapeutics targeting Ebola viruses as well as clinical trials to test the safety and efficacy of these treatments. NIAID supported Mapp Biopharmaceutical, Inc., to develop the investigational drug ZMapp, a combination of three antibodies against Ebola. NIAID has worked closely with partners at DOD, BARDA, and FDA to advance the development and testing of ZMapp. These efforts have led to the recent launch of a clinical trial to test the safety and efficacy of ZMapp in infected people at sites in Liberia and the United States. This trial, which is currently comparing treatment with ZMapp plus optimized standard of care versus optimized standard of care alone, is designed so that additional treatments also may be evaluated and compared.

The NIH Special Clinical Studies Unit (SCSU) at the NIH Clinical Research Center is designated to provide state-of-the-art intensive care in a research setting to U.S. citizens who become infected with infectious diseases requiring high containment, such as Ebola. Two American healthcare workers infected with Ebola virus during the current outbreak have been treated successfully at the SCSU. The facility serves as one of three U.S. study sites for the treatment trial evaluating ZMapp.

Vaccines

A safe and effective Ebola vaccine would be a critically important tool to help prevent Ebola virus disease and contain future outbreaks. Such a vaccine could be licensed and used in the field to protect healthcare workers and individuals living in affected areas. Since 1999, the

NIAID Vaccine Research Center (VRC) has pursued multiple early-generation Ebola vaccine candidates, culminating in a vaccine candidate currently in large-scale clinical trials. VRC scientists, in collaboration with GlaxoSmithKline, developed an experimental vaccine that uses the chimpanzee adenovirus type 3 (cAd3) as a carrier, or vector, to express an Ebola virus protein designed to stimulate protective immune responses. An NIAID-sponsored Phase II/III clinical trial of cAd3-EBOZ is now underway in Liberia as part of the Partnership for Research on Ebola Vaccines in Liberia (PREVAIL) study. The study also is testing an additional vaccine candidate, rVSV-EBOV, developed with support from DOD and NIAID. Interim findings in more than 600 people enrolled in the PREVAIL study indicate that the two experimental Ebola vaccines appear to be safe. Given these findings, the study should be able to advance to Phase III testing in a larger number of participants. As a result of the successful control of the Ebola outbreak in Liberia, discussions are underway with West African officials about possibly expanding the PREVAIL study to other West African countries.

NIAID also has collaborated with the biopharmaceutical industry, academia, and other Federal agencies to develop additional Ebola vaccine candidates. NIAID is supporting a Phase I clinical trial of an investigational vaccine regimen targeting multiple species of Ebola virus and the related Marburg virus. The trial will examine a prime-boost vaccine strategy composed of an adenovirus-vectored vaccine developed by Johnson & Johnson and a modified vaccinia virus Ankara-vectored vaccine developed by Bavarian Nordic. In addition, NIAID scientists are collaborating with investigators at Thomas Jefferson University to produce a vaccine candidate based on an existing rabies vaccine that could generate immunity to Ebola, Marburg, and rabies viruses. The investigators plan to pursue a version of the vaccine for human and veterinary use, as well as a version for use in African wildlife that could help prevent transmission of Ebola

virus from animals to humans. Clinical testing of the candidate rabies/Ebola vaccine for human use is expected to begin later this year. NIAID also is partnering with the University of Texas Medical Branch at Galveston to advance a human parainfluenza virus-vectored Ebola vaccine developed by NIAID scientists. This vaccine candidate is designed to be delivered intranasally, and Phase I trials are planned to begin by the end of 2015.

CONCLUSION

NIAID is an active participant in the global effort to address the Ebola outbreak in West Africa. NIAID will continue to work with our global partners to gain a better understanding of the pathophysiology of Ebola virus infection as well as to develop safe and effective medical countermeasures to treat and prevent Ebola.

DR. ROBINSON OPENING STATEMENT

Mr. COLE. Thank you.

And if we can, Dr. Robinson, we will go to you next.

Mr. ROBINSON. Good morning, Chairman Cole and Ranking Member DeLauro, and distinguished members of the subcommittee. Thank you for the opportunity to speak with you today and for your generous support and funding in our Ebola response efforts. I am Dr. Robin Robinson, the Director of the Biomedical Advanced and Development Authority, or BARDA. And I am also the Deputy Assistant Secretary for Preparedness and Response for Dr. Lurie at the Department of Health and Human Services, as well as a former vaccine developer in industry.

BARDA is the Federal Government agency within ASPR created in 2006 by the Pandemic and All Hazards Preparedness Act to support advanced research and development and procurement of innovative medical countermeasures. We address the needs of the entire Nation to mitigate the medical consequences of manmade and naturally-occurring threats like the current Ebola epidemic.

BARDA serves as a bridge over a critical gap referred to as the valley of death by transitioning medical countermeasures candidates from early development back at the NIH into advanced development towards FDA approval by using direct financial support, public/private partnerships, and technical core service assistance programs.

To date, BARDA has funded and successfully managed the advanced development of more than 160 medical countermeasures for CBRN threats and pandemic influenza. Twenty-one BARDA-supported products have been approved by the FDA with two approvals occurring within the last month. BARDA has made available twelve medical countermeasures under Project BioShield and maintains the national pre-pandemic influenza vaccine stockpile that may protect tens of millions of persons.

Additionally, BARDA has established four core service assistance programs that help medical countermeasure developers on a daily basis. The NIH with Dr. Fauci and DOD have supported basic research in early stage development of Ebola medical countermeasure candidates over the last decade.

Last summer, BARDA entered this space with a strategy for advanced development of Ebola medical countermeasures. Subsequently, we have reached deep into the pipeline and transitioned 10 vaccine and therapeutic candidates into advanced development.

BARDA's Ebola medical countermeasures strategic goals are, one, make experimental vaccines and drugs available from industry partners for the clinical trials; two, support safety and efficacy studies in animals and humans; and three, develop improved products in enhanced manufacturing capabilities.

Towards these goals BARDA is supporting the development of six monoclonal antibody candidates and one antiviral drug candidate. And using the fiscal year 2014 funds and BARDA technical expertise, together, we are developing ZMapp monoclonal antibodies produced in tobacco plants.

ZMapp production continues as NIH's sponsored clinical studies are ongoing that Dr. Fauci talked about, in West Africa and the

U.S. Also, we are having ZMapp made by other tobacco biopharmaceutical companies using fiscal year 2015 Ebola funds, and we will be testing them in nonhuman primate studies later this month.

Further, as a risk mitigation measure, we partnered with two large pharmaceutical companies, Genentech and Regeneron, that specialize in commercial monoclonal antibodies for other diseases to develop Ebola monoclonal antibodies including ZMapp using specialized CHO cells and state-of-the-art antibody technologies. These partnerships are resulting in rapid development of ZMapp and brand new Ebola monoclonal antibodies. Preliminary results have shown that these candidates produced in specialized CHO cells are equivalent to ZMapp.

BARDA has also transitioned Ebola antiviral drug candidate, BCX-4430, from early development supported by NIH and Dr. Fauci to advance development. Clinical lots of this drug candidate are being manufactured for future trials in West Africa.

For vaccines, BARDA, using fiscal year 2015 Ebola funds, is supporting the development of three Ebola vaccine candidates with two more candidates under active consideration. Two of these vaccine candidates are currently in clinical trials, as Dr. Fauci talked about, and BARDA is funding the technical—and providing technical support for enabling the additional clinical lot production, commercial manufacturing scale, and development of more thermal-stable vaccine formulations for easier storage and use.

BARDA has learned several important lessons thus far through the Ebola response. First, direct technical assistance was needed by Ebola medical countermeasures' own site. BARDA transformed its four core service assistance programs into a cohesive national medical countermeasure response infrastructure that has provided rapid response and assistance to our Federal and industry partners.

The investments that we have made since 2010 to create this infrastructure are paying off in the response to our current Ebola epidemic and will be expanded with innovative technologies that afford rapid and nimble product development and manufacturing to meet the challenges of future known and unknown emerging infectious diseases.

In conclusion, BARDA, with our Federal and industry partners, have responded rapidly and successfully with a development of new and innovative medical countermeasures during the epidemic in record time. Not years, but months. These investments in the Ebola medical countermeasures and response capabilities have addressed much of the current epidemic, as well as the underpinning national security threat posed by viral hemorrhagic fever viruses as bioterrorist agents.

Again, I would like to thank you for your support and look forward to answering your questions. Thank you.

Mr. COLE. Thank you. As the chair announced earlier, obviously we have other committees meeting, so just for informational purposes to the committee, we are going to go first to Mr. Dent, who has another meeting to chair at 11:00; then to Ms. Lee, who is also a member of that committee; and then we will go to our distinguished ranking member of the full committee, who is also trying to shuttle back and forth amongst these various committees.

So with that, Mr. Dent, you are recognized.

Mr. DENT. Thank you, Mr. Chairman. Thanks for your courtesy today.

EBOLA TREATMENT CENTERS

And thank you to all the panelists this morning.

Dr. Lurie, as we discussed a little earlier, I have two designated Ebola treatment centers in my district. We have Allegheny Health Network and Penn State's Milton S. Hershey Medical Center. There are four total in my State of Pennsylvania. And, as you know, last year, we provided ASPR with \$576,000,000 in emergency funding for Ebola preparedness, including ensuring hospitals are adequately prepared and reimbursed for the incurred costs and preparation for Ebola patients.

ASPR has released \$194,500,000 total, just shy of \$10,500,000 to Pennsylvania. I have heard from my hospitals that this is not in line with the costs that they have incurred in preparation for Ebola patients. Could you please explain to us why ASPR is holding back the existing amount of \$381,500,000. And why did ASPR establish a limit for hospitals receiving that funding, and shouldn't the hospitals be compensated for their actual costs?

Hospitals also continue to ensure safety of patients and caregivers, and I think it is important that we recognize all the costs that have been incurred for Ebola preparedness and adequately reimburse them for their expenses. And finally, if you could tell us why only CDC-designated hospitals as opposed to State-designated hospitals are eligible for the funding?

Dr. LURIE. Great. I appreciate your questions. And it has, you know, been a complicated area as, you know, with the Ebola emergency funding. Congress asked us to move forward with a regional strategy for care of Ebola patients, and we have done just that. We took a little bit of pause. We went out and we did a number of things. We used data from Customs and Border Patrol to figure out a little bit about what we needed; we met populations around the country; we talked to lots of stakeholders, hospitals, hospital associations; solicited a lot of feedback about what was necessary.

We also got a lot of information from hospitals and the hospital associations about the range of costs incurred in getting ready for preparedness. And at the end of the day, it was our assessment that the amount of money apportioned to the hospital preparedness program was what was needed to prepare. With that, there is sufficient funding for each designated Ebola treatment center, those that have had the CDC visits to receive \$500,000 as part of their costs, and for the States to have pretty broad discretion in terms of the other hospitals, in terms of the amount of funding they allocate to each hospital. And we believe that this amount of money is pretty sufficient to cover the costs of most of these individuals.

In addition, as you know, we have a program to reimburse hospitals for the cost incurred of taking care of an actual Ebola patient, and that program is ongoing. The program calls for a treatment hospital, a regional-designated hospital in each HHS region of the country as well, and there are additional funds provided to do that.

The applications for those are due next week. We anticipate making awards to hospitals—I mean, to the States within 30 days. And from there, the hospitals ought to be able to get the money from this program. So I think we are very much on track to do that.

Mr. DENT. Okay. Thank you.

EBOLA DIAGNOSTICS

And, Dr. Frieden, welcome back, again, to this subcommittee. I certainly appreciated your feedback regarding development of Ebola diagnostics at the last hearing and certainly look forward to more information from you and your colleagues today.

As you know, I am certainly proud to represent the OraSure Technologies Company, which is working with CDC to develop a rapid point-of-care Ebola screening test. And as the world's response for Ebola continues to evolve, how would this test be deployed? And are there any plans to stockpile Ebola diagnostics? And could you show us that cute little diagnostic, if I didn't steal it from you.

Dr. FRIEDEN. Thanks very much. There are many areas of innovation that can help us stop Ebola. Rapid diagnostics is one of them. We already have one FDA-approved test being used in West Africa. The company is known as BioFire, and it can test a single sample in about an hour and a half. But it still requires a laboratory infrastructure.

The OraSure, as well as other rapid diagnostics, allows for a rapid test. The paddle can be used to take a buccal or oral sample that can be done for, for example, assessing people who have died to see if they have Ebola. And a tiny finger stick of blood can be used in one of the wells here. It is placed into a developer. The developer moves through and then the control line shows that it has actually been a valid test procedure, and then the test line, if positive, will show that there is Ebola antigen or Ebola virus present.

This test, as well as some of the others, have been looked at in our laboratory. It performs well, not quite as well as the high technology test that is done in a full laboratory, but probably well enough to get a preliminary answer. And we hope to be in field trials of this product in West Africa as soon as next week.

Mr. DENT. Thank you. That is very encouraging. I see my time is expired. Thank you.

Mr. COLE. Thank you.

We will next go to Ms. Lee, the gentlelady from California.

SEXUAL TRANSMISSION OF EBOLA

Ms. LEE. Thank you, Mr. Chairman.

Good to see everyone, and thank you very much for doing quite a phenomenal job. Come a long way. Still a long way to go, but I think what our country has done to move forward and try to first contain this disease, but also to try to look at ways to prevent it, I think it has been remarkable.

Let me ask you, Dr. Fauci, a couple of things with regard to the sexual transmission of Ebola. According to the World Health Organization, Ebola can be sexually transmitted. It is up to 7 weeks after successful treatment CDC recommends that Ebola survivors

abstain from sex at least 3 months, is it, since scientists really don't know exactly how long the virus can be sexually transmitted.

So I am curious as it relates to the proportion of Ebola cases that are contracted through sexual transmission, what are groups doing, including UNMEER, to identify sexually transmission patterns and the length of time that the virus remains transmissible through semen. And then the other issue is, how are we working with groups to help prevent the transmission of the virus and to inform affected populations that there is a potential of risk there?

Dr. FAUCI. Thank you for that question. As with some other viruses, there are what are called sanctuary sites of residual virus in the body. In these cases, a person can recover from a viral disease, or have no detectable virus in the blood or in any other organ, and yet harbor the virus in these sanctuary sites for a considerable period of time following the clearing of the infection from the blood.

And that is what you are referring to, Ms. Lee, is that there have been clearly-documented situations where the virus, either by a molecular means, or even by actually culturing live virus, has been demonstrated in semen samples for a considerable period of time. This is the reason that the CDC recommendation, as you mentioned correctly, exists regarding safe sex for a period of time following Ebola infection.

We don't know right now how many Ebola cases subsequent to a person being discharged from a hospital have been translated sexually. It is likely a very small number, if any at all, because of the epidemiological patterns that we see in subsequent outbreaks that occur when an outbreak stops. And we don't really see any. We are talking about evidence from previous outbreaks in a number of different countries.

However, that is something that still needs to be followed very carefully. There are follow-up studies that we are doing in collaboration with the CDC, survivor studies. We will be following survivors to monitor their health, as well as for contacts that they might have. So it is a critical question.

Ms. LEE. Is it prevalent enough though to have this as part of the protocol? Are we informing affected populations and countries that this is a possibility?

Dr. FAUCI. Yes, absolutely. They are very much informed. In fact, when we discharged our patient a few days ago, we spent a considerable time talking to the patient about this issue.

Ms. LEE. I see, okay. Well, that is very good to know because that has been under the radar in our own country for a while, I think.

Dr. FAUCI. Yes.

Ms. LEE. So thank you very much for that.

QUARANTINES

Dr. Frieden, let me ask you just about the government-enforced lockdowns. We know that at the end of March in Sierra Leone, Sierra Leone instituted, I guess, it was a second nationwide lockdown which required residents to remain in their homes for 3 days. What is your view on these lockdowns, and do we engage governments on this issue? And have communities been receptive to these

lockdowns as an Ebola-preventive measure, or are people resisting this?

Dr. FRIEDEN. Thank you for that question. It is a very important and challenging area. I believe the Sierra Leone initiatives haven't been well characterized in the media, but we share the concern that is evidenced by your question. Because in general, to stop an infectious disease, you need to make sure that the patients, the contacts, and in this case, the survivors, are treated as VIPs.

The Sierra Leone situation, this is the second time they have done this, and the idea was that everyone should stay home, they would be provided food, and they would be educated about Ebola, and there would be a house-to-house search to make sure there were no hidden cases of Ebola. It is the second time they have done it. It went better than the first time they did it.

But there was one isolated incident where food didn't arrive and people were asked to stay in their home, that understandably made people quite concerned or upset. But in general—and we have had a very large staff contingent from CDC in Sierra Leone, in fact, the largest of any of the three countries because of the challenges there—the sense of our staff has been that, by and large, it has been well accepted by people from within the community as an education and mobilization effort.

Separate from that is some of the issues of a quarantine of contacts, which can be counterproductive, we feel, but we will see how that goes in the West African countries. Guinea just did a similar exercise in one prefecture just last weekend and, again, we had worked with the community so that it was not a lockdown. It was an intensive educational effort that allowed them to potentially find additional cases.

Ms. LEE. Thank you very much.

Thank you, Mr. Chairman.

Mr. COLE. Thank you.

Now we will go to the distinguished ranking member of the full committee from New York, Ms. Lowey.

HOSPITAL PREPAREDNESS PROGRAM

Mrs. LOWEY. Well, I thank you, Mr. Chairman. And it is a pleasure to be here with our distinguished chair and our distinguished ranking member. I apologize for missing the testimony. As you know, we have been skating around the Capitol, many hearings at the same time, but I want to join you in welcoming Dr. Frieden, Dr. Fauci, Dr. Lurie, Dr. Robinson. I want to thank you all for what you do to improve public health.

Because I think it is so important, I want to reiterate the concerns of my good friend, Mr. Dent. In 2014, JFK Airport received about half of all passengers traveling from the most Ebola-affected West African countries. New York's health infrastructure must be prepared to take in cases of Ebola and other infectious diseases.

New York hospitals have the talent and experience to treat these complicated cases, but they are doing so at great costs. And I hear about it on a regular basis. As a result, this committee did include substantial funding to support Ebola treatment centers and hospital preparedness, including funds to be distributed by ASPR to reimburse hospitals for treating Ebola patients.

Dr. Lurie, your testimony States that you are “working with these providers who stepped up to treat Ebola patients by making sure that they do not bear a financial burden for their leadership.” I know that ASPR has already designated nearly \$200,000,000 for States through the hospital preparedness program; however, that covers—I am sure you have heard this—only a small fraction of the costs that providers have incurred.

If your commitment is to ensure that providers do not bear a financial burden, are you planning to allocate additional funds to hospitals through the HPP grant? What are you planning to do with the remainder of the emergency funds at your disposal?

Dr. LURIE. I appreciate that question, and have had extensive conversations with the hospitals about this—

Mrs. LOWEY. As I have.

Dr. LURIE [continuing]. And about their concerns. As I think you know, because of the way that the formula is created to do the hospital preparedness program, which was on sort of a base plus a population plus risk, risk being the number of returning travelers to West Africa, New York City, in particular, I think, received more funding than any other place in the country. And it is, in fact, the case that they bear a pretty disproportionate share and disproportionate risk.

And so New York City in particular, as well as New York State, have wide discretion to allocate those funds to the hospitals who stepped up and the hospitals that have borne the risk. In addition, the hospital in New York City, Bellevue, is in the process of submitting its claims for the uncompensated care costs for taking care of their patient with Ebola. And we should be receiving those claims soon, and they should be compensated quite quickly.

As I explained to Mr. Dent, we went to great pains to try to look at how much money was needed to support the hospital preparedness program. And as you know, within the allocation, there are a number of other competing needs for what appears right now as unallocated funding. And so for now, we are reserving some of those funds to look at what happens to the trajectory of the epidemic, to be certain that we don’t need those funds for other things related to Ebola, to be certain that we don’t end up with clusters here and additional hospitals that we need to compensate, and all of those other things.

But additional potential activities, you know, include additional funding for either PHEP or HPP if it is needed, a countermeasure injury compensation fund, ongoing support for our commissioned corps that responded, doing an Ebola after-action report, many, many other things. And then as the trajectory of this disease declines and we look at additional funds, to look at additional countermeasures that also need to be supported by these funds, as Congress directed.

And so this is still an evolving area, but certainly, our conversations up front with the hospital associations, with the Association of American Medical Colleges, with visiting many hospitals that got themselves prepared suggest that, in most cases, if not all cases, the funding should be sufficient to cover court costs.

I understand that the hospitals may not see it that way.

Mrs. LOWEY. You are correct.

Dr. LURIE. And I understand—you know, and I understand, too, that—and very much appreciate—that the hospitals stood up and stepped up in many ways. And they built, in many cases, very, very nice facilities. Others worked within a more strict budget and certainly have more-than-adequate facilities to care for Ebola patients.

Mrs. LOWEY. Let me just say in conclusion, because I see the red light blinking, I understand that ASPR must look ahead and be prepared for every eventuality, but I am very concerned that with sending the wrong message to hospitals that step forward to be designated centers for Ebola already by imposing a financial burden as a result of their service.

If hospitals elect with the bill, they tell me they may choose not to take the financial risk associated with protecting public health in the future. So I would like to continue this conversation, and maybe we can get in specifics, because there seems to be maybe some misunderstandings. Hospitals feel they went out of their way, and you feel they were reimbursed sufficiently. They don't. So let's continue the conversation.

Thank you, Mr. Chairman.

Dr. LURIE. We would be happy to do that.

Mr. COLE. Just for the record, the red light never blinks on the full chairman or the full ranking member.

Mrs. LOWEY. You are such an elegant chairman. Thank you so much.

Mr. COLE. But it blinks on all the rest of us, okay. Thank you.

LESSONS LEARNED FROM EBOLA OUTBREAK

You know, as I was reading your testimony last night, I must say, I felt like I was reading a Michael Crichton novel. It was just amazing. And Dr. Frieden pointed this out in his testimony how unprecedented this was, and remarkable. Lots of things to learn and reflect on here.

So I am going to ask you first, Dr. Lurie, do we have a system in place that we formally are doing a lessons-learned exercise? Because obviously, we think you all responded remarkably well. We would like, though, to get better each time and be prepared for anything unexpected.

And then I will just go down the line and ask each of you, if I may, what would be the one or two lessons learned from your standpoint, for your respective organizations, and things this committee should know going forward where we could be helpful as you try to institutionalize, if you will, a response to an unexpected event like this?

Dr. LURIE. Great. I appreciate the question. And yes, in fact, we are in the process now of planning a pretty comprehensive review of HHS's activities with regard to Ebola. As you know, each department, and many departments and agencies contributed to this response. I believe each of them is in the process of reviewing their actions, and we all get together and talk amongst ourselves.

So we are in the process of putting that together and anticipate that that will be evolving over the next year or hopefully less. In the meantime, we continue to sit back and take stock as we have done on an interim basis of what are the lessons we are learning,

what are the lessons we have learned, and to begin already to take corrective actions and put those in place.

Mr. COLE. As you do that—and then I am going to move on—this committee would be very interested in any formal documents that you have. It would be very helpful, I think, for all of us to sort of walk through and see your thinking as you prepare a final product. So please make that available to us when it is appropriate.

Dr. LURIE. We would be delighted to do that.

Mr. COLE. Thank you.

Dr. LURIE. Yeah.

Mr. COLE. Dr. Frieden, if we can go with you, just lessons learned.

Dr. FRIEDEN. Really three from our perspective, and we look forward to the more formal process. But the first is that it is critically important to strengthen national capacities around the world. If the countries of West Africa had had the public health systems in place to find, stop, and prevent Ebola, the world would have looked very differently over the past year.

Second, when a country's national capacities are overwhelmed, as occurred in West Africa, we need a stronger global architecture to intervene. Much has been written about the World Health Organization and their role here. I think they would agree that it should have been different than what it was. WHO is an essential organization, and it is in all of our best interests to strengthen their capacity and the global capacity to assist when national capacities are overwhelmed.

And third, I think for this country, it emphasizes how important and challenging infection control in healthcare facilities is. And we know that even without Ebola, there are about 75,000 deaths per year in this country from hospital-acquired infections and healthcare-acquired infections. So those I think would be three of the top line big picture items.

Mr. COLE. Dr. Fauci.

Dr. FAUCI. A couple of lessons learned Mr. Chairman. First, I think it is a lesson that is relearned as opposed to newly learned, and that is that outbreaks do occur. It is very difficult to get people excited about an outbreak before it occurs, and that is the reason why we need to continue the kinds of work that we do at the level of surveillance and at the level of research, because this will happen again. This is not a one-off event, and it will happen again, and I am sure we will be testifying before this committee again about a similar outbreak.

Next, I think it is important—and we have seen this with other diseases, particularly with malaria—that when you are dealing with countries that do not have resources, when you get involved with them, you need to make sure that you leave them with sustainable capacity so that you don't, at the end of this, have the West African countries starting from ground zero, but they could actually learn from this and have both manpower capacity as well as physical capacity.

And then, finally, with regard to the United States, we have learned again, as we did with HIV, that the perception of risks in this country are very interesting; that we are willing to accept risks every day that are far greater than some of the risks that are new

risks. And it is very interesting that at a time when West Africa was suffering terribly, because of two infections of healthcare workers in this country, the United States panicked.

And we spent a lot of energy trying to tamp down the panic, when at the same time, there was extraordinary suffering going on in West Africa. So those are the three lessons that I have learned.

Mr. COLE. Thank you.

If we can go to you, Mr. Robinson. And my time is brief, so if you could be brief.

Mr. ROBINSON. Sure. So in my testimony, I actually provided one already, and that was that we moved our core service assistance programs that actually help developers every day into actually becoming a national medical countermeasure response infrastructure to formalize that. And so that actually helped not only our Federal partners, but also our industry partners, many of who were small companies.

The second one is that there needs to be clear regulatory guidance and pathways for medical countermeasures regardless of peacetime or emergencies. I have to say that FDA unprecedentedly became a true partner to help industry sponsors and Federal partners, and in that way that they did that, we can actually replicate that going forward. But that is important to make these medical countermeasures approved by the FDA.

Mr. COLE. Thank you very much.

With that, we will go to the gentlelady from Connecticut, the ranking member.

HOSPITAL PREPAREDNESS PROGRAM

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

And my first comment or questions is to Dr. Lurie, Dr. Frieden. Public health emergency preparedness awards over the last 5 years declined \$165,000,000, 20 percent, after you addressed for inflation. Funding is used by State, local health agencies to deal with surveillance, laboratory capacity, employ epidemiologists to identify, investigate, track disease. The funding also supports rapid response in case of an outbreak or an international attack.

Likewise, hospital preparedness program declined \$200,000,000, 44 percent over the last 5 years. Funds, again, used to improve surge capacity, enhance community and hospital preparedness for public health emergencies. Rather than provide sufficient and consistent funding over time, Congress chooses to fund emergency by emergency.

When I gathered all of my hospitals together and met with them during this crisis, they all—one said we appreciate what you are saying and what you are doing and how we cope with this crisis, but please understand that we can't go emergency by emergency. If you want us to be able to respond or prevent or respond, we need to have consistency of funding to deal with the infrastructure and the policies that are necessary to move forward.

Your views, Dr. Lurie, Dr. Frieden, did the cuts impact State and local health departments' ability to respond to Ebola? If the health departments hadn't been cut in recent years, would emergency funding for Ebola have been less necessary? Given the recent les-

sons we have learned from Ebola, isn't it important to maintain stable, consistent funding for these programs?

Dr. LURIE. So very much appreciate the question and have very much appreciated your support of the hospital preparedness program and the public health emergency preparedness programs. They are critically important.

You know, a chain is as strong as its weakest link, and our challenge is really to be sure that no matter where you live in this country you are protected by a health department and a healthcare system that has a basic level of preparedness. As I said in my testimony, preparedness is forever. It is not that you can buy a bunch of stuff in that you are done; that you need to continue to train to exercise and to be ready at a moment's notice.

In fact, I believe that it was a lot of the investment in preparedness that got our country to the point where we could recognize, test, isolate, treat, surge, do all of those things. But we obviously saw some shortcomings. We have a long way to go. What was needed for Ebola was different than many of the other investments that we have made so far. Having said that, the core things that people can do time and time again, they could do.

Last point, we cannot fund a system on an every 5-year emergency, as you point out. It has to be sustainable, reliable, year-to-year funding, but we also need funding to get out of the blocks when the unexpected thing happens.

Ms. DELAURO. But if it is not Ebola, it is going to be something else.

Dr. LURIE. It is going to be something else, and so that core thing has to be in place.

Ms. DELAURO. Dr. Frieden.

Dr. FRIEDEN. We are very grateful for the support of Congress, of this committee for emergency preparedness work. And that work at the State and local level is essential and was used, in this case, to track travelers, to respond rapidly, to support hospitals and provided the vehicle for the \$30,000,000 in supplemental funding that was provided last year and then for the emergency supplemental.

I think your point about flexibility is a very important one. At the very outset of this outbreak—it is hard to remember back, but at the very outset, last summer, at CDC, our funding is so constrained by different areas that we virtually had problems paying for the plane tickets of our staff who were going to West Africa. So the ability to move rapidly in an emergency—and that is one of the reasons for the proposal and the fiscal year 2016 budget for a fund that can be used in any emergency—is very important, as I point out.

Ms. DELAURO. Just in terms of that fund, as I said, I know what you are going to say to this. You know, I think we do provide funding for hurricanes. We provide them for floods. There is disaster assistance wherever you turn here, and on a dime, we deal with disaster assistance.

This is a disaster that we can—and I welcome your and I welcome the chairman's view as to how we try to push forward to make sure that there are dollars that are set aside for these particular kinds of public health emergencies.

LABORATORY CAPACITY

Let me just say, the emergency funding, my understanding is on laboratory capacity, where we didn't have that capacity to perform the lab tests in the past, but the emergency funding has now, they said there are 56 labs in 44 States that can perform an Ebola test. Does that mean they can perform other tests with regard to infectious diseases that are similar to——

Dr. FRIEDEN. Yes. These are generally part of the laboratory response network that CDC coordinates which allows the rapid testing for Ebola and other high-threat diseases.

Ms. DELAURO. Mr. Chairman, just understand that before the—— at the beginning of the Ebola outbreak, only CDC could perform an Ebola lab test. But this funding has provided the opportunity to take us nationwide. Thank you.

Mr. COLE. Thank you. I did not realize the gentlelady from Alabama was also on MILCON. And so she has a markup underway. So we are going to move to her so she can ask whatever questions she likes and move on to her next committee. The gentlelady is recognized.

CDC STATE AND LOCAL TECHNICAL ASSISTANCE

Mrs. ROBY. Thank you to my chairman and to the rest of the committee for letting me jump ahead. I appreciate you all being here. And, Dr. Frieden, I want to follow up on the 55 facilities that you had mentioned, that they are prepared to handle an Ebola patient. And I have got a series of questions, but we will take each one. Are there partnerships that have been formed so that these facilities can continue to receive extra support from the CDC for treating patients with either Ebola or other highly-infectious diseases?

Dr. FRIEDEN. Thank you very much. We provided extensive technical cooperation. We visited each of the facilities. We provided them with essentially a punch list of what additionally needed to be done. We also worked very closely with the State health departments and strengthened their ability to provide that kind of support and guidance for the facilities and were available for sight visits, training. The goal is to make sure that they are ready and remain ready. And, of course, the Hospital Preparedness Program, which Dr. Lurie's office oversees, has a granting program to do that as well.

FRONTLINE WORKER TRAINING

Mrs. ROBY. How do we ensure that the medical staff on the front-line at these facilities and other places across the Nation are properly trained for when the time comes? Clearly that is a huge concern for their well-being and the larger population.

Dr. FRIEDEN. I will start and ask Dr. Lurie to continue. One of the essential aspects of the guidance that CDC has provided for healthcare facilities is that training should be extensive and hands-on, so that people actually have used the equipment before they would see a case. The second thing that we have done, which is broader than that but intersects with it, is to establish a monitoring and movement program for travelers returning from West

Africa. We oversee a screening process in each country so that people with fever don't get on the plane there.

We work with Customs and Border Protection of the Department of Homeland Security, which funnels all returning travelers, essentially all returning travelers to five hospitals—sorry, to five airports to monitor them at the airports, take their temperature, and provide a check and report Ebola kit, which includes a thermometer and a way to contact them. And we connect them with the local health department, or State health department which monitors them every day. That has happened in every single State of the U.S. Since the start of this outbreak, more than 12,000 travelers, more than 200,000 contacts in that 21-day period. So that if someone develops fever, they can be safely transported and the hospital knows someone is coming in. Dr. Lurie.

Dr. LURIE. Sure. Let me amplify on some of Dr. Frieden's comments. In the \$208,000,000 that is going to the Hospital Preparedness Program, there is also funding for a national training and education center, this is a collaboration between my office and CDC, to support hospitals that have taken care of Ebola patients, to over the next 5 years, go out and train and exercise the other treatment facilities about how to do this, to be sure that they continue to train and continue to exercise. So the requirements in the grant program require these regional centers to train and train and exercise their staff quarterly, and for the other hospitals to be able to train annually. In addition, the States and the training center are required to use metrics that also assess the frontline worker training and level of preparedness. In every level and in almost all communities, there are healthcare coalitions that also are there to support some of the smaller institutions to do training and exercise together so that it is a much more efficient and less costly process.

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

Mr. COLE. Thank you. We will next go to the distinguished gentleman from Pennsylvania, my good friend, Mr. Fattah.

ADDITIONAL CONGRESSIONAL ACTION

Mr. FATTAH. Thank you, Mr. Chairman. And let me thank the panel. I want to echo what has been said which is to commend the great work that has been done to deal with this very challenging circumstance. I, myself, met with local hospitals in the Philadelphia area, Main Line Health in Pennsylvania. I went out and visited St. Christopher's. And I think the healthcare professionals did an extraordinary job. But I think that the Federal Government in so many respects, led by the people obviously here, but also our military in terms of the work that was done. And we have private sector people, like my friend, Bob Johnson, who owns a hotel in Liberia, he made his hotel available for healthcare professionals who traveled there to do work.

The other night, I had dinner with the African Union Commission. And, obviously, this crisis is still a challenge in many countries and there is still very important work that is going on. So I want to start with, first, a question, DARPA has released a grant led by, a \$45,000,000 effort led by a Philadelphia area firm to take a different approach at trying try to think anew about how to both create a vaccine and to treat people with Ebola. But I know that

you mentioned the effort, the vaccine effort with Merck. Glaxo has got an effort, and so on. If you talk a little bit about is there anything that Congress could be doing, any more that we could be doing in terms of this particular area in terms of treatment and prevention, whether the FDA, whether others are doing the work that needs to be done in a fashion that it needs to be done to address this challenge.

Mr. ROBINSON. Sure. Thank you for that question. Certainly the work that we have been doing with CDC, FDA, ASPR, and NIH has set the stage for these medical countermeasures. They need to be completed. The development all the way to FDA approval needs to happen, not only for bioterrorism reasons, but also for the next outbreak of Ebola. And so the funding that was provided already will get us so far. We will have exhausted all our funding this fiscal year. But we will need to complete the job. And so we will be requesting funds going forward to do that, to actually have these funds. In addition, we need to actually have the infrastructure to respond to the next Ebola, to the next unknown and known emerging infectious disease.

Dr. FAUCI. So just to reiterate what several of the members have said, these outbreaks are unpredictable. But in order to be prepared for them, you have to have a predictable type of support which is consistent. And we are very appreciative of the fact that this committee has been extraordinarily generous in their consistency of support for what we do at the NIH. And if it had not been for the consistency of that support over the years, we would not have a vaccine in trial right now, which is currently being tested in Liberia.

INTER-GOVERNMENTAL COORDINATION

Mr. FATTAH. Speaking of predictability, you look at the stats over the 20th century, about 160 million or so people died from wars. We know a lot about war efforts. But 10 times that many die from infectious diseases. We know there is going to be this challenge for humankind. And it is very important that we prepare, not just in terms of dealing with this crisis, but future crises. And that is something that the committee is obviously, you know, grappling with now as we deal with the budget, the appropriations for NIH and for the Centers for Disease Control and for all of our other activities. I am just wondering when we see the, is there coordination, I guess is the question, between DARPA's work and the work that is being done? I know theirs is a little more, has more of an edgier side of this. But I am wondering whether or not there is good communications.

Dr. LURIE. Certainly. I am happy to address that question. And thank you for that. I would first go back to a comment that Dr. Fauci made, it is hard to get excited about these infectious diseases when there are no infectious diseases or crises going on. And so I will also just reiterate this issue about the sustainable funding. I chair the Public Health Emergency Medical Countermeasures Enterprise.

And with that, all the different parties across the government that are involved in making countermeasures, from the early-stage research at NIH, through the advanced development at BARDA,

through the work, both on surveillance and diagnostics at CDC, to regulatory affairs with FDA. And then work with DOD, with DARPA, with DHS, with USDA, everybody is a part of this.

And it is, at this point, highly coordinated. We have priority products that we work on. We get together every year to discuss each category of products, whether it is Ebola countermeasures or we did one 2 weeks ago for MERS, to look at what is in the pipeline, how we help each other out, how we take hand-offs from DARPA through into HHS if that is appropriate, and moving those things forward. So, at this point, I think there is a lot of visibility. And it is highly coordinated.

Mr. FATTAH. Thank you, Mr. Chairman.

Mr. COLE. Next, just on basis of order of arrival, we will go to the distinguished gentleman from Maryland, Dr. Harris.

HOSPITAL PREPAREDNESS PROGRAM

Mr. HARRIS. Thank you very much. I want to thank all of you involved. And certainly if you look at the global response, it looks like the U.S. kind of led it. And I think, Dr. Frieden, you are absolutely right, I am not that is absolutely the role we are supposed to play. There should be a global initiative and architecture to deal with it. But, unfortunately, I guess, we filled in the gap. We filled it in pretty well I thought.

You know, it is interesting, my daughter works at Hopkins in the pediatric ICU. And in the midst of this—as you know, we have a West African immigrant population—she actually had to be trained at that time as to how to do real isolation, how to gown properly and things like this.

So, I am going to follow up on what the ranking member asked about, which is how in the world were we not prepared? How could my daughter working in the pediatric ICU at Hopkins not have been trained at some level in how to actually take care of a highly-infectious patient? Let's put it in perspective.

Dr. Fauci, you are right, it is difficult to get people excited about outbreaks until they occur. But that is your job. I mean, the public health community and the preparedness community is supposed to think differently than the general public. Now, the bottom line is, and the ranking member brought up the funding issue, the fact of the matter is, Dr. Lurie, you know, the Hospital Preparedness Program was funded in the \$350- to \$380,000,000 range between 2011 and 2013. And the President requested a cut to \$255,000,000 in fiscal year 2014, and requested \$255,000,000 again in fiscal year 2015, despite the fact that Ebola has been on a National Threat Assessment list since 2004. That is the bottom line. The PHEP Program level funded—we have spent, by my back-of-the-napkin estimate, probably \$8,000,000,000 to \$9,000,000,000 since 2002 on the PHEP Program, in addition to whatever we are spending on the Hospital Preparedness Program. And we have nurses at leading hospitals who don't know how to protect themselves?

You know, sometimes it is better to be lucky than good. And I will tell you the fact that we didn't have as many healthcare workers contaminated and infected in this country was luck, not preparedness. And I hope you are realistic enough to admit that, that that's what it was. So how in the world are we going to be certain

that, first of all, and I have got to ask, someone said well, we didn't get funding. And a very direct question to you, Dr. Lurie, because if Secretary Burwell was here, I would ask her. You have a \$1,000,000,000 prevention and public health fund in the ACA. How many dollars of that was spent toward preparedness, toward this kind of event out of that fund? \$1 billion a year, additional funding came online a few years ago, years after Ebola was identified as a national threat, on the National Threat Assessment list. How many dollars out of that fund, additional dollars? This was additional money put on the table.

Dr. LURIE. I don't have access to those numbers now. I am certainly happy to be get back to you with information.

Mr. HARRIS. I went down the list, Dr. Lurie. I can't identify anything from that fund that made sure that my daughter knew how to put on an isolation gown and be protected, because she was going to be asked to take care of patients potentially, and now we know Hopkins is one of the designated centers, take care of patients who could infect her and potentially kill her.

I have got to tell you, I have real concern when people come in and say we haven't put money on the table for this, when we have a fund that could have been used for this and we chose not to use for it. Your point is absolutely right that the public needs wake-up calls. But the groups you represent shouldn't need the wake-up calls. You should wake up every morning and go to bed every night worrying about things that the public doesn't worry about. This was one of them. So I have got to ask you: Why in fiscal year 2014, and I don't know if you prepared the HPP budget request or someone else, why was there a \$100,000,000 decreased request?

Dr. LURIE. I think if you look at what happened in fiscal year 2014, and you trace that back, what you saw was some initial conceptualizations from several years ago about what the Hospital Preparedness Program needed and didn't need. There were continuing resolutions over those couple of years which, fortunately, were able to sustain the program at a higher level of funding until 2014. If I look at what we have learned with Ebola and with all the other cuts in the Hospital Preparedness Program, I agree, we have to ask ourselves some hard questions about how much money is needed and to be sure that we are able to sustain all the public health emergency preparedness programs at a level that lets us all do the day-to-day, year-to-year work so that as, Congresswoman DeLauro pointed out, we are not dependent on emergency funding that comes every 4 or 5 years.

Mr. HARRIS. Doctor, as the budget was prepared for fiscal year 2014 and 2015, the administration requested \$100,000,000 less. Was the assessment that we were ready for Ebola? Was that the assessment? Because you asked for less money. My assumption is you said we have solved the problem, we don't need as much money. Was that the assessment?

Dr. LURIE. I think the assessment is always a balancing act between lots and lots of competing needs.

Mr. HARRIS. Thank you very much. Thank you, Mr. Chairman.

INTERNATIONAL FACILITY CONSTRUCTION

Mr. COLE. You are welcome. We will go next to Mr. Rigell for whatever questions he cares to pose.

Mr. RIGELL. Thank you, Mr. Chairman. Thank you all for being here this morning. And I am going to ask that you decide among yourselves who should best answer this question because I am not really sure, even based on looking at your resumes here, but my question is relating to an article that ran recently in The New York Times about our massive investment in Liberia, principally for these emergency treatment facilities, and just the lack of use of these and really questioning the wisdom of the construction in general. So who would be best to direct, okay, Dr. Frieden, thank you.

The numbers are pretty striking, 11 treatment facilities; 10 of them opened after December 22nd, only 28 patients total treated; 9 have seen no patients whatsoever. And I know because of the district that I represent that many of the ships and personnel that were there came from the Norfolk area and the Virginia Beach area. And I question the wisdom of all of our troops there. But let's just look here, because there were a number of experts, recognized experts, that were saying this is not a good use of funds. And it strikes me, at least on the surface, I mean at first glance, and this is why you have the opportunity to respond to it, that we were doing something to do something. This is our American—you know, we are going to do something and do something big as Americans. And so we are constructing things. How can you reconcile that investment with the lack of the use of these?

Dr. FRIEDEN. When the initial plan was made, cases were doubling in Liberia every 21 days and were spreading throughout the entire country. This was the first time Ebola had ever acted like this anywhere in the world. We were seeing really a horrific situation. I, myself, traveled to Liberia in August and September and saw an Ebola treatment unit which was designed for 50 people, and it had well over 100 Ebola patients. There were so many people who had died, that people couldn't even remove the dead bodies fast enough.

So the goal was to get treatment facilities around the country so that that wouldn't happen elsewhere. What we found over the following months was that if we got there quickly, we sent teams in by helicopter and canoe, we could cut the outbreak and stop it from exploding in that way. But it was an insurance policy.

Mr. RIGELL. Let me ask you just as a follow-up, because our time goes so quickly here. Let's go ahead and agree upon that, perhaps, at the beginning, it was a wise project. Let me just concede that if you will. The fact that we didn't pivot, though, when the disease was actually—the outbreak was subsiding significantly, and many experts were saying this is not a wise use of our funds, I think our ability to be nimble and quick, one of the experts, basically, he was saying look, it was like a locomotive freight train coming, you really couldn't stop it.

Once Americans start to do something, and I know there is a lot of inertia here and the government is big, our ability to pivot at that point wasn't there. And at what point, Dr. Frieden, do you say hey, this is really not a good idea, this is not a good use of taxpayer

money, and really exposing our troops unnecessarily. And I know the risk is minimal in some ways, but go ahead and explain why we didn't pivot as we should have. Or do you agree that we should have pivoted?

Dr. FRIEDEN. First of all, we did pivot.

Mr. RIGELL. I am talking about timing here.

Dr. FRIEDEN. But we reduced the number of facilities, the size of facilities, the staffing of facilities. But we made the judgment at that time that it was better to have too many beds than too few. Because the tipping point that allowed that explosive spread was having too few beds. And the idea of having empty capacity, those are Ebola patients that didn't occur. That is a good thing to have not had that kind of explosive outbreak. In any situation, you can look back and say well, if we had perfect foresight, we would have done something different.

Mr. RIGELL. And I fully appreciate that. By the way, I hold each of you in high regard. And I thank you for what you are doing. So the purpose of my question is not to pile on. But we need to learn as an institution and learn from things that we didn't do quite well. And I would submit that the evidence is pretty clear that we should have pivoted earlier in a more significant way. That is not easy for the Federal Government to do. Perhaps the caution was because of the seriousness of this and it getting away from us. But I do believe that just looking back, especially when other noted professionals who hold credentials, I think, equal to the ones here at the table, as significant and respected as they are, they were saying that this was not wise, it was not needed. And I think we could have pivoted 6 weeks, 8 weeks, maybe even sooner than that. But I thank you for your testimony. And I thank you for your service to our country. And I want to yield back.

Mr. COLE. If we can, Mr. Fleischmann, you are next up.

MEDICAL COUNTERMEASURES RESEARCH

Mr. FLEISCHMANN. Thank you, Mr. Chairman. Doctors, good morning. I want to thank each and every one of you for your commitment to this devastating disease, to the fight against it, and for your responsiveness, particularly Dr. Frieden. During the height of this crises, I reached out, I know members of this committee reached out. And I really appreciate the prompt responses and answers back that we got at a very difficult time when you were burdened with the immediacy of response and dealing with this. So I thank you for that. It is not an easy situation.

In that regard, I have got some questions. Congress provided more than \$2,800,000,000 in fiscal year 2015 for Ebola response and preparedness, \$88,000,000 in September 2014, and over \$2,700,000,000 in December. A large portion of that funding was appropriated for the development and purchase of medical countermeasures, vaccines, and therapies, and remains available to you beyond the end of the current fiscal year.

I have spoken with Dr. Frieden and others about the promising research that is being done in this area. And I am interested in hearing from the entire panel about your interactions with companies doing Ebola research. In addition, I would like to know what are your agencies doing to leverage private sector research into ad-

ditional drug and therapy options besides those mentioned in your testimonies.

Dr. LURIE. I appreciate the question. And certainly without these public-private partnerships, it would be exceedingly difficult to develop the kind of products we have. They are vital to what we do for Ebola and for all the other countermeasure preparedness that we have.

One of the terrific things that BARDA has is a program called Tech Watch where new developers and people with ideas can come in. It is a one-stop shop. And they can discuss and propose their ideas. We have had well over 100 requests to Tech Watch through all this, I think it is 88, so face-to-face or telephone conversations with developers to give them guidance. Many of them have developed white papers. Some of those are being supportive. That is a program that is a core program that we have within BARDA and will continue it. It has played a very essential role in Ebola.

Mr. FLEISCHMANN. Thank you.

Dr. FRIEDEN. We have had a series of activities on particularly diagnosis, where we have helped companies develop assays that can be used rapidly. We have assessed assays, worked with the companies and the FDA to get them approved and in the field or assessed. So that is one area that is very helpful for more rapid diagnosis.

The second is on treatment. And here, NIH and BARDA have the lead. But we are facilitating in-country trials so we can determine whether these drugs work. On the vaccine work, we have worked quite intensively in Sierra Leone on a trial called STRIVE, the Sierra Leone Trial to Investigate a Vaccine Against Ebola. That trial launched in the past week. We already have vaccinated hundreds of healthcare workers. It is going very well. And that is one additional trial that may give us an answer about the efficacy of the vaccine, that we would have it available in the future.

Dr. FAUCI. At the NIH, we are intimately involved in interactions with industry and biotech companies. In fact, virtually everything that we are doing now and have done, our original work and collaborations with these companies has resulted in the vaccines that have now been in trial for several months in Liberia. It is a very classic example of a government-industry collaboration and co-operation.

One of the things we do is the fundamental basic research that opens up the door to the clinical work and the ultimate production of a vaccine. For example, the NIAID Vaccine Research Center's chimp adenovirus vaccine is being developed in collaboration with GlaxoSmithKline. The VSV vaccine that we are, together with the CDC, testing in clinical trials is being developed together with Merck.

We are running a trial right now testing ZMapp, which is being developed by Mapp Biopharmaceutical, that we are involved in doing the clinical trials. So virtually everything we do in that interface between basic and clinical research that results in a product, or an intervention, is in collaboration with industry, essentially everything we do.

Mr. FLEISCHMANN. Thank you.

Mr. ROBINSON. Public-private partnerships are always part of the lifeblood of what we do at BARDA. We have industry and also Federal partners. In addition to the Tech Watch programs, as I said, we have six monoclonal antibodies and one antiviral drug that have been actually transitioned over from the NIH to us to go into advanced development.

Also we have consideration for a new diagnostic that has been shown today. And three vaccine candidates that we are already supporting, with two under consideration now. And there were some great stories about the monoclonal antibodies in which competing companies actually worked together and actually came to make new products not in years, but in months, that now have passed some of the nonhuman primate studies and can go into clinical studies.

MEDICAL COUNTERMEASURE RESEARCH FUNDING

Mr. FLEISCHMANN. I appreciate that. Chairman, I know my time is about up. A real quick question, I can take a yes or no, do you all have the funding necessary from the influx that was provided last year to invest and acquire promising private sector treatments? Do you have enough money from that influx, yes or no?

Dr. FAUCI. The NIH got \$238,000,000 out of the larger request. And that is enough to do what we need to do right now with this current outbreak.

Mr. FLEISCHMANN. Thank you.

Dr. FRIEDEN. For the current outbreak, from the Ebola supplemental, we anticipate it will be sufficient.

Dr. LURIE. I would agree with that. But I think as you heard from Dr. Robinson, in order to complete the job with developing additional vaccines, monoclonal therapeutics, we will have spent all our money by the end of this year and still have more work to do.

Mr. FLEISCHMANN. Thank you so much. Mr. Chairman, I yield back.

Mr. COLE. All the caveats and qualifications noted. We will next move to my good friend from Arkansas, Mr. Womack.

ADDITIONAL CONGRESSIONAL ACTION

Mr. WOMACK. Thank you, Mr. Chairman. And to our distinguished panel. Again, thank you for the work that you do on behalf of the country. I am very familiar with the work of Dr. Frieden and Dr. Fauci, not so much so on the other two. But I know that you give it your all. And we really appreciate what you do for our country.

I am going to throw this one out on the table. I would like a response from everybody. Now, this question comes from my background as a military guy. And I have a saying that I use with my staff a lot, that hope is not a method. And I know you are faced with a lot of threats out there, a lot of different contingencies that you have to prepare for. I don't envy your job. And we certainly hope that they never come to fruition. But the fact is we have to be prepared for them.

I also am well aware of the stovepipe nature of government a lot. And I have dealt with that in a previous political life as a mayor. And sometimes the stovepipe nature of government, particularly at

a level as big as the Federal Government with all of these agencies, as big as they are, and spread out as they are, from Department of Defense, to NIH, to CDC, and on and on and on, coordination has to be very difficult at times, particularly when it is a matter of great urgency.

So, here is my question: Is there either a policy matter or a matter of statute of law that this Congress needs to address so as to better prepare us for future such outbreaks that would make our response more seamless? Based on your lessons learned, is there a policy matter or a matter of statute that needs to be addressed? And I will just start here with Dr. Lurie.

Dr. LURIE. Sir, I would answer that the national response framework and the authorities given to us in the Pandemic and All Hazard Preparedness Act provide us the statutory authority to act, to coordinate across the government for public health and medical responses. So from an authorities and statutory perspective, I think we are in good shape. As I think you heard a little bit earlier on in this hearing, a place where we really struggle is to have the funds to get out of the blocks quickly. This idea of having a contingency fund that we can use to respond to a crisis before it becomes a global emergency is terribly important. Congress has been terrific about coming through with emergency funding and emergency supplementals. But, as you know, those come pretty late in the game. And to be able to start day 1, week 1, to implement the strategies we think are necessary is critically important.

Mr. WOMACK. Mr. Frieden.

Dr. FRIEDEN. I think from the CDC perspective, the major issue is flexibility. And one of the aspects of flexibility is funding. I mentioned earlier when this started, we had a terrible time sending people over. We had experts who wanted to go, needed to go, were needed there. And yet we didn't have sufficient dollars to get them there. And that was relatively small amounts of dollars. So when we give \$3,000,000 from another part of the U.S. Government, that was enormously helpful to allow us to respond over the summer. But that required a lot of effort and it delayed our response.

There may be other aspects of flexibility which the assessments that are done over the coming months will identify. But certainly, flexible dollars to respond to an emergency immediately is one of the key areas for a future challenge that we might face.

Mr. WOMACK. From the NIH perspective, Dr. Fauci.

Dr. FAUCI. Very similar to what Dr. Frieden said. We do not need any different authorities. But we do need consistency and flexibility of funding to be able to move quickly to do the kinds of things that we are able to do to respond. Because when we first started with the response to this Ebola outbreak, we had to move a considerable amount of money out of other areas to get the Ebola research accelerated. And that was something that slowed down the response, but also took away from other important research areas. So we need that kind of budgetary flexibility.

Mr. ROBINSON. I would concur with my colleagues here exactly. We need that flexibility. We had to do exactly the same anything in fiscal year 2014, to actually move funds to start the ZMapp project back in August. And if we had not, then we wouldn't have ZMapp today.

Mr. WOMACK. I yield back.

Mr. COLE. Thank you very much. We have had a long run of Republican questions. So I want to go to my friend, whose dizzying assent here is remarkable, and recognize Mr. Fattah for whatever questions he cares to ask.

INTERNATIONAL EFFORTS TO COMBAT EBOLA

Mr. FATTAH. Thank you, Mr. Chairman. And in these matters, there aren't really Republican or Democratic questions. This is really about saving lives. And I met with IBM yesterday, they were telling me about their participation in setting up a texting system where people in villages could text in information about potential new cases and that there could be—they thought it was very helpful, obviously, in the process of getting control of things. There is a lot of different parts of the U.S. society that participate, not just the government.

But I want to go to something that was said by Dr. Harris. He asked this question about leadership in the world and what others are doing. And, you know, we aren't the only country in the world, but we are, obviously, at the very forefront of a number of capabilities in this regard. But the European Union has been doing a lot of work, and I know that China and others. If you could give us a sense of what some of the other pieces to the puzzle have been and what others countries are doing, that would be helpful.

Dr. FRIEDEN. There has really been an extraordinarily international collaboration in this effort. In Sierra Leone, the U.K. Government has played a pivotal role and has provided very substantial assistance. In the laboratory work, throughout the three countries, it is a virtual United Nations of countries involved in laboratory work, about a dozen countries, from the EU, from Africa to South Africans, to Canadians, the British, I will leave out some. There is an Italian lab, there is a Russian lab, there is a Chinese lab all doing laboratory testing in the region.

I want to make a particular note of the involvement of African leaders, African experts, and African countries in the response, because that has been very encouraging, and in some ways, somewhat new. So the African Union provided what I like to call the health keepers, kind of parallel to peacekeepers. They provided hundreds and hundreds of staff to go into the three affected countries.

We also worked with the World Health Organization to bring in trained doctors that we had trained to stop Ebola in DRC and in Uganda. I traveled in rural Liberia with a doctor who we had trained in Uganda to stop an Ebola outbreak. And he was there helping to stop the outbreak in Liberia but also training Liberian doctors in how to do that. That was very encouraging.

I also met in Guinea where we need French-speaking public health experts with 10 Congolese epidemiologists, doctors from DRC, who CDC had trained in our field epidemiology training program, who had come through this process to be part of our team there. We also have seen the Nigerians effectively stop Ebola in their country. And that was because of the kind of capacity there. And coming out of this process, as you may have seen, the African Union has now committed to establishing a center for disease con-

trol with regional presence throughout Africa, so that African governments and African experts can do more about this. This builds on a program that CDC has run for more than 30 years called the Field Epidemiology Training Program, or FETP, where we train local doctors for a 2-year intensively mentored, hands-on experience. More than 80 percent of them stay within their country and usually in leadership positions. And that kind of capacity is what we need to develop more of in West Africa and anywhere there may be weaknesses.

AFRICAN UNION PARTNERSHIP

Mr. FATTAH. The African Union and the idea of a CDC is something I have been interested in for a number of years here in the Congress. Because there are obviously, when we focus on some of these challenges around infectious diseases, Africa is a place where a lot of these challenges emanate. So the CDC is going to work with the African Union on the development of a sister agency for lack of a better word?

Dr. FRIEDEN. Absolutely. In fact, we already are working with them. We will provide embedded staff to them if they wish, so that they are there to help them establish it. We proposed that, perhaps, some of the people finishing that Field Epidemiology Training Program spend a year or 2 loaned or seconded to the African Union CDC. And we will help them think through what they might want to do with initial steps to have an emergency operation center, to have outbreak response capacity, to build on their experiences from this outbreak.

NON-GOVERNMENTAL ORGANIZATIONS

Mr. FATTAH. The success of our CDC, which is quite successful, is, in part, the fact that you have an NIH, you have these other pieces of the puzzle. In Africa, you have a situation where you have a lot of NGOs with a lot of capacity, and you have health departments in the government that have very little capacity. I am exaggerating, but making, I think, the point that does exist in which you have little capacity on a governmental side which really needs to be, I think if we are going to deal with these challenges, is going to have to really be strengthened. And maybe the way to do it is do it regionally through a CDC, NIH type of approach. But that would require all of these governments to work together also.

Dr. FRIEDEN. One of the things that we are also working on through the global health security funding and others is to strengthen national capacities in each of the countries there, that they can be moved further along in laboratory networks, surveillance systems, epidemiologists, and emergency response capacity and other areas.

Mr. FATTAH. Thank you. Does anyone else want to comment?

Dr. FAUCI. We agree exactly with what Dr. Frieden said. In fact, with regard to collaboration, I am meeting this evening with the French equivalent of the National Institutes of Health, INSERM, to talk about our collaborations in West Africa. So it is an ongoing, highly-collaborative effort.

Mr. FATTAH. Thank you, Mr. Chairman.

LOCAL DISTRUST OF INTERNATIONAL RELIEF EFFORTS

Mr. COLE. You are welcome. As my friend said, there are no Democratic or Republican questions here. So I want to build a little bit on the points he was making, the questions he was asking. One of my staffers has a good friend who was a missionary in one of the nations not affected, but immediately in the vicinity. And my staffer was telling me that one of his friend's observations was there was enormous distrust by the local population of their own governments and of us as outsiders coming in. Some questions about what were our motives, you know, what were our medicines actually causing the outbreak, et cetera. I would like you to talk a little bit about that kind of problem and any early thoughts you would have on what are the sorts of things we can do going forward to create trust, if you will, that makes it a little bit easier to deliver care?

Dr. FRIEDEN. This has been an extraordinary issue and continues to be probably the major challenge remaining in Guinea. And the extent of the distrust is sometimes just hard for us to grasp. For example, at three different Ebola treatment facilities that I visited in Guinea just last month, the doctors told me that patients believe that the food was poisoned, that they were going to be killed there. And those were patients who were coming forward and being treated in the Ebola treatment units.

There is a lot that we can do to address that. And there is a lot we have been doing to address that. Most importantly is to ensure that every aspect of the response is conducted with a great deal of respect and sensitivity to the individuals who we are providing services for. And we found that sometimes unintentionally, some of the responders, for example, in burial teams, may be doing things that they didn't realize but were deeply offensive to the communities being assessed. But the challenges are partly a reflection of the environment that we are working in. And to give a sense of how hard that is, there are many communities we have been in the past year where there is no cell phone coverage, no Internet coverage, no roads, and not even radio coverage.

What we found in Guinea is as we were able to work with the government and others to establish radio transmission capacity, resistance decreased, as we could get basic messages out. But we are in communities which have 70 percent illiteracy rates where the germ theory of disease is not understood. And what we found in many communities is kind of a progression of believing Ebola was not real, to believing it was caused by outsiders, to believing it could be cured by the traditional healer, to recognizing that they needed help, by which time it had often gone to the next community.

So, that intensive education and social mobilization has been critically important. And what we did in Liberia when cases were increasing exponentially, we actually called in leaders from every district in the country for a micro-planning exercise. We explained everything about Ebola. We worked with them. And we had them come up with ideas of until we had the Ebola treatment units built, where could they care for patients, what could they do to care for

contacts. And involving communities has been critically important to the response.

CONTINGENCY PLANNING AND FUNDING

Mr. COLE. One of the impressive things about this is the number of people and the speed, to me at least, with which you mobilized and got folks into difficult situations. And I think we all ought to be grateful for what you have done in that regard. You have all made the point, the need for contingency funding, flexibility of funding, which I think is a point very well made.

Let me ask you this: In the military, I sit on Defense Appropriations, we maintain forces that are rapid deployment forces literally, that is what they are set up to do. And so if there is something happening, we can be there in 24 to 48 hours, and they know that is their mission. Do we have the equivalent of something like that? And should we? Should that be one of the lessons learned if we don't?

Dr. FRIEDEN. There are both national and global components of that. And Dr. Lurie may want to comment more. Starting with the global component, there is something called the Global Outbreak and Response Network, or GOARN. It is hosted by the World Health Organization. It has been effective for small outbreaks. It was clearly overwhelmed by the size and scope of this outbreak. And one of the things that we want to do globally is to make it a much stronger entity going forward.

In the U.S., at CDC, we do something called Epidemic Aid, or Epi-Aids, on pretty much on a daily basis where we send people out the minute we get a response, a request from a State or a local government or an international entity. We can have someone on the plane that day with expertise in that area. But in this response, the size of the needs in West Africa, and the speed with which it got worse was just overwhelming.

Mr. COLE. Dr. Lurie.

Dr. LURIE. Both our Public Health Service and the National Disaster Medical System also represent rapid deployment forces. As you know, the U.S. public health service went to the Monrovia medical unit. One of the challenges we found within National Disaster Medical System in a place that we hope to work with Congress is that it turns out that our ability to compensate them if they became injured or disabled or died isn't commensurate with what is needed or with what Federal employees get. So we found that we couldn't put them in harm's way and be fair to them. But there is a rapid deployment force. We hope to fix that so that in the future, they too can serve.

Mr. COLE. Thank you very much. Dr. Harris.

MEDICAL COUNTERMEASURE PRIORITIZATION

Mr. HARRIS. Thank you. Let me just make the observation that—again, you know, we, certainly on the global level, we did a good job. I think any observer would have to agree, though, that we internally weren't prepared for Ebola. Whether that was because we didn't consider it a serious enough threat to make sure that our Hospital Preparedness Program, for instance, made sure that all

our hospital personnel, like that those two nurses in Texas, actually knew how to protect themselves, and things like this.

So Dr. Robinson, I am going to ask you, because there are many threats out there clearly. And we can't, I don't blame anyone for not figuring out that Ebola was going to be one of these things that was going to affect us. But what is your—in your estimate, what threats are we not prepared for now? And I will ask the question a little differently. But that is what I am trying to seek out is what medical countermeasure development projects are your top priorities for the next 2 years? What, on your radar screen, are the threats that we are not prepared for that we need to prepare for in the immediate future?

Mr. ROBINSON. Thank you for the question, Dr. Harris. Certainly Ebola, we need to complete that mission because it is, again, a bioterrorism agent and also an emerging infectious disease, which leads me into emerging infectious diseases. Dr. Fauci has 294 different pathogens I think that he is responsible for every day. I don't think we can make him answer for every single one. But we certainly can prioritize those that are most that we see that, there is Chikungunya virus. And there are others that—the MERS Coronavirus, that we need to be prepared, and what PAHPA actually told BARDA to do, in addition to CBRN and pan flu, was also emerging infectious disease. We are standing up a program for that. And to be able to work with our colleagues at CDC and FDA and NIH to be able to get the low-hanging fruit, the ones that do need help in advanced development, what we can do.

I really seriously worry. What we are doing, though, in CBRN is moving forward with our Rad/Nuke medical countermeasures, certainly some of our CHEM antidotes, and to finish up with our antibiotics that actually may, bio threats, actually may have some public health benefits for these high-priority antimicrobial drug resistant ones. On the other side, I cannot leave pandemic influenza because it is there all the time, that threat. So we are working with the NIH on universal influenza vaccine development and also for immunotherapeutics for, as an antiviral for pandemic and seasonal influenza.

BARDA FY 2016 BUDGET REQUEST

Dr. HARRIS. We have passed the special funding for Ebola. But I am going to call that rear-view mirror funding. Okay? Particularly, is your funding, because you named a lot of priorities for the next 2 years actually. Is the amount of money needed for BARDA and the special reserve fund, is the funding adequate? I am going to ask you to look forward about funding. Because this is multiple billions of dollars we are spending in the rear-view mirror. And I just want to know how short are we on the spending looking forward?

Mr. ROBINSON. Provided that the budget that we submitted in fiscal year 2016 is appropriated and can continue that way, that we can then have at least 12 more medical countermeasures secured under Project BioShield, I think towards the \$2,800,000,000, I think we will be in good stead. If we are not, then we have got real problems, not only with the existing preparedness that we have,

would the medical countermeasures will be diminished, but we won't have any of the new ones.

Mr. HARRIS. And the new ones being?

Mr. ROBINSON. New ones would be new cell therapies for radiation treatment, new chemical antidotes, even some of the Ebola medical countermeasures that we have been starting to work on. We have those available under the CBRN.

Mr. HARRIS. Because you still mention Ebola, and I think the question was asked was the funding adequate with what we—I think Mr. Fleischmann asked it.

Mr. ROBINSON. Not to finish it.

Mr. HARRIS. It is not?

Mr. ROBINSON. Not to finish it.

Mr. HARRIS. Thank you very much. Thank you, Mr. Chairman.

CHAIRMAN COLE CLOSING STATEMENT

Mr. COLE. Thank you. I have checked with Mr. Fattah and we have both exhausted our questions. So I want to, number one, thank each of you for appearing here today and offering your testimony. And let me make a couple of observations in closing. First, the committee, quite appropriately, had some tough questions to ask. But I want to congratulate all of you, not only on what I think was a brilliant effort, improvised to some degree, but that is what I would expect.

Dr. Frieden said it best, this was an unprecedented, unexpected event, much larger scope and scale than we could have anticipated. But I think Dr. Fauci also said it won't be the last time. And I think that is true too. And so you not only responded well, but I think there is a lot of lessons to be learned here. I also would very much appreciate staying in touch with you, so this committee, as it tries to think ahead, because I do think we are at the beginning of an era in which we need to do a lot more in this area, build the partnerships, the relationships, have the infrastructure, play an appropriate role.

But this is not going to be episodic, it is going to be systematic probably going forward. And so we, as a committee, need to think about a better way to do that. And I am very pleased with both your testimony here and your written testimony, how self-critical you guys were, we should have done this better, we might have seen this different, here is what we should do different going forward.

Mr. FATTAH. We don't do a lot of that in the Congress.

Mr. COLE. We don't do any of that, at least we don't do it out loud and in public. And you did it in testimony both written and verbal. And I think the country is very well served for that.

And so, again, appreciate each and every one of your efforts. I think this is actually something where the government can look at its various arms and agencies and say the folks that we entrust with these really important jobs did an excellent job under very difficult circumstances. The Congress needs to learn some things. We need to do some things better. But at the end of the day, when the check needed to come, it came. And it came in a bipartisan fashion. And it came quickly.

So while we all want to learn something, I think there is also a lot of good here. Just, again, thank you very much for what you do on behalf of the American people each and every day and, quite frankly, what you do for people all over the world each and every day. The ability of this country to bring unprecedented resources and knowledge and capability to a situation like that obviously served the American people well. But it just served people well everywhere. And we have the ability in this country to do that. And it is refreshing in a case like this to see those abilities and resources put to such good use.

Thank you very much and look forward to working with you going forward. We are adjourned.

Department of Labor, Health and Human Services and Education and Related Agencies

FY 2016 Budget Hearing on Ebola

April 15, 2015

Questions for the Record – Chairman Cole

1. CDC Domestic Response Activities – Lab Capacity

CDC received \$571 million of supplemental Ebola funds to support domestic Ebola response. Specifically, I understand CDC's justification for these funds were to support domestic laboratory capacity across the states to build, expand, and improve capacity and biological safety practices.

A. Please describe how much of these funds are being used to build state's lab capacity.

Specifically,

- a. How will you determine the needs and gaps in the states to determine which states will get these funds?**
- b. What are the specific gaps CDC is attempting to address relative to domestic lab capacity?**
- c. How will CDC measure effective deployment of these funds?**
- d. Finally, when will these funds be disbursed to the states and are they being competitively awarded?**

Response: Domestic Ebola preparedness is a top priority for CDC. Since the beginning of the current Ebola epidemic in West Africa, CDC has worked side by side with state, local, and national partners to ensure an effective domestic response. For example, CDC quickly worked with states through its Laboratory Response Network (LRN) to increase the number of LRN laboratories that could test for Ebola. On August 1, 2014, there were 13 LRN laboratories that could test for Ebola. There are now 55 LRN laboratories in 43 states approved for Ebola testing. Test results are typically available 4 to 6 hours after receipt of a specimen in the lab, allowing clinicians to make patient-care decisions in a shorter timeframe.

As part of the \$571 million CDC received to support domestic Ebola response activities, the Agency awarded \$20.164M to 62 state, local, and territorial (STLT) health department labs through the Epidemiology and Laboratory Capacity (ELC) cooperative agreement and \$145M for state and local Ebola preparedness and response activities through the Public Health Emergency Preparedness (PHEP) cooperative agreement on March 30 and April 1, 2015.

The ELC funding will support public health departments and partners to improve lab and biological safety practices for dealing with emerging infectious diseases. Expected outcomes for the ELC funding include a better prepared workforce, improved practices for handling/processing Ebola (as well as other highly infectious specimens) in public health and clinical labs, improved coordination, and improved practices for specimen inactivation and disposal of lab waste.

The PHEP funds are allocated according to a legislatively established base plus population formula. Minimum awards were established for 50 states, Washington, D.C, and Puerto Rico. The guidance allows states to allocate funds for seven types of activities/capabilities, one of which is the purchase of lab equipment as recommended by CDC's Epidemiology and Laboratory Capacity for Infectious Diseases Cooperative Agreement (ELC), training, packaging and shipping

Public health agencies must ensure their jurisdictions have the ability to quickly, safely, and accurately perform laboratory testing on suspected Ebola virus specimens as well as manage any surges of specimen testing and analysis. Awardees should support and advance Laboratory Response Network (LRN) activities including:

- 24/7 availability of Ebola virus disease (EVD) testing in designated LRN facilities
- Appropriate collection and handling of hospital and other clinical laboratory specimens that require EVD testing
- Acquiring and maintaining advanced lab equipment
- Adhering to infection control precautions and practices, specifically for handling blood-borne pathogens, when collecting and handling specimens
- Supporting EVD training, including but not limited to laboratory safety and diagnostic methods
- Rapidly reporting Ebola test results between the laboratory, the public health department, and healthcare facilities to support public health investigations

To assure effective use of these funds, CDC is working with the state and local health departments to develop performance measures and a monitoring strategy. Measures will focus on a number of items including:

- Completion of lab biosafety risk assessments;
- Hiring/training of designated lab Biosafety Officers; and
- Development/update of lab biosafety plans.

B. Is it safe to assume the increased lab capacity supported by these Ebola will enhance public health laboratory capacity and safety that goes beyond just Ebola? If so, please describe how it will enable states and CDC to respond to other outbreaks, unexplained illnesses, pathogen identification or other public health issues?

Response: Although the laboratory capacity funding specifically focuses on Ebola, the Public Health Emergency Preparedness (PHEP) and Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) cooperative agreements provide the foundational capacity for responding to a variety of emerging infectious diseases. Specifically, these resources support awardees in their development of a robust state and local public health response platform. Such capacity leads to better (e.g., quicker, more targeted) disease outbreak response. In addition, biosafety risk assessments and plans will provide broad guidelines to ensure safe handling and response for Ebola and other infectious agents in labs across the country.

2. CDC Global Health Security Agenda

The FY 2015 budget requested funds to support the Global Health Security Agenda (GHSA) for high priority countries around the world as a means to help prevent, detect and respond to infectious disease outbreaks. The Ebola supplemental and the base bill provided CDC with significant support for the multi-year GHSA plan originally proposed by CDC.

For years, CDC has had a global presence around the world to work with countries on public health training, lab capacity, surveillance, monitoring and other global infectious disease activities. I have a few questions related to the GHSA and traditional CDC global activities. Specifically:

A) What is the difference from the GHSA activity and traditional CDC global activity?

Response: CDC's global activities and funding historically have been disease specific, oriented towards building approaches around single disease areas. Implementation of GHSA enables CDC to focus on building capacity to improve and strengthen public health systems to prevent, detect, and respond to all infectious disease threats. The GHSA is broader and focuses on a set of 12 targets. General information on CDC's contributions to Global Health Security Agenda can be found at <http://www.cdc.gov/globalhealth/security/actionpackages/default.htm>

B) How did CDC identify the gaps and how will it ensure the GHSA does not create a dependency or expectation from these countries for CDC to expand into other public health activities beyond preventing, detecting and responding to infectious disease outbreaks?

Response: The United States has committed to assist at least 30 countries over five years to achieve the objectives of the GHSA. The United States has prioritized actions to improve laboratory systems, combat antibiotic resistant bacteria, support biosafety and biosecurity on a global basis, enhance public health workforce development, and build surveillance systems. CDC is working closely with host governments in an initial set of countries (known as "phase one" countries). The phase one countries are focused where there is an ability to work reasonably quickly to achieve the 12 GHSA targets, where there is risk of emerging infectious disease outbreaks, as well as nations that are high-priority due to poor infrastructure, countries serving as major transport hubs, and high population density centers. CDC is working with these countries in 2015 to identify priorities and develop plans that are specific to country needs, recognizing current gaps within their systems as well as existing capacities that can be expanded.

GHSA has the goal of improving countries' ability to prevent, detect, and respond to infectious disease threats by strengthening their public health systems. By improving the foundational systems for essential public health functions (such as surveillance, laboratory, emergency operations, and workforce development), the countries will be better equipped to identify and control future infectious disease threats before they overwhelm public health systems.

C) How many other countries are contributing to this program?

Response: This is an international effort that includes a significant role for CDC and our US Government partners in leading implementation of the Global Health Security Agenda. In 2014, 44 countries came together to make commitments to Global Health Security. The 2015 Chair for the GHSA is Finland, which presides over a 10-country Steering Group that also includes the United States, Indonesia, Canada, Chile, Kenya, India, Italy, the Kingdom of Saudi Arabia, and the Republic of Korea. Many countries have made significant commitments to improve their own security and implement the GHSA in target countries around the world.

D) How many countries will the U.S. is plan to support now and over time?

Response: CDC will use the Ebola emergency funds to support Global Health Security Agenda implementation in the Phase One countries as indicated above. The GHSA started in 2014 and CDC will continue to support additional countries from its base funding. CDC is coordinating closely with our US Government partners. During the next five years, the US Government will support implementation of GHSA in 30 countries.

E) What requirements are in the program to ensure the countries receiving U.S. funds will maintain the long-term capacity?

Response: Over time, host countries will assume a larger share of financial and technical responsibility for sustaining the public health systems that will be strengthened as a result of GHSA investments. . Because each country will be starting with a different baseline of capacity, the level of investment to meet GHS goals will vary from country to country. Low-income country partners will contribute at least 10% (in-kind or financial) of total costs during the first year, with countries averaging 50% by 2025. Middle-income countries will contribute at least 10% (in-kind or financial) of total costs during the first year, and more than 90% by 2025. After establishing a new baseline of capacity, U.S. investments will be reduced to a maintenance level as participating nations assume greater financial responsibility to sustain their own global health security activities. To improve effectiveness and efficiency of USG resources, an agency or multiple agencies will be responsible for specific GHS measures and performance outcomes. CDC and other countries committed to GHSA will continue to provide technical guidance as needed to ensure that these capacities can be maintained, ensuring improved health security.

3. Advanced development of therapeutics and vaccines

We understand collectively your organizations have been working at no less than a dozen preclinical or clinical vaccine and therapeutics candidates related to Ebola. I imagine that to actually conduct clinical trials on disease like Ebola is a challenge. Obviously, we do not want outbreaks to serve as the platform to further develop therapeutics and vaccines for deadly diseases. Can each of you describe how we conduct research and clinical trials on vaccine and therapeutics of potential health threats that are not present or present in sufficient numbers in the world to allow for clinical trials?

NIH Response: Basic and applied research builds a strong foundation of knowledge upon which to develop vaccine and therapeutic candidates for potential health threats. Laboratory studies help to characterize pathogen/host cell interactions and identify new drug targets and ways to accelerate vaccine development for such threats. When clinical efficacy trials are not feasible due to low disease incidence, progress can still be made. For candidate therapeutics, safety and proof of concept can be derived even without human efficacy data. For vaccines, safety and immunogenicity can be demonstrated even in the absence of human efficacy data.

When it is not ethical (e.g., with biodefense pathogens) or feasible (e.g., with low incidence health threats) to test candidate medical countermeasures in people, the Food and Drug Administration (FDA) has provided a regulatory approach known as the Animal Rule. Under the Animal Rule, scientists can use animal models as a proxy for human responses to pathogens, therapeutics or vaccines. For example, the National Institute of Allergy and Infectious Diseases, National Institutes of Health, in collaboration with FDA, supported the testing of licensed antibiotics for efficacy against pneumonic plague, a biodefense pathogen for which human studies were not possible. Studies examined the pharmacokinetics, toxicity and efficacy of licensed drugs in African green monkeys exposed to aerosolized *Yersinia pestis*. These studies led to the first label indication under the Animal Rule when FDA approved ciprofloxacin and levofloxacin as treatments for pneumonic plague.

BARDA Response: BARDA has supported the development of many vaccine candidates for smallpox and anthrax that must use the FDA's Animal Rule for licensure by the FDA. Since efficacy studies in humans are not possible, animal efficacy studies in two animal species must be done to show immunogenicity and protection. Additionally safety studies with this vaccine in healthy adult persons and in special populations (e.g., immunocompromised persons for the smallpox MVA vaccine) are needed to support FDA licensure.

BARDA also supports the advanced development of pandemic influenza vaccines. Since seasonal influenza vaccines provide immunogenicity correlates of protection that inform pandemic influenza vaccines, clinical studies in healthy adults and elderly and pediatric populations are conducted with the goal of showing sufficient immunoprotection. Further BARDA and industry sponsors have commitments to perform Phase IV post-licensure effectiveness studies with pandemic influenza vaccines during an influenza pandemic. This roadmap is used for FDA licensure of pandemic influenza vaccines including GlaxoSmithKline's H5N1 vaccine licensed in 2013 with BARDA support.

BARDA and other federal agencies support the development of multiple Ebola vaccine candidates including animal challenge studies in guinea pigs and nonhuman primates that show efficacy against Ebola and on-going human immunogenicity and efficacy studies in West Africa. If the Ebola epidemic in West Africa wanes to the point that suitable efficacy data packages are not available, then additional animal efficacy studies may be needed to demonstrate immunoprotection correlates between nonhuman primates and humans.

4. Regional Ebola and other Special Pathogen Treatment Centers

Dr. Lurie,

I would like to better understand the HHS approach to ensure the ASPR Hospital Preparedness Program and the CDC's Preparedness and Response Activities are fully coordinated to ensure hospitals are prepared to screen, treat and care for Ebola and other pathogens of this nature. The Ebola supplement provided specific funding to ASPR and CDC to build hospital preparedness and a regional treatment center approach.

I sense confusion in the community about how the 54 hospitals, in 19 states, which are ready and willing to treat Ebola patients are going to participate in the regional treatment approach.

Please describe:

- a. How the regions will work with these 54 facilities;**
- b. What is the total funding for both programs and the funding opportunities for the 54 certified hospitals compared to the regional treatment centers?**
- c. How does HHS expect to monitor to ensure the capacity is maintained?**
- d. Finally, what metrics will be used to ensure the approach is successful?**

Response: The Hospital Preparedness Program's (HPP) Ebola Preparedness and Response Activities Funding Opportunity Announcement (FOA) and the Centers for Disease Control and Prevention's (CDC) Public Health Emergency Preparedness (PHEP) Ebola FOA were crafted to be complementary, but not duplicative. The HPP Ebola FOA developed primarily to ensure the nation's health care system is ready to safely and successfully identify, isolate, transport, and treat patients with Ebola or persons under investigation for Ebola, and that it is well prepared for a future Ebola outbreak. The majority of the direct costs supported with the HPP Ebola FOA – 90 percent – are intended to support health care coalitions and health care facilities. By contrast, the supplemental funding provided through CDC's PHEP Ebola FOA is to support accelerated state and local public health department preparedness planning and operational readiness for responding to Ebola, including active monitoring and surveillance of returning travelers.

HPP's Ebola FOA will establish a nationwide, regional treatment network for Ebola and other infectious diseases. This network will balance geographic need, differences in institutional capabilities, and will account for the potential risk of needing to care for an Ebola patient. This network will consist of:

- Up to ten regional Ebola and other special pathogen treatment centers (one in each of the ten HHS regions), which will be selected from among the 54 state- or jurisdiction-based Ebola treatment centers. Selected centers will serve as preferred treatment facilities for confirmed Ebola patients in the U.S.

- State- or jurisdiction-based Ebola treatment centers (the remaining 44 facilities designated by state health officials) will serve in a surge capacity in the event that a cluster of Ebola patients overwhelms the regional Ebola and other special pathogen treatment center.
- Assessment hospitals that can safely receive and isolate a person under investigation for Ebola and care for the person until an Ebola diagnosis can be confirmed or ruled out and until discharge or transfer are completed.
- Frontline health care facilities that can rapidly identify and triage patients with relevant exposure history or symptoms compatible with Ebola and coordinate patient transfer to an Ebola assessment hospital.

With the funding provided in the HPP Ebola FOA, all 62 of HPP's awardees (the public health departments in each of the 50 states, Washington, DC, Chicago, Los Angeles County, New York City, and for all U.S. territories and freely-associated states) will develop and implement a health care system concept of operations (CONOPS) for the care of Ebola patients. This CONOPS must link state activities related to active monitoring of returning travelers to designated assessment hospitals and treatment hospitals. The CONOPS must also address how patients will be safely transported to a regional Ebola and other special pathogen treatment center and/or a state or jurisdiction Ebola treatment center in the event that they are not the same or the regional facility cannot accept patients. Awardees must ensure their funding strategy for state/jurisdiction Ebola treatment centers, assessment hospitals, and health care coalitions (including frontline health care facilities, emergency medical services (EMS) and other partners) matches their CONOPS. Each awardee's health care system CONOPS for Ebola will be maintained and exercised annually throughout the project period.

HPP Ebola FOA awardees will assure readiness of regional Ebola and special pathogen treatment centers, state- and jurisdiction-based Ebola treatment centers, assessment hospitals, and health care coalitions (with, at a minimum frontline health care facilities and EMS) through quarterly or annual trainings and exercises, depending on their respective roles. Exercises in the first year should be specific to Ebola. If in subsequent years there are no global outbreaks of Ebola, exercises may address other infectious diseases, such as MERS-CoV and measles.

The HPP Ebola FOA will provide a total of \$194.5 million to awardees and is broken down into two parts (detailed below). The bulk of the activity to prepare the regions, states and jurisdictions, health care facilities, and health care coalitions will take place in year one of the five-year project period while the four subsequent years will focus on exercises and continued training to maintain capabilities. In addition to the funding for awardees, \$7 million will support a National Ebola Training and Education Center; \$3 million will support Ground Ambulance Services; \$2 million will support Technical Resources Assistance Center and Information Exchange; and \$2 million will support program administration and other costs.

Part A provides \$162 million through a funding formula to all HPP awardees to support health care facilities that are capable of serving as Ebola treatment centers and assessment hospitals for their states or jurisdictions. The funding will also support health care coalitions (HCCs) to prepare frontline hospitals, emergency medical services agencies, and the overall health care system. For Part A, HPP awardees must limit their own direct costs (excluding sub-awards to HCCs and health care facilities)

to no more than 10 percent of their allocation. Of the remaining 90 percent in direct costs for sub-awards:

- At least 30 percent must be allocated to health care coalitions in the jurisdiction.
- No more than 70 percent may be used to provide funding directly to Ebola treatment centers and/or assessment hospitals.

The awardee allocations for Part A range from approximately \$203,000 to over \$15 million. This variation is due to the funding formula distribution, which is based on Ebola risk factors and population. The 54 hospitals that were designated as state- or jurisdiction-based Ebola treatment centers as of February 14, 2015, will receive no less than \$500,000 through the HPP Ebola FOA through sub-awards. Awardees have the discretion to provide additional funding to these facilities as their allocation allows. Funding sub-awarded to any individual health care facility (whether a state- or jurisdiction-based Ebola treatment center or an assessment hospital) must be generally limited to no more than \$1 million; however, funding for a state- or jurisdiction-based Ebola treatment center should be greater than for an assessment hospital.

The 30 percent set aside for HCCs is intended to develop the capabilities of HCCs to enable their members to care for Ebola patients. HCCs are formal collaborations among health care organizations and public and private partners that are organized to prepare for, respond to, and recover from emergencies that impact the public's health. HCCs support a regional, rather than facility-by-facility, approach to link health care, public health, and other community partners to allow for a comprehensive and coordinated preparedness and response effort. As demonstrated in past response operations, strong regional coordination through HCCs can mitigate challenges associated with scarce supplies and resources during an outbreak or other public health event. Nationwide, HCC membership is growing rapidly. Between 2013 and 2014, there was a 47 percent increase in HCC membership; 24,000 total participants representing hospitals, local health departments, EMS and emergency management agencies.

Part B provides \$32.5 million to up to ten HPP awardees to establish regional Ebola and other special pathogen treatment centers. These centers will be ready within a few hours to receive a confirmed Ebola patient from their region, across the U.S., or medically-evacuated from outside of the U.S., as necessary. These centers will also have enhanced capacity to care for other highly infectious diseases. All HPP jurisdictions are eligible to apply for this funding, but their facility sub-recipients chosen to serve as a regional Ebola and other special pathogen treatment center must have had a CDC-led Rapid Ebola Preparedness team visit as of February 20, 2015.

The states/jurisdictions that receive funding through Part B must agree to provide no less than 90 percent of the total award to at least one health care facility to serve as a regional Ebola and other special pathogen treatment center. At least \$2,250,000 will be provided during the first year of the five-year project period and \$250,000 in the four subsequent years to maintain and sustain the capabilities of these regional centers.

Program performance measures for Part A and B will be finalized soon. Specific measures will be issued for the HPP Ebola funding awardees, regional Ebola and other special pathogen treatment centers, state- or jurisdiction-based Ebola treatment centers, assessment hospitals, and health care coalitions. The measures will largely be based on the required exercises (e.g., no notice drills) for

each entity, the frequency of which is quarterly or annually depending on the entity's particular role. An entity may substitute real events for exercises to meet the performance measure requirements. Further, HPP will require awardees to submit annual progress reports over the full five-year project period detailing how they are spending federal resources, as well as progress toward building and maintaining Ebola preparedness and response capabilities.

In addition, through a separate FOA ASPR is jointly establishing with CDC, a National Ebola Training and Education Center (NETEC) comprised of staff from hospitals that have successfully evaluated and treated Ebola patients in the U.S. In collaboration with staff from CDC and ASPR, the NETEC will offer expertise, education, training, technical assistance, peer review assessments, recognition reporting, and, if feasible, certification to regional Ebola and other special pathogen treatment centers, state- and jurisdiction-based Ebola treatment centers, and assessment hospitals.

5. Centers of Advanced Development of Manufacturing (CIADMS)

Dr. Laurie,

I want to focus on the money Congress appropriated to your agency for the Ebola crisis. I understand ASPR has not awarded a single contract to the Centers of Advanced Development of Manufacturing to address the Ebola crisis, even though on Sunday's 60 Minutes, Dr. Robinson said he wanted to see a vaccine for Ebola on his shelves within a year.

A. It is my understanding that none of the Ebola related task orders to these Centers have even received a response from ASPR and just last week two of the four task orders have been cancelled. Why?

Response: During the Ebola response, BARDA has requested the Centers for Innovation in Advanced Development and Manufacturing (CIADM) to submit proposals on five task orders for manufacturing of Ebola vaccine and monoclonal antibody candidates. As the Ebola epidemic has evolved, the requirements for three of the task orders became obsolete due to the absence of need (e.g., fill finish manufacturing of Ebola vaccine candidate using live virus vectors when GlaxoSmithKline decided to use their own facilities and the production of two Ebola monoclonal antibodies in CHO cells from Canada was no longer needed) and alternative contracting methods became available when CIADMs were unable to provide reasonable and feasible project plans (i.e., production of ZMapp at other manufacturers using alternative tobacco plant systems). Issuance of the task order for production of new Ebola monoclonal antibodies developed by Genentech awaits the results of upcoming nonhuman primate challenge studies in early June with these new antibodies at the United States Army Medical Research Institute of Infectious Diseases prior to a commitment for large-scale production to supply clinical studies. Issuance of the task order for purification of new Ebola monoclonal antibodies developed by DuPont awaits final proposals from the CIADMs to enter final negotiations. Additionally task orders for production of two next-generation anthrax vaccine candidates for clinical studies are in final negotiations with the CIADMs with expected start dates this summer.

B. Within this same interview, it was noted that HHS' own bureaucracy has prevented a "fast and nimble" response to Ebola. What are you doing to eliminate the bureaucracy within ASPR, especially within the contracting function, to allow BARDA to do its job effectively?

Response: HHS, ASPR, and BARDA are always searching for better methods to develop requirement, solicit proposals, award contracts, and execute projects. Discussions are underway internally at HHS and with CIADMs to look at other contracting mechanisms (e.g. ID/IQ contracts) to issue task orders with the nimbleness and rapidity that BARDA used for vaccine development and manufacturing projects during the H7N9 avian influenza outbreaks of 2013.

C. What are the other challenges preventing better utilization of the Centers of Advanced Development of Manufacturing such as intellectual property considerations, industry cooperation, and scale-up and manufacturing considerations?

Response: Simultaneously, the CIADMs are completing the necessary facility construction, commissioning, and validation to become fully operational for both preparedness and response activities and becoming operational and on-line in a staged process as facilities become on-line. The timeline for the CIADMs to become fully operational was originally in 2016, but the need to respond to the H7N9 outbreaks in 2013 and the Ebola epidemic in 2014–15 has expedited these timelines and plans. Ebola projects are expected to move forward this summer. Issues surrounding intellectual property, industry cooperation, and manufacturing scale up have been reviewed with the CIADMs and stakeholders and resolved.

D. If the downward trend in the Ebola epidemic continues, what is the HHS plan on moving forward with multiple Ebola vaccine and therapeutics candidates?

Response: BARDA's Ebola MCM strategic goals are: (1) make experimental vaccines and drugs available from industry partners for clinical trials; (2) support safety and efficacy studies in animals and humans; and, (3) develop improved products and enhanced manufacturing capabilities.

Toward these goals, BARDA is supporting the development of six monoclonal antibody candidates and one antiviral drug candidate. Using FY 2014 funds and BARDA technical expertise, we are developing ZMapp monoclonal antibodies produced in tobacco plants. ZMapp production continues as NIH-sponsored clinical studies are on-going in West Africa and the U.S. Also, we are having ZMapp made by other tobacco biopharmaceutical companies using FY 2015 Ebola funds, and we will be testing in nonhuman primate studies later this month. Further, as a risk-mitigation measure we partnered with two large pharmaceutical companies that specialize in commercial monoclonal antibodies for other diseases to develop Ebola monoclonal antibodies including ZMapp using specialized CHO cells and state-of-the art antibody technologies. These partnerships are resulting in rapid development of ZMapp and brand new candidates. Preliminary results have shown that these candidates produced in specialized CHO cells are equivalent to ZMapp.

BARDA has also transitioned an Ebola antiviral drug candidate, BCX4430, from early development supported by NIH to advanced development. Clinical lots of this drug candidate are being manufactured for future trials in West Africa.

For vaccines, BARDA using FY 2015 Ebola funds is supporting the development of three Ebola vaccine candidates with two more candidates under active consideration. Two of these vaccine candidates are currently in clinical trials in West Africa. BARDA's funding and technical support are also enabling additional clinical lot production, commercial manufacturing scale up, and development of more thermostable vaccine formulations for easier storage and use.

BARDA will continue implementing and adapting the Ebola MCM strategy to remain ready to perform clinical studies as new outbreaks occur in West Africa or elsewhere and to finish these clinical studies showing whether these and next-generation Ebola therapeutic and vaccine candidates are safe and efficacious. Improvements to Ebola manufacturing to ensure robust and controlled manufacturing at commercial scale will be pursued to ensure mass vaccination and widespread therapeutic usage are feasible. Better formulations of Ebola therapeutics and vaccines for field usage and storage will be developed. Multivalent vaccines effective for prevention of Ebola and other viral hemorrhagic viruses will be developed to address future epidemics and may be stockpiled for potential bioterrorism acts with these viruses. Teaming with NIAID and CDC, BARDA will invest in research and clinical infrastructure in West Africa and elsewhere to have readily available relationships and networks to test rapidly new MCMs for emerging infectious diseases. BARDA will support development of next generation rapid diagnostics for Ebola and other pathogens. Lastly, BARDA will formalize and expand the capabilities of our national MCM response infrastructure with innovative technologies that afford rapid and nimble response to meet the challenges of future known and unknown emerging infectious diseases.

6. Global Lab Capacity

- A. Please describe the long term plan related to sustainable laboratory system in the Ebola affected countries?**
- B. Please describe the collaboration between countries on the development and implementation of standard tests to detect Ebola and how will laboratory reporting be coordinated?**
- C. Is there a plan to establish a laboratory network between Guinea, Liberia and Sierra Leone? If so, please describe.**

Response: The Ebola epidemic has highlighted the importance of having core public health capacity in place to protect the health and safety of a population. Going forward, CDC will work with the three affected countries to identify the priority areas for recovery. These plans will be country-driven, and supported by technical assistance from CDC and other agencies. CDC is working with these countries to assess their systems to find out how they have been impacted, where there are gaps, and how to prevent future outbreaks. Public health system recovery in these countries will focus on how we prevent future infectious disease threats (by improving systems to prevent, detect, and respond) as well as assisting in the re-establishment of public health services. During 2015, CDC offices will be established in each of the three countries to engage with the Ministries of Health; cooperative agreements are being established to provide funding from CDC to Ministries of Health and partners for significant ongoing activities; and staff will be put in place to support ongoing operations.

Laboratory capacity is one of the initial four focus areas. The other three are surveillance, workforce development, and emergency response capacity. CDC will work to build laboratory capacity in the affected countries by assisting with the establishment or modification of national laboratory strategic plans and support for creation or expansion of a tiered laboratory network in each country that links a central public health laboratory and strategically placed laboratories in each country. The development of these networks will require infrastructure improvements, procurement of equipment and reagents, establishment of maintenance agreements, training in lab capacity, development of standard procedures and establishment or strengthening of quality assurance programs.

The laboratory capacity work will be specific to the needs and capacities of each country. However, there will be cross-border collaboration in the region as appropriate and efforts will be made to tie the laboratory capacity building work to regional surveillance efforts. At the regional collaboration level, efforts will also be made to use common definitions and platforms to enable data sharing and communication. CDC will also work with WHO to help coordinate laboratory capacity building efforts with each country's Ministry of Health.

Questions for the Record from Rep. DeLauro

1. **At current case levels, and with the potential need for simultaneous trials on several Ebola vaccine candidates, will there be sufficient efficacy data from the trials in Sierra Leone? If not, what kind of data do you anticipate from the trials in Sierra Leone, as well as the trials in Guinea and Liberia?**

Response:

On April 30, 2015, the Liberia-U.S. Joint Clinical Research Partnership completed enrollment of all 1500 planned participants into the Phase II component of the Ebola vaccine trial known as PREVAIL (Partnership for Research on Ebola Vaccines in Liberia), which is sponsored by the National Institute of Allergy and Infectious Diseases, National Institutes of Health. The placebo-controlled study is evaluating the safety and effectiveness of two experimental Ebola vaccines (cAd3-EBOZ and VSV-ZEBOV). Participants will continue to be followed by the study team for 12 months from the date of their enrollment. The PREVAIL Phase II trial is expected to generate a robust set of study data in both men and women (women constitute 37 percent of the participants) on the safety of the vaccines as well as their ability to stimulate immune responses that may be protective against Ebola. In addition, participants will be studied more intensively during the one-year follow-up period in order to gain important information on the durability of the immune response to a single vaccination. Because cases of Ebola in Liberia have fallen to and remained at zero for more than a month, the Phase III, or efficacy, segment of the PREVAIL trial currently cannot be carried out in Liberia. The Partnership believes that a regional approach is needed to complete the Phase III trial and therefore is in discussions to explore the possibility of expanding the Phase III trial to other countries in West Africa.

In the absence of definitive efficacy data to support licensure of the Ebola vaccine, the linkage of data from nonhuman primate challenge survival studies and the immunogenicity data from human clinical studies will be important to demonstrate whether there is a threshold level of antibodies in vaccines that correlates with immunoprotection in animals.

2. **If there is insufficient comparative data for all viable vaccine candidates, how will the decision be made as to which vaccines to advance through development and potential scale up and procurement?**

Response: BARDA is already supporting the advanced development of multiple Ebola vaccine candidates. It is doing so to increase the likelihood that at least one successful vaccine will be identified. BARDA expects to support the scaling up of two vaccine candidates' manufacturing processes from pilot to commercial scale. It also expects to develop more thermostable vaccine formulations using lyophilization technologies. This development would make it possible to conduct mass vaccination campaigns if the need should arise in 2015–16 in West Africa. Further BARDA support for advanced development may depend on the results of the on-going immunogenicity studies for these Ebola vaccine candidates. Especially important metrics will be the level of neutralizing antibodies, the level of immunoprotection, the length of the resulting immunity, and the level of cross-protection against other filoviruses. We will also closely examine results from nonhuman primate challenge studies. We note that, while BARDA does expect to support advanced development of these

vaccines, we do not expect to procure them for mass vaccination campaigns. Instead, GAVI, the Vaccine Alliance, plans to procure the vaccines for this purpose on behalf of the WHO. When multivalent vaccines with long shelf-lives for Ebola and Marburg viruses has been developed sufficiently, BARDA will consider procurement of those vaccines under Project BioShield for U.S. stockpiles against these viruses as a bioterrorist threat.

3. **The Center for Infectious Disease Research and Policy (CIDRAP) report released in February 2015 highlighted a number of challenges in implementing an Ebola vaccine strategy. It also outlined a Target Product Profile for the development of an Ebola vaccine that could help address these challenges early in the vaccination program. For the prevention of Ebola in the current or in future outbreaks, the optimal Ebola vaccine would have high efficacy, be heat stable and could be produced efficiently and expeditiously, among other characteristics. How well do the several leading vaccines in development meet these criteria?**

Response: The present Ebola vaccine candidates were in early development when the Ebola epidemic emerged last year. The vaccine development gaps included commercial manufacturing scalability, thermostability, elicitation of long term protective immunity, and cross-protection against Ebola and Marburg viruses. BARDA began support last year for three Ebola vaccine candidates to address these gaps with a fourth vaccine candidate in final contract negotiations. Several of these candidates partially meet the target product profile established by the PHEMCE; however BARDA support of further development for the most promising candidates will be based on cross-protection afforded against filoviruses - Ebola Zaire and Sudan virus strains and Marburg viruses, long immunity, robust and controlled manufacturing processes at commercial scale, thermostable for long shelf-lives, and easy cold chain management.

4. **The CIDRAP report states that “There is a high possibility that at least two types of vaccine will be needed: (1) a single-dose vaccine that provides immediate immunogenicity and protection for outbreak containment and (2) a vaccine that produces durable protection for use during non-outbreak settings to vaccinate key healthcare workers, for whom a prime-boost strategy may work.” How many of the vaccine candidates are estimated to require a boost of some sort, and is that the expected vaccine regimen at this point?**

Response: Animal challenge study results indicate that the GSK and J&J Ebola vaccine candidates may require a vaccine booster to achieve long term protective immunity. Results from animal challenge studies show that long term immunity is not afforded from a single dose of these Ebola vaccine candidates. Indeed, the Ebola vaccine candidate from Johnson& Johnson requires vaccination with a primer vaccine dose followed by a booster vaccine dose from a different Ebola vaccine to achieve long lasting protective immunity in nonhuman primate challenge studies. GlaxoSmithKline, which is developing an Ebola vaccine candidate, is currently testing booster vaccine candidates to achieve long lasting protective immunity.

Other Ebola vaccine candidates from Newlink Genetics/Merck and Profectus are live, attenuated virus-vector vaccines. Results from animal challenge studies show that long-term immunity is afforded long-term protective immunity. Results from on-going human immunogenicity studies are not available to show whether the Ebola vaccine candidates using the VSV vectors afford long lasting protective immunity or whether a booster would be necessary.

5. **A specific challenge highlighted in the CIDRAP report was that not all of the leading vaccine candidates are designed to be delivered in the health systems common to West Africa. It states that, “some candidate vaccines may require storage at -80°C; maintaining this level (or even -20°C) of cold chain will be challenging under field conditions in the affected areas of West Africa. Efforts are under way to develop these vaccines to have more manageable cold-chain requirements, and at least one candidate vaccine already has been reported to have less stringent storage condition.” Describe the challenge of having a vaccine that can be stored and transported for appropriate use in affected urban and rural environments of West Africa. Are the leading vaccine candidates expected to meet the cold chain criteria outlined in the CIDRAP report?**

Response: Cold chain storage of vaccines requiring freezing is challenging under the best circumstances but is significantly challenging in the Ebola vaccine studies in West Africa. Several of the Ebola vaccine candidates require freezing at ultra-cold temperatures to remain stable. In field studies in Sierra Leone, BARDA was able to secure cold storage conditions for vaccine storage and transfer to the clinical site of the rVSV EBOV vaccine candidate; however BARDA is already supporting the development of more thermostable Ebola vaccines that will permit storage at refrigerated temperatures.

Questions for the Record for Ebola Panelists from Rep. Roybal-Allard

Lessons learned from 2014 Ebola Outbreak

Dr. Frieden: In its 2014 report: **Outbreaks: Protecting Americans from Infectious Diseases, Trust for America's Health** found that the U.S. Ebola outbreaks exposed serious gaps in the country's ability to manage severe disease threats. There has been a declining commitment to fund public health preparedness activities, our public health workforce is thinning due to age and inadequate sustained funding, and there are serious inconsistencies in states' infectious disease prevention and control capabilities.

1. Please describe what is needed in terms of core public health and healthcare preparedness capabilities to be ready for the next infectious disease threat?

Response: Public health threats, including the next infectious disease threat, are always present. Whether caused by natural, accidental, or intentional means, these threats can lead to the onset of public health incidents. Being prepared to prevent, respond to, and rapidly recover from public health threats is critical for protecting and securing our nation's public health. CDC supports 15 core capabilities for public health preparedness that enable a coordinated response to public health threats:

- Community Preparedness
- Community Recovery
- Emergency Operations Coordination
- Emergency Public Information and Warning
- Fatality Management
- Information Sharing
- Mass Care
- Medical Countermeasure Dispensing
- Medical Materiel Management and Distribution
- Medical Surge
- Non-Pharmaceutical Interventions
- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation
- Responder Safety and Health
- Volunteer Management

In addition, the Hospital Preparedness Program's (HPP) Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness released in 2012, assists state, local, and regional healthcare coalition leaders identify gaps in preparedness, determine specific priorities, and develop plans for building and sustaining health care specific capabilities. The eight capabilities detailed in the guidance, along with their associated functions and activities, facilitate and guide preparedness planning and ultimately assure safer, more resilient, and better-prepared communities. The eight capabilities are: health care system preparedness; health care system recovery; emergency operations coordination; fatality management; information sharing; medical surge; responder safety and health; and, volunteer management.

Originally, HPP awardees were targeting all eight health care preparedness capabilities. However, HPP funding was reduced in 2014 by 30 percent causing HPP awardees to prioritize investments. A recent HPP impact assessment showed areas of diminished investment including:

- 68 percent of awardees are unable to sustain progress made since 2012 related to responder safety and health;
- 90 percent of awardees reduced exercises, evaluations and corrective actions; and,
- 70 percent of awardees reduced health care worker education and training.

It is important to note that while responder safety and health is not among the prioritized capabilities for many awardees, and the problems with health care worker safety during the Ebola outbreak emphasized the importance of investing in efforts to strengthen responder safety.

Despite the recent reductions, HPP funding is supporting strong regional coordination through health care coalitions (HCCs) to mitigate challenges associated with scarce supplies and resources during an infectious disease outbreak or other public health event. For example, if a regional health care system has extra personal protective equipment (PPE) available in some of its facilities, this equipment can be dispersed to local health care providers to augment requirements. HCCs are formal collaborations among health care organizations and public and private partners that are organized to prepare for, respond to, and recover from emergencies that impact the public's health. HCCs support a regional, rather than facility-by-facility, approach to link health care, public health, and other community partners to allow for a comprehensive and coordinated preparedness and response effort.

To strengthen and build a national network of hospitals capable of treating highly pathogenic infectious, funds are being provided through the HPP Ebola funding opportunity announcement (FOA) (EP-U3R-15-002: HPP Ebola Preparedness and Response Activities). The capabilities and capacity of HPP awardees, health facilities, and HCCs that will be supported through the supplemental Ebola funding will be maintained for the full five-year project period through quarterly or annual exercises and trainings, according to their respective roles. While the focus is on preparedness for Ebola it is likely that preparedness for other novel, highly pathogenic diseases will also be enhanced through these activities.

2. How can we avoid serious inconsistencies across states – such as developing dozens of different quarantine and isolation policies in the midst of the Ebola outbreak – for future events?

Response: Isolation and quarantine help protect the public by preventing exposure to people who have or might have a contagious disease. In addition to serving the public health goal of reducing disease transmission, isolation and quarantine are also legal procedures that involve a combination of federal, state, local and tribal law.

The federal government derives its authority for isolation and quarantine from the Commerce Clause of the U.S. Constitution. Under section 361 of the Public Health Service Act (42 U.S. Code § 264), the U.S. Secretary of Health and Human Services is authorized to take measures to prevent the entry and spread of communicable diseases from foreign countries into the United States and between states.

The exercise of federal isolation and quarantine authority is limited to diseases listed in an Executive Order of the President.

The authority for carrying out these functions on a daily basis has been delegated to the Centers for Disease Control and Prevention (CDC). CDC routinely monitors persons arriving at U.S. land border crossings and passengers and crew arriving at U.S. ports of entry.

States have “police powers” to protect the health, safety, and welfare of persons within their borders. State “police powers” predate the U.S. Constitution and include isolation and quarantine. To control the spread of disease within their borders, states have laws to enforce the use of isolation and quarantine. While CDC provides guidance to state, local, and tribal jurisdictions, those governments have discretion, within the limits of their respective statutes, regulations, and ordinances, whether to follow that guidance. These laws can vary from state to state and can be specific or broad. In some states, local health authorities implement state law. In most states, breaking a quarantine order is a criminal misdemeanor.

Tribes also have authority to take actions that promote the health, safety, and welfare of their own tribal members. Tribal health authorities may enforce their own isolation and quarantine laws within tribal lands, if such laws exist.

During an outbreak, such as Ebola, CDC maintains regular communication with health departments regarding changes in policies and procedures. Although CDC may offer guidance on specific quarantine and isolation policies, a state may elect to implement a more restrictive or less restrictive policy.

3. What funding commitment is needed to prepare and sustain an adequate public health workforce for the future?

Response: The nation's public health workforce is facing ongoing and emerging challenges—health problems that require multifactorial solutions, use of new technology, collaboration with the health care sector, and the need for continuing education and training. In addition, over 58,000 state and local public health jobs have been lost since 2008. A well-trained public health workforce is critical to ensuring the highest level of efficiency and effectiveness in protecting America's health, a responsibility only the public health system can ensure.

CDC supports a competent, sustainable, and empowered public health workforce through programs that:

- Strengthen education, training, and professional development of the public health workforce
- Enhance service, response, and consultation
- Provide leadership in national public health workforce efforts

The FY 2016 President's Budget includes \$67,404,000 for CDC's Public Health Workforce and Career Development, a \$15,204,000 increase for Public Health Workforce above the FY 2015 Enacted level. With this increase, CDC will continue to focus on high-priority activities like the Epidemic Intelligence Service (EIS) and Public Health Associate Program (PHAP), and will strengthen

informatics and population health training, supporting almost 80 additional fellows. CDC will increase the number of fellows in these and other programs (many of which place fellows at state and local health departments) and will provide greater support for public health e-learning, which benefits state and local partners.

CDC supports the current public health workforce by offering tailored public health training and continuing education. CDC is the only HHS agency accredited to award seven types of continuing education for health professionals. CDC provides a central location for quality public health e-learning, training information, and learning resources through the [CDC Learning Connection](#). This website provides access to CDC TRAIN, a free resource where individuals across public health and health care can identify educational activities to support their professional development. In FY 2015, CDC will focus on enhancing the training of and service provided by Public Health Associates, Epidemic Intelligence Service officers, and other fellows; expanding informatics training, focusing on the needs of state and local public health agencies; and strengthening collaboration with the healthcare sector, particularly for fellow assignments and projects.

Hospital Preparedness Program

Dr. Lurie: The Hospital Preparedness Program is a glaring example of the complacency we have developed in our approach to public health preparedness. The program has been cut by 50% since its peak funding level of \$515 million in FY 2003. Given the lack of hospital preparedness we saw during the Ebola crisis last year, the President's FY16 budget proposal to level fund the program for a third year in a row at \$255 million seems to be a rather shortsighted budgetary decision.

Questions:

- 4. Please describe what the impact of these cuts has been to healthcare preparedness?**
- 5. What specific capabilities have healthcare coalitions and hospitals lost over the years that funding has been declining?**

Response: States, local governments, and hospitals have received approximately \$12 billion over the past decade for preparedness activities, with approximately \$4.8 billion available specifically for hospitals and healthcare systems. The Budget seeks to balance healthcare system preparedness with funding for other preparedness programs, such as medical countermeasure development and funds to combat anti-biotic resistant bacteria. Initially, funding for hospital preparedness provided significant support for the establishment of interoperable communications and other systems to maintain situational awareness. Now, these funds primarily support planning and the development of capabilities across the health care system, and the Budget request targets funds for those activities.

Additionally, in FY 2012 the first joint funding opportunity announcement was issued for the Hospital Preparedness and Public Health Emergency Preparedness (at the Centers for Disease Control and Prevention) programs; this improved the Federal level of effort to administer grants, and reduced the administrative burden on grant awardees. The joint funding awards have better enabled the programs to organize their preparedness efforts around 15 core capabilities (eight of which are specific to healthcare preparedness) and has streamlined awardees' abilities to conduct joint exercises.

It is important to note that preparedness funding is a joint partnership across State, local, and Federal, and each level is required to do their part.

6. Will the Ebola supplemental funds provided by Congress be sufficient to help fill that gap or provide any long-term hospital preparedness?

Response: The funding provided through the HPP Ebola funding opportunity announcement (FOA) (EP-U3R-15-002: HPP Ebola Preparedness and Response Activities) is intended to ensure the nation's health care system is ready to safely and successfully identify, isolate, assess, transport, and treat patients with Ebola or persons under investigations for Ebola, and that it is well prepared for a future Ebola outbreak. As stated previously, while the focus is on preparedness for Ebola, that preparedness for other novel, highly pathogenic diseases will also be enhanced through these activities.

It is vital that health care systems maintain a baseline level of preparedness on all capabilities, so that whatever the event—be it Ebola, a terrorist attack, or natural disaster—the health care system can respond quickly and effectively to save lives.

THURSDAY, APRIL 23, 2015.

**PANEL ON PROGRAMS SUPPORTING NATIVE
AMERICANS**

WITNESSES

**W. RON ALLEN, TRIBAL CHAIRMAN AND CEO, JAMESTOWN S'KLALLAM
TRIBE**

**STACY A. BOHLEN, SAULT STE. MARIE TRIBE OF CHIPPEWA INDIANA,
EXECUTIVE DIRECTOR, NATIONAL INDIAN HEALTH BOARD**

**JAMES PARRISH, EXECUTIVE EDUCATION DIRECTOR OF SCHOOL
PROGRAMS, CHOCTAW NATION OF OKLAHOMA**

Mr. COLE. Good morning. We will open the hearing, but we are beginning this hearing in rather unusual circumstances. The President of the United States is momentarily going on the air, evidently to announce an unsuccessful hostage rescue in which we lost some Americans who were being held hostage by a terrorist group and evidently some European, Italian nationals as well. I am not sure.

But I just think the appropriate thing, if nobody minds, is for us to begin with a moment of silence for the lives lost and the families that are grieving right now.

[Moment of silence.]

Mr. COLE. Thank you very much.

I want to acknowledge before I get into my formal statement that, as my ever-able committee staff was reminding, "Mr. Chairman, this hearing is for you." Okay, this really is, obviously, one of my favorite topics as not only a member of the Interior Approps Committee, but as a tribal member and somebody with deep interest in Native American history and the Native American circumstances.

So I appreciate my fellow members of this committee also indulging me in this sense, but it is an important topic. And I want to also begin by recognizing, frankly, this is an area where there has been significant bipartisan cooperation in recent years in Congress, and I want to laud the President of the United States. He has actually, I think, done a terrific job in this area, everything from Native American—or the Native American summits, Native nation summits that he hosts every year, genuine effort.

Certainly both the Secretaries of the Interior and the Assistant Secretaries, including my good friend and fellow tribal member Kevin Washburn, and I have had the opportunity to work with, are really trying to make significant progress in an area that has been very long neglected.

Now nobody can fix a problem that is 500 years old in a matter of years, but so when we talk about things where we can do better, I want to acknowledge that this is not in any sense meant to be

a criticism of the administration because I think it is really trying to do better and is really trying to work across the aisle here.

So it is just to try and educate us as a committee and, more broadly, the Congress where can we do more, what should we do, because I think there really is both parties, both chambers, but particularly between the administration and the Congress, an effort to try and begin to correct some wrongs that are very, very longstanding.

So our aim is just to get better at what we do and not to be critical of anybody because I think, again, the administration has very, very much to be proud of. And I think, quite honestly, Republican Congress and particularly Republican House has a great deal to be proud of, of what they have been trying to do over the last few years.

So, again, good morning. My pleasure to welcome our witnesses today to the Subcommittee on Labor, Health and Human Services, and Education to discuss Native American issues. Looking forward to all your testimonies.

The Federal Government's relationship with federally recognized Indian tribes is guided by a trust responsibility to ensure the well-being of tribes and respect their status as sovereign nations. This trust responsibility is established in the Constitution, treaties, executive orders, and court decisions.

The Federal Government is required to manage tribal lands and resources in a manner beneficial to tribes and Native people. This trust responsibility is not limited to those programs that are specifically targeted to American Indians and Alaska Natives. Many of the largest agencies that serve American Indians, such as the Indian Health Service and the Bureau of Indian Affairs, are outside this subcommittee's jurisdiction. However, there are many programs funded under our bill that impact American Indians and Alaska Natives, including those targeted to those populations as well as broader programs that are used by tribes and tribal organizations.

For example, the Department of Health and Human Services makes funding available through the Centers for Disease Control and Prevention to build capacity within public health systems to improve population health in tribal and nontribal communities, while the National Institutes of Health makes grant funding opportunities to study and improve the health of all Americans, including Native Americans.

The Department of Education makes supplemental grants to local education agencies that serve a disproportionate number of Native students, and these school districts also receive IDEA funding to help provide services for students with disabilities, a group in which Native children are disproportionately represented.

The Department of Labor has dedicated funding under the Workforce Innovation and Opportunity Act for workforce education and training programs that are designed to meet the diverse needs and traditional cultural values of Native Americans. Indian communities face extensive challenges related to health, unemployment, poverty, and education. Heart disease is the leading cause of death among American Indians and Alaska Natives.

The CDC has funded an atlas of heart disease and stroke among American Indians and Alaska Natives to help health professionals tailor prevention programs to those communities. One-third of American Indian and Alaska Native children live in poverty. The high school graduation rate for Indian children is 67 percent, which is the lowest of any racial or ethnic group.

Only 13 percent of Native Americans and Alaska Natives have completed a bachelor's degree or higher, compared to 29 percent of the population in general. Indian students are disproportionately suspended and expelled and are less likely to attend schools that offer challenging coursework that would help prepare them for higher education.

Many programs in our appropriations bills are designed to address these issues, but there are obstacles that prevent these programs from meeting the Nation's trust responsibility to Native Americans. Our goal for the hearing will be to define the challenges that exist for Native American tribes in working with the Federal Government and learn about how the Government could better serve them and be a better partner.

Today, I look forward to hearing from our witnesses about their perspectives on these issues. It is a particularly distinguished panel.

I would like to welcome Ms. Stacy Bohlen, a member of the Sault Ste. Marie Tribe of the Chippewa Indians. She serves as executive director of the National Indian Health Board with support of a strong tribally elected board of directors. Ms. Bohlen's service at the NIHB has contributed to the organization's successful work to establish and elevate tribal presence for improving healthcare in Congress, to promote it, and strengthen the organization's service to all federally recognized tribes.

James Parrish currently serves as the executive director of education for the Choctaw Nation and has been the senior director of School of the Choctaw Language since 2009. He is an enrolled member of the Choctaw Nation, a native of southeastern Oklahoma.

Mr. Parrish is a third-generation educator who retired from public education in 2009 after a 34-year career in public education. He currently serves as chair of the Governor's Oklahoma Advisory Council on Indian Education.

And Mr. Ron Allen is the tribal chairman and CEO of the Jamestown S'Klallam—

Mr. ALLEN. S'Klallam.

Mr. COLE [continuing]. Tribe. [Laughter.]

Mr. Allen is responsible for representing the tribe as the elected leader and for addressing political and policy issues and/or positions at national and State and local levels. As chief executive officer, he is responsible for the executive administration of all the tribe's programs, including education, career development, social services, housing, health, economic development, natural resource management, and cultural affairs.

I look forward to hearing all your testimonies, and now I would like to yield to my good friend and ranking member, the gentlelady from Connecticut, Ms. DeLauro.

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

And let me say a thank you to you for holding this hearing. It is a very important topic, and I know how personally important it is to you. And it is okay for the chairman to be able to have a hearing that he would like to have on an important topic.

So, you know, as a former staff person many years ago, when the chairman wants to go, and you are going. And this is great. This is great, and we welcome all of you today.

The Federal support that we provide to Native American tribes represents a vital lifeline to so many people. Moreover, as I say, I know how close this issue is to the chairman's heart, proud member of the Chickasaw Nation, and I would just say to him that I admire your work on Native American tribes and your strong support, Mr. Chairman, for the Indian Health Service, which is funded through the Department of Interior.

The Labor, HHS bill, too, contains a number of programs that are specifically designed for Native American communities, as well as several programs with set-asides for tribal grants. So I am sure we are going to have an opportunity to discuss these today, and I welcome that opportunity.

To our distinguished witnesses—Director Bohlen, Director Parish, Chairman Allen—we thank you for being here today and really for your efforts and your advocacy on behalf of the communities that you represent and support. You are outstanding advocates and committed to the well-being of people who put their faith and trust in you.

Many programs funded by this subcommittee are intended to provide services and opportunities. It is about opportunity to disadvantaged people in communities. Partly as a result of poverty, historical and ongoing discrimination, and a lack of adequate resources, Native American tribes face unique challenges in this regard.

For example, as Director Bohlen points out in her testimony, when compared to other Americans, Native Americans have a shorter life expectancy, higher rates of mortality from diabetes and heart disease, and two and a half times the rate of suicide among the young.

Almost one-third of Native American students live in poverty, as compared to 6 percent among whites. Native American students are more likely to drop out of high school and college and are likely to be less prepared for career success. This means that the programs funded through the Labor, HHS bill are particularly important to Native American communities and tribes.

And I would just say, for me personally, unfortunately, for the past 5 years, we have persisted in cutting those very programs. Yesterday, the majority passed an allocation for the Labor, HHS bill that cuts our budget still further by some \$3,700,000,000 next year.

I raise this issue here today because I know that today we will discuss some very important programs, programs that benefit children, families, unemployed workers, those who need treatment for mental health or substance abuse issues and many others. We should be increasing Federal support for these programs, but that will be next to impossible if the budget for the Labor, Health, Edu-

cation, Human Services Subcommittee allocation is cut by almost \$4,000,000,000.

It is the backdrop against which we consider the testimony of our witnesses. You raise important issues that I look forward to discussing. Both Director Bohlen and Chairman Allen express strong support for the tribal behavioral health grants through the Substance Abuse—Substance and Mental Health Services Administration. I could not agree more with you.

These grants reduce the impact of substance abuse, mental illness, and trauma by addressing these issues through the public health system. The administration is requesting an increase of \$25,000,000 for tribal behavioral health grants, which is something that I strongly support.

Director Parrish highlights the importance of Title I education, that funding and its ability to close that achievement gap for disadvantaged students. Again, I wholeheartedly agree. It is one reason I support the administration's request for an additional \$1,000,000,000 for Title I, including additional funds for Native American students.

And I think both the chairman and I may have been in agreement on this issue, and I would just say this with regard to the administration. When we moved in the direction of a competitive program for education, I am a firm believer in Title I, and that is the way our low-income kids, our disadvantaged kids are able to access education, educational opportunities. Vital programs we talk about today.

But I will again point out that we need to fund them adequately, and that is going to be extremely difficult if this subcommittee's allocation is cut. I will be delighted to work with the chairman to boost funding for these and other programs under the jurisdiction that provide Native American communities with the high-quality health services, education, and job training that are not just needed, but required for individuals. We owe it to your communities to make sure that they have adequate support.

I thank you, and I look forward to our discussion today.

Thank you, Mr. Chairman.

Mr. COLE. I thank the gentlelady. And just to make a quick point. It is a long and winding road until we can finally get to the end of the line, and we may find some places along that road we can work together.

Ms. DELAURO. I am sure we can.

Mr. COLE. So I look forward to that.

But now I want to go to our witnesses, and we are going to start with you, Chairman Allen, because, after all, you are the leader of a sovereign nation. So let us start—

Ms. DELAURO. Mr. Chairman, can I make one point? I am looking at the jewelry, and man, it is really great. Look at this. [Laughter.]

I am sorry. And the chairman knows I am a great admirer of his ring, which is a family heirloom. But terrific.

Mr. COLE. Yes. We get great displays of Indian jewelry here and in Interior in particular. So, but anyway, it is wonderful to have you here. Your full remarks, of course, will be entered into the record.

You are recognized, Chairman Allen, for 5 minutes for whatever opening remarks you would care to make.

Mr. ALLEN. Well, thank you.

Mr. Chairman and members of the committee, it is always an honor to come before any of the committees in Congress to share our views about how the Federal Government can improve its partnership with tribes to help us elevate the quality of life in our respective communities. So I appreciate you accepting our testimony and recommendations that we made to the committee with regard to this subject matter.

When you think about the 566 Indian nations from the small tribes to the large tribes, as remote up into Alaska, you know, to the Everglades of Florida, we have a very diverse set of communities, and we have a longstanding history. Your opening remarks by you and the ranking member certainly do capture, you know, the highlights of what we are challenged with in terms of advancing our agenda.

I currently am a co-chair of the self-governance—Tribal Self-Governance Advisory Committee for IHS, and I work also—I am the chairman on the DOI side, and I currently chair the CMS TTAG, which advises the TTAG group. And I also serve on the Secretary's Tribal Advisory Committee. So I am definitely deeply engaged in HHS and the programs that serve the tribes. It is a challenge.

So when you—when the Congress asks us, you know, what are the challenges that we have with regard to just specifically the HHS department and all its various agencies, it is a challenge. You know, 700-plus programs are speckled throughout this department that serve America, and you have to ask yourself how many of those programs actually reach Indian Country?

When the tribes, you know, when we are reflecting on the Department of Interior BIA programs or IHS programs, you know, you are talking about \$2,500,000,000, maybe \$5,000,000,000, and the OMB says, well, there is about \$19,000,000,000 that goes out to Indian Country. So we asked the open-ended question that, okay, wait a minute. How much are we—how well are we accessing those programs?

And a significant portion of those \$19,000,000,000 is in HHS because of the whole array of programs that are in HHS. You know, HHS, Health and Human Services. So without a doubt, we know that healthcare is critically important.

ACA certainly is a piece of legislation that tries to address it in the way that Congress and the administration has proposed. There are lots of complications, and you are well aware about those complications. But our challenge, quite frankly, is how regardless of whether it gets amended and gets modified or gets improved on, how does it affect Indian Country?

And so, in our testimony, and I know Stacy will address, some of those recommendations in terms of how to make it more effective so that Indian Country is not off the bench with regard to how we can elevate healthcare.

The ranking member referenced a couple of the statistics. There is a lot more that goes to it with regard to Indian Country. But we can tell you that, as a general observation, accessing the various programs in HHS is a challenge. It is a bureaucratic, complicated,

overregulated, over guideline set of circumstances that, for the most part, the tribes that are more sophisticated—and your tribe is one of them—that is very effective at accessing and reaching out to those programs.

There are a myriad of tribes that simply don't have those resources. They don't have planners, grant writers. They don't have the personnel that deal with the reporting requirements that go along with these different programs.

And/or, you know, if you add money to programs like childcare programs, et cetera, then quite frankly, because of the criteria the department or the administration will wrap around those programs, we don't qualify. I can tell you right now as just a simple example, Head Start program.

My tribe is 600 people. We don't have the numbers to qualify. And the logistics of sister tribes in the area, if we were to collaborate with them, the logistics don't make it work. Do we need Head Start programs? Absolutely, yes. So the issue can be how do we make that work more effectively and better?

There are some programs out there right now—and self-governance is certainly one of them, and 477 programs is another good example—where tribes have advanced and the administration and the Congress has blessed to move these new legal venues where the tribes can access many of these programs, maybe not in great numbers but allows us to have a little more diversity, a little more flexibility to take these programs and accomplish their objectives, but more clearly defined within our programs, within our communities to make a better fit.

So what Barrow, Alaska, needs versus what Jamestown needs versus Chickasaw are going to be very different in terms of how they fit. And so, the self-governance initiative, which works exceptionally well, a phenomenal success for 25 years at IHS and the Department of Interior, BIA, and we want to move that agenda into HHS.

Interestingly enough, when we concluded the Bush administration, the very end of it, they said, yes, it is a good idea. But it turns into now we have got the Obama administration. And the Obama administration examined it for 6 years, scratched their heads and say, "Ah, I am not sure it is going to work."

We are kind of going, "Are you kidding me? All we asked for is a pilot initiative." A pilot initiative to show it can work. We are not asking to change your way of doing business.

So you are dealing with bureaucracy that doesn't want to change their way of business. You have got all these different departments, all these different agencies, all the different programs, and they are protecting them. And so, the bottom line is we need to move that agenda forward.

So the other one is 477, which is very similar, but it is with regard to employment assistance, about creating jobs, elevating the capacity of our tribes to become more employable, to get them employed and to help them with their families. So there is that program, and I know there are some bills being proposed to try to improve it. Big challenge has been HHS in terms of turning into, you know, over excessive grant writing.

So the issue to me, Mr. Chairman, is we have got an opportunity, and we got solutions. If the Congress would listen to the tribes in terms of our recommendation, many of these are just pilot initiatives. And we urge and encourage you to work with us, and we can find solutions to help access these programs to better serve our people.

[The information follows:]



**Testimony of
W. Ron Allen, Tribal Chairman/CEO, Jamestown S'Klallam Tribe
House Appropriations Committee
Subcommittee on Labor, Health and Human Services, Education and Related Agencies**

April 23, 2015

Chairman Cole, Ranking member DeLauro and members of the Subcommittee, thank you for inviting me to this important hearing. In addition to serving as the Tribal Chairman/CEO of the Jamestown S'Klallam Tribe, I am Vice-Chairman for the Indian Health Service Tribal Self-Governance Advisory Committee (TSGAC), serve on Secretary Sylvia Mathew Burwell's Tribal Advisory Committee (STAC), which advises the Department of Health and Human Services (HHS) on issues of importance to Tribal governments and their citizens, and I also serve as Chair of the Tribal Technical Advisory Group (TTAG) for the Centers for Medicare and Medicaid Services (CMS). You asked that I address challenges of Tribes in working with the Federal government, and opportunities to improve this partnership. I appreciate this opportunity to briefly address several issues with HHS and provide the Committee with suggested recommendations and steps to resolve them.

Affordable Care Act Implementation: The formation of STAC and TTAG has provided important avenues of communication that enable Tribes to communicate more consistently and effectively with HHS and CMS. Nonetheless, there remain a number of ways that HHS and CMS could improve collaboration with Tribes by addressing the Indian-specific issues that Tribes have raised regarding the Patient Protection and Affordable Care Act (ACA) implementation. We request the support of the Subcommittee on the following four matters under CMS's existing authority which would make common sense adjustments to improve health care coverage for American Indians and Alaska Natives (AI/AN):

1. Waive the Employer Mandate for Tribes. The application of the employer mandate requires that Tribes qualifying as large employers buy insurance for their Tribal-member employees or pay significant fines, even though Tribal members are exempt from the ACA's individual mandate. This runs counter to the Federal trust responsibility. It also means that AI/ANs are less likely to benefit from the new resources for health care offered through ACA, which are so important to help fully fund the Indian health system. If Tribes do offer insurance

to their Tribal-member employees, those employees will no longer be eligible to receive premium assistance through the health insurance exchanges. Tribes have repeatedly requested administrative relief from the employer mandate. The employer mandate should be waived for Tribal employers with regard to employees who qualify for the Indian exemption to the ACA's individual mandate;

2. *Provide Indian-Specific Enrollment Data.* Indian-specific data is necessary to gauge AI/AN marketplace enrollment and Medicaid enrollment and to assess outreach and education efforts. Tribes, however, have not been able to obtain Indian-specific enrollment data from CMS despite numerous requests over the past 6 months. CMS should make this information available to Tribes and use the data for more effective management of marketplaces to assure that AI/ANs are participating to the maximum extent possible;

3. *Establish Indian Desk for the Federally Facilitated Marketplace (FFM) Call Center at CMS.* Tribes have also repeatedly requested that CMS establish an Indian Desk for the FFM Call Center. Currently, AI/AN callers are frequently being misinformed by call center staff who do not understand the Indian-specific provisions of the ACA. This has created much confusion and frustration as AI/AN consumers seek Indian-specific answers regarding enrollment, plan changes, tax exemptions, and other ACA-related matters; and,

4. *Fund Indian-Specific Enrollment Assistance.* Funding for enrollment assistance is essential to increasing the low proportion of AI/ANs currently enrolled in health coverage. Navigator grants, however, have not proven to be an effective mechanism for funding Indian-specific enrollment assistance, because very little of this funding has been awarded to Tribes and Tribal Organizations, and the constraints and reporting requirements make it difficult to use these funds effectively in Tribal settings. Funding is needed for enrollment assistance that is tailored to the needs of Tribal communities.

Expansion and Improvement of the 477 Program: Public Law 102-477 advanced Tribal self-determination by permitting Tribes and Tribal organizations to consolidate into a single plan consisting of employment- and training-related grant funds from four agencies, including the three major ones under this Subcommittee's jurisdiction. The 477 Program reduces administrative expenses and allows Tribes to tailor services to the needs of their communities. The 477 program has proven very successful, and was scored highly by OMB's Performance Assessment Rating Tool (PART). The full potential of the Act has not been realized, however,

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due to resistance by the agencies on several fronts. Representative Don Young (R-AK) has introduced H.R. 329, the Indian Employment, Training and Related Services Consolidation Act of 2015, which would make the 477 program permanent, extend it to eight additional agencies, and clarify the authorities and responsibilities of the agencies and the Tribes. Unfortunately, HHS recently testified in opposition to the bill, based on a bureaucratic turf-protection rationale at odds with the Federal policy of Tribal Self-Governance. We ask for this Committee's support and assistance as H.R. 329 moves through the House.

Tribal Consultation: The health of the government-to-government relationship depends on timely and effective communication. In some respects, HHS is to be applauded on this score; the Department has established an effective budget consultation process that we hope will continue beyond this Administration. In other respects—for example, with some of the ACA implementation issues discussed above—HHS has fallen short of the principles and practices set forth in its Tribal Consultation Policy by failing to involve Tribes at the earliest stages in the development of regulations and policies with important Tribal implications. We would appreciate this Committee's assistance in ensuring that the agencies under its jurisdiction adhere to Executive Order 13175, Consultation and Coordination with Indian Tribal Governments to fulfill the Federal trust responsibility to hold timely and meaningful Tribal consultations before taking actions with significant impacts on Tribes and their citizens.

Federal Advisory Committee Act: One impediment to Tribal-Federal communication in recent years has been the Administration's interpretation of the Federal Advisory Committee Act (FACA). Tribal-Federal workgroups and advisory committees operate under the intergovernmental exemption from the requirements of FACA such as making documents available to the public. The Administration's narrow interpretation of the exemption, however, has led to the agencies imposing prescriptive rules of conduct that are at times ridiculous and offensive to Tribal leaders and their designated representatives. For example, Tribal leaders who attend a meeting but are not official members of the committee are not allowed to speak. The unnecessarily restrictive protocols deter free exchange of information and viewpoints. Tribal leaders would appreciate this Committee's assistance in directing HHS (which has a large number of advisory groups subject to FACA) to work with Tribes on a pragmatic approach to preserving the FACA exemption while facilitating full and open dialogue.

Appropriations Issues: We would appreciate any assistance this Committee can provide in advancing the following initiatives with HHS Secretary Burwell and with your colleagues in the House:

- *Advance Appropriations for IHS:* Tribes and Tribal health organizations currently administer over half of the Indian Health Service (IHS) budget through contracts and compacts under the Indian Self-Determination and Education Assistance Act (ISDEAA). While not directly under this Committee's jurisdiction, appropriations for the IHS profoundly affect Tribal relations with HHS as a whole. The ubiquity over the past 15 years of partial and delayed appropriations through the continuing resolution process has made it very difficult for Tribal health providers to plan budgets, retain medical professionals, and simply maintain operation of facilities. IHS should receive advance appropriations authority, similar to the Veterans Health Administration, which serves a similarly vulnerable constituency under unique Federal obligations.
- *Sequestration:* With Tribal health care already chronically underfunded, cuts due to sequestration further undermine the ability of IHS and its Tribal partners to meet the needs of AI/ANs. Congress should enact legislation exempting IHS, and all Tribal program funding, from sequestration.
- *Mandatory Contract Support Cost Appropriations:* Following two Supreme Court decisions affirming that payment of full contract support costs (CSC) is required under the ISDEAA, the Administration has proposed that CSC appropriations be shifted from discretionary to mandatory appropriations. This would bring the funding mechanism in line with the legal obligation to pay full CSC, eliminate contract claims against the U.S., and ensure that Indian health care funding is not eroded by administrative costs.
- *Behavioral health programs:* The Administration has requested Tribal behavioral health funding for a number of years but with little success. This year they requested an additional \$25 million under SAMHSA as part of its multi-agency Native youth behavioral health initiative. We join with the National Indian Health Board (NIHB) and National Indian Child Welfare Association (NICWA) who are also testifying before this Subcommittee in asking for \$50 million for behavioral health programs. We need enough funding to make a difference. Ideally, at some point funding will be available to all Tribes on a recurring basis.
- *Funding so Tribes can utilize their authority to administer the Federal entitlement program for foster care and adoption assistance:* For the first time, the Administration requested start-up funds (\$27 million) and proposed program adjustments for Tribes with approved Title IV-E plans. Currently, only a few Tribes directly administer this program. Additional funding could facilitate additional Tribal participation.
- *Funds to build the capacity of child welfare programs:* The Administration has for the first time requested funding (\$20 million) under the Promoting Safe and Stable Families Act to help Tribes build the capacity of their child welfare programs which will put them in a better position to keep families together, to protect children, and when needed have available alternatives.

Expansion of Tribal Self-Governance within HHS: In Title VI of the ISDEAA, Congress envisioned expanding Tribal Self-Governance beyond IHS to other programs within HHS. In 2003, HHS issued a study concluding that such an expansion was feasible, identifying 11 HHS programs as likely candidates for a Self-Governance demonstration, and providing recommendations on legislation to establish a demonstration project. Despite this favorable report, however, HHS leadership has never supported such legislation. In 2013, a Tribal-Federal workgroup established by then-Secretary Kathleen Sebelius to re-examine the issue concluded that “the overarching barrier to expansion of Self-Governance is the lack of legislative authority to conduct a Self-Governance demonstration project in HHS programs outside of IHS.” Yet, HHS took the position that it could not collaborate with Tribes on developing such legislation. Expansion of Tribal Self-Governance to non-IHS programs in HHS such as Native Employment Works (NEW) and Tribal Temporary Assistance for Needy Families (TANF) represents the next logical step in the evolution of the Federal policy of Tribal self-determination. We ask that this Committee direct HHS Secretary Burwell to re-convene the Title VI workgroup and authorize HHS representatives to engage in dialogue with Tribal representatives over draft legislation to establish a Self-Governance Demonstration Project that both HHS and Tribal leadership can support.

Such legislation would address a broader issue regarding the grant-making process itself. Within HHS alone, there are 558 grants available to AI/AN Tribes and organizations, all with different application processes and reporting requirements. Tribes have difficulty accessing these grants—in particular small Tribes with minimal capacity. As a result, the grants are underutilized and do not get to the neediest Tribes. If Tribes could access the funding using a Self-Governance vehicle, the funds would be utilized more efficiently and effectively and Tribes could tailor programs to meet their community needs.

Thank you again for the opportunity to provide this testimony. If you have any questions or would like further information on these issues, please do not hesitate to contact me.

Mr. COLE. Thank you very much.

Director Bohlen, we will go to you next. Again, your remarks will be entered into the record, and you are recognized for 5 minutes.

Ms. BOHLEN. Thank you, Mr. Chairman, and thank you, Ranking Member DeLauro and members of the committee, the subcommittee.

Thank you for holding this very important hearing on American Indian and Alaska Native programs. As the director of the National Indian Health Board serving all 566 federally recognized tribes in the United States, I offer these comments on the HHS programs.

The Federal trust responsibility to the tribes extends to all agencies of the Federal Government. When it comes to health, this is not just the Indian Health Service. Today, I will focus my remarks on ways that this responsibility to tribes can be improved throughout HHS.

Devastating consequences from historical trauma, poverty, lack of adequate treatment resources continue to plague our communities. In Indian Country, as the ranking member so eloquently stated, our life span is 4.2 percent less than the general population, and on some reservations, it is as low as 48, life span of 48 years. That is actually 14 years less than the life span in Haiti, the poorest country in the Western Hemisphere.

Native youth suffer suicide rates at 2.5 times the national average. It is the number-two cause of death of our youth. The percentage of our adults who needed treatment for alcohol or illicit drug problems in the past year has doubled the national average. Unintentional injuries are experienced by our people at rates higher than any other ethnic group in the United States.

In many ways, these statistics are not surprising. Eight of the 10 poorest counties in the United States are in Indian Country. On several reservations, the unemployment rate soars beyond 80 percent.

With all of these serious problems, it is critical that Congress expand assistance for public health and healthcare, health professions, to Indian Country beyond the Indian Health Service. Over the last several years, tribes have developed a strong working relationship with HHS leadership, have educated HHS. These are frequently productive.

But tribes are consistently left out of key funding opportunities, as Chairman Allen articulated very well. Across the agency, leadership often understands and supports the unique situation of tribal governments, but bureaucratic processes that score grant applications are stacked so that tribes miss out on critical opportunities.

We respectfully request that this committee consider using the appropriations process to develop tribal set-asides at HHS in order to ensure that the first people of this Nation receive a fair share of the grants coming from HHS.

For example, last March, CDC did not fund any organization familiar with working with tribes or the tribes to do capacity building for HIV prevention. Not one opportunity was funded, despite the fact that HIV rates are rising among our people when they are declining everywhere else.

Additionally, the CDC puts forth significant funds to support data and surveillance activities, but only at the State and national

level. The CDC has done little to invest in a surveillance system that honors tribal sovereignty, supports respectful and reliable data collection methods, and we are eager to see tribally directed funding from CDC support the tribal epidemiology centers.

These reasons for the lack of access to these funds across HHS for tribes are complex. Many tribal communities do not meet stringent eligibility criteria for certain Federal grants or do not have the staff or capacity to write competitive grant applications, and they are competing with State agencies and major universities.

Many tribes simply do not hear about funding opportunities. Out of the 10 block grants that HHS manages, 4 do not allow tribes to access them directly. Tribal governments must go through the States to get these funds, and the States have a very mixed record of ensuring that these monies ever reach the tribes, and they are not compelled to do so yet.

One way some of these issues could be addressed would be for the committee to clarify the intent of the Federal Advisory Committee Act, which presents significant challenges when working with HHS. Tribal advisory committees have an intergovernmental exemption from this law, but often strict interpretation by the HHS means that other tribal leaders, tribal employees, or technical support cannot address concerns at these committees even when invited by a sitting committee member.

This would be like a Member of Congress attending a committee hearing, and their staff would not be allowed to see any of the hearing documents in advance or provide technical support.

Similarly, we request funding travel expenses, et cetera, for technical advisers at the advisory committee level so that tribal leaders are assured to be adequately staffed throughout these important meetings. As all elected officials, like you, tribal leaders wear many hats. So the needed issue area expertise is often not possible to engage in a complete and detailed way without the support of the people they have asked to support them. Like you, tribal leaders depend on their technical support staff.

Finally, we would like to reiterate the support for tribal-specific funding at SAMHSA. As noted above, mental and behavioral health issues are experienced by Native people at far higher rates than other Americans, but these problems are compounded by a lack of access to adequate mental health services.

The administration has requested a substantial increase for tribal behavioral health grants in 2016. NIHB and tribes are requesting that this program be funded at at least \$50,000,000.

It is critical that behavioral health programs also have a strong cultural component to be successful. Tribal leaders have insisted that traditional healing methods be honored, as they worked for tribes for thousands of years. They are working now on the Special Diabetes Program for Indians and in self-governance programs throughout Indian Country.

In the case of Special Diabetes Program for Indians, tribally directed programs are saving the Federal Government \$100,000 per person per year who does not have to go on dialysis. That is a winner. That is a proven winner because the tribes know how to make these programs win if given the chance.

Thank you again for holding this critical hearing on programs serving our people. We look forward to working with you, and there are many opportunities across HHS.

We have 1,550 physician and nurse vacancies across the Indian health system. HRSA could be helping with that. We have some of the worst cancer rates in the country. CDC could be helping with that. And adverse childhood experiences, known to change the physiology of a child as they grow, we have a great need for help with that. And HHS has ways to help with that.

And now I am going over my time, but thank you.

[Speaking Native language.] Thank you.

[The information follows:]

National Indian
Health Board



**TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD
STACY BOHLEN, EXECUTIVE DIRECTOR
HOUSE APPROPRIATIONS COMMITTEE, SUBCOMMITTEE ON LABOR, HHS, EDUCATION
APRIL 23, 2015, 10:00AM**

Chairman Cole, Ranking Member DeLauro and Members of the Subcommittee, thank you for holding this important hearing. On behalf of the National Indian Health Board (NIHB) and the 566 federally recognized Tribes we serve, I submit this testimony on FY 2016 budget for the Department of Health and Human Services (HHS). The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and Tribes. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace.¹

Devastating consequences from historical trauma, poverty, and a lack of adequate treatment resources continue to plague Tribal communities. American Indians and Alaska Natives (AI/ANs) have a life expectancy 4.2 years less than other Americans² and suffer significantly higher mortality rates from suicide, type 2 diabetes, and heart disease than other Americans. According to CDC data, 45.9 percent of Native women experience intimate partner violence, the highest rate of any ethnic group in the United States. AI/AN children have an average of six decayed teeth, when other US children have only one. These health statistics are no surprise when you compare the per capita spending of the IHS and other federal health care programs. In 2014, the IHS per capita expenditures for patient health services were just \$3,107, compared to \$8,097 per person for health care spending nationally.

While IHS is the primary agency providing health care delivery for AI/ANs, the federal trust responsibility is the responsibility of all government agencies, including other departments within HHS. During the last several years, Tribes have developed a strong working relationship with HHS leadership and its agencies. While these

¹ The Snyder Act of 1921 (25 USC 13) legislatively affirmed this trust responsibility. Since its creation in 1955, IHS has worked to fulfill the federal promise to provide health care to Native people. In 2010, as part of the Indian Health Care Improvement Act, Congress reaffirmed the duty of the federal government to AI/ANs, declaring that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians -- to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." (Indian Health Care Improvement Act, §103(2009).)

² On some reservations, life expectancy is over *20 years less* than that of the general population.

conversations are frequently productive, much remains to be done as Tribes are consistently left-out of key funding opportunities. The reasons for this are multi-faceted. For example, many Tribal communities do not meet stringent eligibility criteria for certain federal grants or do not have the staff or capacity to write grant applications that are competitive with state agencies or large universities. NIHB respectfully asks this committee to consider using the appropriations process to develop Tribal “set-asides” at HHS in order to ensure that the First People of this nation receive a fair share of the grants coming from agencies across HHS.

NIHB also supports Tribal requests to expand Tribal Self-Governance to agencies at HHS beyond the IHS. A 2003 study done by the agency determined this was feasible. The Obama Administration reopened this dialogue with Tribes and convened a workgroup to discuss this further. The workgroup determined self-governance expansion was feasible but that legislation would be needed to move forward with expanding self-governance at HHS. Tribes are eager to work with HHS on the development of a legislative proposal that would expand self-governance. For many Tribes, the choice to self-govern ensures efficiency, accountability and best practices in managing and operating Tribal programs and administering federal funds at the local level. For FY 2016, we request that the Committee direct the HHS to reconvene the Self-Governance Tribal Federal Workgroup in order to develop legislative language that would expand self-governance within HHS.

Center for Disease Control and Prevention (CDC): The CDC leadership has made important gains in fostering communication between agency and Tribal leaders and, as a result, the agency has been more responsive to the Tribes. However, these improvements have not had a big impact on funding decisions at the agency. For example, the CDC has funded organizations in the past specifically to work with American Indian and Alaska Native communities on HIV prevention, and this funding has helped to establish and re-affirm national leaders in HIV prevention, care and treatment in Indian Country. However, during the last round of funding for five-year grants, CDC did not fund *any* AI/AN-specific organization to provide support or capacity building.³ We

³ See: PS14-1403, “Capacity Building Assistance for High-Impact HIV Prevention.” This failure to fund Tribal organizations is especially troubling when considering the rates of HIV incidence in American Indian and Alaska Native communities has continued to rise over the past decade while the rates have fallen in other communities.

respectfully request that the Committee use its authority to ensure that Tribes and Tribal organizations are receiving important capacity building funding streams.

The CDC puts forth significant funds to support data and surveillance activities, but only at the state and national level. The CDC has done little to invest in a surveillance system that honors Tribal sovereignty, successfully navigates jurisdictional competition, and supports respectful and reliable data collection methods. *Tribal Epidemiology Centers (TECs)* work in partnership with the area Tribes to improve the health and well-being of their Tribal community members by offering culturally-competent approaches that work toward eliminating health disparities that are experienced by AI/AN populations. The CDC, as written into the Indian Health Care Improvement Act,⁴ has an obligation to support TECs in their role as public health authorities to the Tribes in their areas. CDC is the most appropriate agency to support these centers. TECs are already nominally funded at approximately \$360,000 each year by the Indian Health Service. CDC should use its authority to support TECs through specific funding streams and request that CDC fund TECs directly, as CDC does for all 50 states.

The Administration has not requested any additional funding for the CDC's unintentional injury program in the FY 2016 request. This is problematic for Tribes, as unintentional injury is the third leading cause of death among AI/AN people and we experience injury mortality rates that are **2.4 times greater** than other Americans. Opportunities to expand these prevention efforts into Indian Country will be severely limited by flat funding. Congress should allocate a funding stream dedicated to Tribes for motor vehicle accident prevention and this funding should **not** be a component of a state plan or state grant.

Substance Abuse and Mental Health Services Administration (SAMHSA): Mental and behavioral health issues are among some of the most serious issues experienced by Tribal communities. AI/ANs struggle with complex behavioral health issues at significantly higher rates than other Americans. Destructive federal Indian policies and unresponsive or harmful human service systems have left AI/AN communities with unresolved

⁴ 25 U.S.C. § 1621q

historical and generational trauma.⁵ Native youth experience suicide at rates 2.5 times the national average, with suicide the second leading cause of death for AI/AN youth. This disproportionate burden of mental health issues is further complicated by the fact that many Tribal communities lack access to quality mental health care.

Tribal Behavioral Health Grants (“Native Connections”) are critical to improving mental health in Indian Country. According to SAMHSA, the goal of this program is to “reduce the impact of substance abuse, mental illness, and trauma on AI/AN communities through a public health approach.” These are competitive grants designed to target Tribal entities with the highest rates of suicide per capita over the last 10 years. The FY 2016 request includes a \$25 million increase for this program for a total of \$30 million. This investment is critical; the seriousness of mental health and substance abuse issues in Indian Country cannot be exaggerated. NIHB and Tribes recommend funding this program at \$50 million for FY 2016 to address this crisis in Indian Country.

Tribes encourage the Committee to provide oversight to ensure that mental health and substance abuse funds are coordinated across agencies. Tribes have asked that the Administration develop a plan of action, led by HHS, which will demonstrate how programs for mental health and substance abuse serving AI/ANs are coordinated across agencies. SAMHSA leadership has responded that they will pursue this effort, and we look forward to working with them to carry this out in order to improve and increase coordination for mental health services across government agencies. NIHB recommends that the Committee request that HHS provide a report on what it is doing to coordinate treatment for mental and behavioral health across federal agencies.

NIHB also supports the *Circles of Care* program at SAMHSA. Circles of Care is designed to help Tribal communities plan and develop programs to model for children with mental health challenges and their families. It is the only other program outside the Tribal Behavioral Health Grants that allows Tribes and Tribal organizations to apply for funding without competing with other governmental entities. There are currently 11 Tribal entities

⁵ Brave Heart, Maria Yellow Horse; DeBruyn, Lemya M. “The American Indian Holocaust: Healing Historical Unresolved Grief.” *American Indian and Alaska Native Mental Health Research*, v8 n2 p60-82 1998.

with Circles of Care funding. We recommend increasing funding to \$8.5 million to ensure that more Tribes have access to this critical program.

Center for Medicare and Medicaid Services: NIHB would like to reiterate its request from FY 2015 for the Committee to streamline *the definition of Indian in the Affordable Care Act (ACA)*. The law's definitions require that a person is a member of a federally recognized Tribe or an Alaska Native Claims Settlement Act corporation in order to receive certain benefits and protections under the law including monthly enrollment periods, cost-sharing protections and an exemption from the individual mandate.⁶ These definitions are narrower than those used by IHS and CMS, thereby leaving out a sizeable population of AI/ANs that the ACA was intended to benefit and protect. NIHB is grateful for the language contained in the FY 2015 Explanatory Statement that requested that CMS and the Internal Revenue Service write a report detailing these varying definitions. We believe that CMS and IRS also have the authority to adjust this through regulatory means and respectfully request that the Committee clarify Congressional intent on this matter. Failure to clarify these definitions will result in a class of "sometimes Indians" who are eligible for certain services but not others, thereby creating confusion and inconsistent application of federal benefits for AI/ANs.

Tribes have also made numerous requests of CMS for several other ACA-specific implementation issues. NIHB and Tribes have requested that the agency provide AI/AN-specific staffing at Health Insurance Marketplace call centers. This would allow an individual to speak with someone that is familiar with not only the AI/AN benefits under the ACA, but also the Indian health system, leading to less confusion and increased access to health services for AI/ANs. NIHB would appreciate assistance from the Committee to address that request.

Thank you for the opportunity to offer this statement. We look forward to working with the Appropriations Committee as Congress considers FY 2016 Appropriations. If you have any questions, please do not hesitate to contact the National Indian Health Board.

⁶ In June 2013, HHS did issue a "Hardship Exemption" for these individuals from the individual insurance mandate.

Mr. COLE. I know about the vacancies. I travel with my good friend to my left, Chairman Simpson, through Indian Country, and every tribe said, "As soon as you are done with Congress, come back and be a dentist for us." [Laughter.]

Multiple. He has a career.

Next, Director Parrish, if we could go to you. Again, great pleasure to have you here and good to see you again.

Mr. PARRISH. [Speaking Native language.] Hello. Good morning.

[Speaking Native language.] My name is Jim Parrish.

[Speaking Native language.] I am director of the School of Choctaw Language and also the executive director of the Choctaw Nation.

I would also like to address Representative Cole in his Native language.

[Speaking Native language.] Good to see you.

In the next few minutes, I would like to underscore several points that I can sum up as follows. Choctaw Nation has accomplished a lot with very little, and much more remains to be done, and we sure could use your help.

I want to share what we have accomplished. Our Choctaw Nation's education department has touched the lives of thousands of Choctaws and of our neighbors. Our accomplishments are the direct results of the partnerships and collaborations with 85 public schools across our vast 10½ county service areas in mostly rural southeast Oklahoma. And I will refer you to the POSSE map of our treaty tribal boundaries.

Our challenges are a bit different from those of the tribal governments which have jurisdictions over contiguous tribal land base with tribally administered schools. Choctaw Nation has just one tribally administrated school, Jones Academy in Hartshorne, Oklahoma.

Jones Academy is a stellar model of the top-notch Indian education that can be produced when a tribe partners with the U.S. Bureau of Education and U.S. Department of Education and the local public schools. However, most of our Choctaw students attend public schools, and their success depends on the success of those public schools which receive vital support through Title I, Title VII, and IDEA programs funded by this committee.

I want to briefly survey some of our partnerships with the public schools. First, Choctaw's Partnership of Summer School Education. Our POSSE program is a program designed to improve the reading and math skills of low-achieving K through third grade students. This program provides 24 days of summer intervention in reading and math and enriched by Choctaw culture, art, music, and physical education.

The uniqueness of this program is twofold. One, it is open to any student, tribal or nontribal, attending a public school in our Choctaw territory. The second is the teacher ratio is 1 teacher for every 10 students in this program.

POSSE has had dramatic results and success. In summer 2014, second and third graders scored on average in the 20 percentile at the beginning of summer school instruction. Then they progressed to the 30 percentile by the end of the summer school, and they have progressed to the 40 and for 50th percentile during this school

year. And you can see more evidence of this in my written testimony.

Choctaw is at capacity on our POSSE program in 19 school districts. With additional support, we can expand and grow POSSE until all 85 school districts are involved.

Secondly, Choctaw's Making A Difference, or MAD, program partners with school districts to provide programs and services to help 9 through 12th grade students graduate. Counselors, teachers, administrators use an early warning system to target a student's individualized learning needs with the help of tracking data. MAD gets active alerts for Choctaw students falling off track in the area of attendance, grades, discipline, high-stakes assessment, graduation, and college and career readiness.

Third, our School of Choctaw Language is restoring dignity and self-respect to the teaching of Choctaw language as a world language in our public schools. We are currently teaching Choctaw in 38 school districts. The Choctaw Nation led efforts to persuade the Oklahoma legislature to have Native languages recognized as world language in our public schools.

Title I and Title VII funds are vital to the success of our efforts to help public schools bridge the achievement gap confronting disadvantaged students. As State education funds diminish, schools are more and more looking to the Choctaw Nation for assistance, which leads me to my last point.

The Choctaw Nation has yet to realize the promise of its Promise Zone designation. Promise Zone is an innovative program supported by President Obama and Majority Leader McConnell. We are the only tribe designated.

Choctaw earned its designation in 2004 due to the many challenges that we face in our region, due to the proven—and due to the proven leadership and capacity of the Choctaw Nation to efficiently use resources to make a difference and to leverage Federal investments for ourselves and our neighbors throughout partnerships and collaboration.

We are eager to change this abysmal statistic that led to this designation. Part of our problem is that most of our public schools are in small, remote, rural districts, which lack the capacity to chase or administer complex Federal programs.

But when they turn to the Choctaw Nation to help, we have been dismayed to discover that the U.S. Department of Education funding support largely has been unavailable to tribal governments because statutes and regulation don't expressly list Indian tribes or tribal education department as eligible grant applicants alongside State governments and State Departments of Education in public schools. In other words, when it comes to many Department of Education grant applications, the Promise Zone's priority points are pointless.

So we ask the help of this subcommittee to change these restrictive laws and treat tribes as States and tribal education departments like State Departments of Education for purposes of determining eligibility to apply for and administer grant funding provided through the Department of Education, Labor, Health and Human Services. If we are not up to the department's criteria, so be it. But we should be able to compete for these grants.

In conclusion, we are honored by this opportunity to testify and thank you for your time today. We especially appreciate your leadership on this subcommittee, Mr. Chairman, and your unparalleled commitment to Indian Country and to our homeland, the United States.

We seek to improve the educational attainment of all residents of southeast Oklahoma. Your continued support in these matters is critical to the success of education in Indian Country.

[Speaking Native language.] Thank you, and God bless you.

[The information follows:]



Choctaw Nation of Oklahoma

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Gary Batton
 Chief

Jack Austin, Jr.
 Assistant Chief

TESTIMONY OF JAMES PARRISH CHOCTAW NATION OF OKLAHOMA

Before the House Committee on Appropriations Subcommittee on Labor, Health and
 Human Services, Education, and Related Agencies

Oversight Hearing on Native American Issues
 April 23, 2015

Halito,

Miko Gary Batton micha Chahta vhleha yvt 'Halito' chim achi. Sv hohchifo yvt Jim Parrish. Chahta Anumpa Aiikhvna i noshkoboka micha Nan Ikhvna i noshkoboka sia. Chi afama li kvv sv na yukpa. Himak nittak anumpula chi ka, achukma hoke!

Halito and good morning.

Mr. Chairman and Members of the Subcommittee, my name is James Parrish, and I am the Executive Director of Education for the Choctaw Nation of Oklahoma. On behalf of our Chief, the Honorable Gary Batton, I thank you for the opportunity to testify today on the educational success the Choctaw Nation has realized, and the further challenges we face.

In my current capacity, I am responsible for the Choctaw Nation's School of Choctaw Language, as well as its early childhood and K-12 programs for youth. The overall goal of the Choctaw Nation Education Department is to increase the quality of education in all schools in southeastern Oklahoma. Previously, I worked for 34 years as an educator and school administrator in our public schools. I had direct, first-hand experience with the Title I, Title VII, and IDEA programs.

In recent years, the Choctaw Nation has significantly expanded its support for early childhood through secondary education. Our accomplishments are the direct result of partnerships and collaboration with public schools across our vast treaty territory in southeastern Oklahoma.

As you know, Mr. Chairman, the Choctaw Nation's jurisdictional boundaries encompass approximately 11,000 square miles, including 10½ counties in southeastern Oklahoma. This mostly rural area is home to 85 different school

districts. Because of our large geographic area, checkerboard land ownership, and commingling of tribal and nontribal communities, our challenges in education are a bit different from tribal governments exercising jurisdiction over a contiguous tribal land base with tribally-administered schools. Given its unique situation, Choctaw Nation has just one tribal school, Jones Academy in Hartshorne, Oklahoma. Jones Academy is a stellar model of the top-notch Indian education that can be produced when a tribe like Choctaw Nation partners with the U.S. Bureau of Indian Education (BIE), the U.S. Department of Education, and the local Hartshorne Public Schools.

Most of our Choctaw students, however, attend public schools across our Choctaw territory. There are approximately 8,500 Choctaw students within our treaty territory, and 14,329 Choctaw students throughout all public schools in the state of Oklahoma. The success of Choctaw students thus depends on the success of the public schools with whom we partner. And those schools are supported in important ways by the Title I, Title VII, and IDEA programs that are funded through this Subcommittee.

One shining example of these partnerships is the Choctaw Nation's Partnership Of Summer School Education Program, or "POSSE Program." POSSE works with local school districts to provide summer intervention in reading and math for **any** K-3 student, tribal or non-tribal, attending a public school within Choctaw territory. Selection of eligible students is based on end of year math and reading assessment benchmark scores or teacher recommendations. The summer instruction includes 24 days of learning and mornings are devoted to reading and math. Afternoons provide enrichment opportunities for students in STEM activities as well as Choctaw culture, art, music, and physical education. Morning instruction is delivered in a small group setting with a ratio of 1 teacher per 10 students.

To measure the program's effectiveness, grade level appropriate assessments are given at the beginning and ending of summer school instruction. We have seen remarkable success in this program with students' achievement during the summer, as well as continued into the school year. For example, 2nd and 3rd graders from Summer 2014, on average, scored in the 20th percentile at the beginning of summer school instruction. They then progressed to the 30th percentile by the end of summer school, and then to the 40th and 50th percentiles as the school year progressed. Intensive summer school helped bridge that gap and prevent summer learning loss. Students are then empowered to achieve even more as they enter regular classrooms during the school year. (See Appendix A)

POSSE's remarkable results are the compilation of many factors. POSSE started as a pilot program and is now expanded to 14 locations throughout Choctaw territory and involves students from 19 school districts. Choctaw Nation hopes to expand and grow POSSE until all 85 school districts are involved throughout all of Choctaw territory. The POSSE summer school program is 100% funded by the Choctaw Nation from its tribal funds. However, increased funding to the U.S. Department of

Education is needed with a focus on tribal educational departments to help this and other results-based programs grow and expand and to serve as a model for Indian Country. Reading opens doors to many great life achievements, and Choctaw Nation wants to make reading skills a reality for all young people in southeastern Oklahoma. Tribal Education Departments need a bigger seat at the table at the federal level to promote positive youth educational and empowerment programs like POSSE.

The Choctaw Nation Tribal Council fully supports this program. It is wonderful to have the support of our Nation's legislative body, but additional federal support is needed to uphold the federal trust responsibility to Indian tribes and their members. Unfortunately, many grants programs and other funding opportunities from the U.S. Department of Education do not expressly list Indian tribes or their Tribal Education Departments as eligible grant applicants alongside states governments and state departments of education and public schools. Tribes like the Choctaw Nation need parity with state departments of education and schools to apply for these grants to support our educational programs. We seek equality of opportunity. Many of the schools that serve tribes are small, remote, rural schools. They do not have the internal capacity to apply for many of these complex federal programs. The Choctaw Nation is the uniting factor among all the school districts in Choctaw territory and has the leadership and capacity to lead these team efforts to positively impact education for all of southeastern Oklahoma.

Nationwide, approximately 90%¹ of tribal youth are **not** served by BIE schools, but instead attend public schools. In Oklahoma alone, 130,000 Native youth are enrolled in public schools. Continued and increased funding to Tribal Education Departments is needed to ensure tribal youth needs are met in public school systems through partnership and collaboration.

Another example of the Choctaw Nation's efforts to partner with school districts, on programs and services they could not otherwise obtain, is the Choctaw Nation Making A Difference Program, MAD, that serves 9-12th grade students. Established in 2011, our MAD program helps at risk Choctaw students residing in Choctaw territory to stay in school and graduate. We are taking responsibility for our Choctaw students in public schools to make sure they don't fall through the cracks. We're providing key supplemental assistance to counselors, teachers, and administrators serving our students. Additionally, MAD compiles student achievement and real time data to serve as an early warning system to address a student's individualized learning needs. This program works collaboratively with the Oklahoma State University Educational Research division and Mizuni Inc. to establish formulas that will measure the long term effectiveness of the program by monitoring student performance of the cohort groups (from POSSE and MAD)

¹ National Indian Education Association, "Cultivated Ground: Effective Teaching Practices for Native Students in a Public High School" p. 4, available online: http://www.niea.org/data/files/research/dorer.fetter.2013_cultivated%20grnd%20effective%20tchgng.pdf

throughout their public school education. As identified Choctaw students enter high school they are assigned a “Making A Difference” counselor. This counselor will provide intervention strategies for students falling “off track” in the areas of attendance, grades, high stakes assessment, on track graduation, and college readiness as well as assist students with academic information to promote education and/or career path beyond high school. Program effectiveness will be measured by Choctaw students’ secondary education graduation rate as well as post-secondary placement. (See Appendix B)

Choctaw’s MAD Program provides an early warning indicator to intervene and positively impact students’ lives. We developed it together with the Oklahoma State Department of Education and our public school districts. To help facilitate and collect data from all our school districts, Choctaw Nation has partnered with Mizuni, a nationwide provider of K12 data management software solutions to create a custom next-generation software platform that delivers secure, cloud-based data management on Choctaw students attending a public school district within the boundaries of the Choctaw Nation. This platform is utilized by the POSSE and MAD programs. We worked diligently with each school district residing in our Nation to form a partnership allowing Choctaw Nation to see data such as grades and attendance on students who have a parent permission form. Mizuni K12 Aspire Platform allows us to see real time data on students. Of 63 high schools in the Choctaw Nation, 51 of those have agreed to allow our Choctaw Nation Education Department to see real time data on students. We hope to reach agreement with the remaining 12 school districts by the end of this school year.

The Choctaw K12 Aspire Platform is a next-generation platform that delivers secure, cloud-based data management solutions for our K-12 District Partners. Aspire provides data visualization, proactive notifications and predictive analysis in a user interface developed with a mobile responsive design. It consists of modules that solve specific problems common to K-12 school districts. The Choctaw K12 application provides an early warning system that delivers active alerts for Choctaw students falling “off track” in the areas of attendance, grades, discipline, high stakes assessment, on track for graduation, and college readiness. Choctaw Nation provides this system free of charge to all school districts that sign up, and many of our schools would not be able to afford sophisticated software like this independently. Additionally, each Choctaw student is assigned a counselor from Choctaw Nation to provide assistance tailored to their needs. This combination of real time quantitative data, as well as a hands-on personal connection is truly “Making A Difference” in the lives of Choctaw students. To our knowledge, there is no other entity or tribe in the country building consortiums of this size and magnitude to serve Native youth.

The School of Choctaw Language is another trail-blazing program that provides cultural and financial benefits to students in our public schools. Currently, Choctaw Nation is working with 38 schools districts throughout our territory to teach the Choctaw language. Another five schools will be added for the next school year.

Choctaws – growing as one with pride, hope and success

Choctaw Nation led the advocacy efforts with the Oklahoma Legislature to have Native languages recognized as world languages in Oklahoma's public schools. This victory has opened the door for many students to learn more about their heritage and to have their language taught in school and recognized for academic credit as they work toward high school graduation. School of Choctaw Language instructors are certified teachers by the State of Oklahoma and by the Choctaw Nation of Oklahoma. The School of Choctaw Language is located in Durant, Oklahoma, but remotes in to 38 schools around our vast treaty territory. This interactive class provides world language teachers to schools that may not be able to afford full time language instructors. Choctaw Nation of Oklahoma saves each of these public schools up to \$50,000 annually by providing for these teachers' salaries and services.

Title I funds are vital to our school districts in southeastern Oklahoma serving Native students. Our schools work with Title I funds to bridge the achievement gap for disadvantaged students and lift up our students. However, our schools need even more resources to enhance their work. State budgets are squeezed tighter than ever, and our schools look to the Choctaw Nation for connections and additional resources. We are working with our schools and continually building programs like POSSE and MAD that build even stronger bridges to help students over the gap and to thrive academically. Our programs supplement the hard work our schools are already doing and help empower administrators, counselors, and teachers as they serve our students. Title VII funds are another valuable resource for our public schools in the Choctaw Nation. Title VII's structure is important as it includes tribal government as well as parent committee participation in providing educational funds to schools serving Native youth and in shaping culturally relevant educational services.

Through its commitment to collaboration and partnership, the Choctaw Nation has realized great benefits for more and more Choctaw students. However, many more students remain in need of these services. We still have a path of ahead of us to bridge academic achievement gaps in the Choctaw Nation and we need the support of this Subcommittee and of the Congress as a whole to reach those goals.

Choctaw Nation was designated as the first tribal Promise Zone by President Obama in 2014. We earned this distinction due to the many challenges we face in our region, and due to proven leadership and capacity of Choctaw Nation to efficiently use resources to make a difference and leverage federal investments in southeastern Oklahoma for all residents through partnership and collaboration.

Promise Zone statistics leading up to the designation included 20% of the population with less than a 12th grade education, and 15% of the population that lack basic literacy skills. We are motivated to change these statistics. It is our mission to enhance education for students in southeastern Oklahoma, both tribal and non-tribal residents.

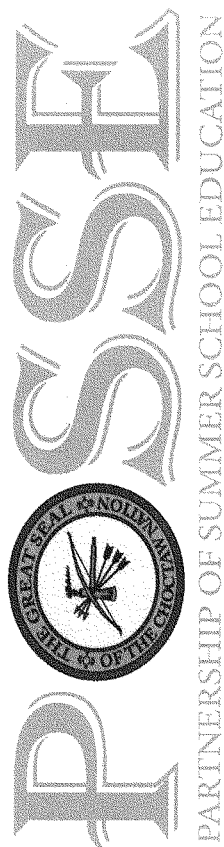
Choctaws – growing as one with pride, hope and success

The Promise Zone designation comes with significant priority points on grant applications from many different federal agencies, including the U.S. Department of Education. However, several of these Department of Education grant programs do not include Indian tribes or their Tribal Education Departments as eligible applicants. This creates a barrier to federal funds that could be put to good use in Indian Country. Even though we have “priority” as the **only** tribal Promise Zone in the whole country, we still do not have access to all programing from the U.S. Department of Education.

We are well-positioned to fully implement these programs by working with public school systems serving Native students. We ask for congressional consideration to treat Indian tribes as states, and their Tribal Education Departments as state departments of education, for purposes of determining eligibility to apply and administer all U.S. Department Education grant programs.

We are honored by this opportunity to testify and thank you for your time today. We appreciate your leadership on this Subcommittee, Mr. Chairman, and your stellar commitment to Indian Country and to our homeland, the United States. We are committed to continuing this dialogue and our enduring service to improving educational attainment for all residents of southeastern Oklahoma. Your continued support in these matters is critical to the success of education in Indian Country.

Yakohe (Thank you)



We believe intervention should begin at an early age.

We believe education is the best opportunity for individuals to break the cycle and crime.

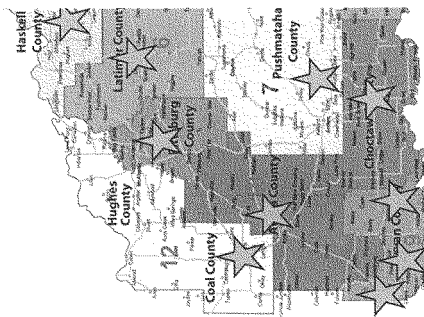
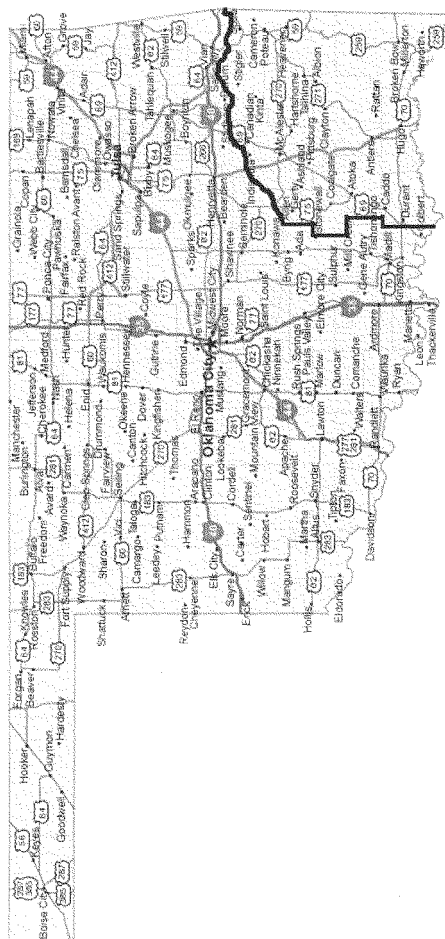
Promise Zone Statistics

- **Poverty:** The Promise Zone Poverty rate is 22.56%, nearly seven points over the national average. All the USDA **Extremely High** Poverty Designation. Nine census tracts with this region have poverty rates
- **Crime:** The Promise Zone has the highest rate of violent deaths in the state.
- **Unemployment:** McCurtain and LeFlore Counties have the two highest unemployment rates for the
- **Education:** 20% of adults have less than a 12th grade education and 15% lack basic literacy skills.

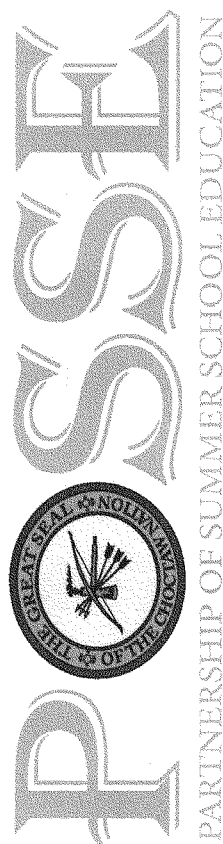


PARTNERSHIP OF SUMMER SCHOOL EDUCATION

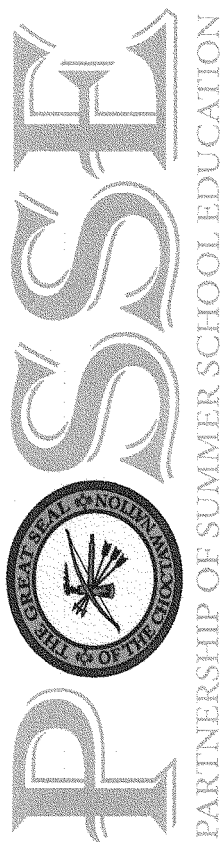
**2015 Summer
14 Locations
19 Schools Par**



**85 School Districts in the boundaries of the
Choctaw Nation. Approximately 40,000
School Age Students**

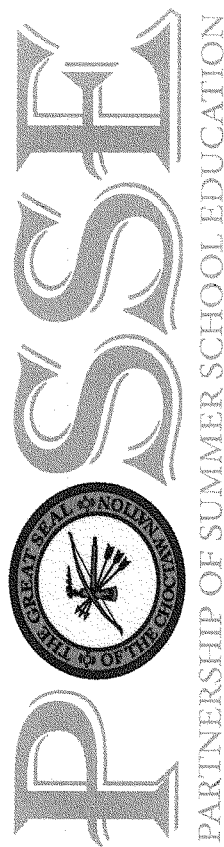


The Partnership of Summer School Education (POSS) is a Choctaw Nation initiative that partners with local school districts within the geographical boundaries of the Choctaw Nation. The program is designed to provide summer **intervention** in reading and math for **any** K-3 student attending a public school within these boundaries.



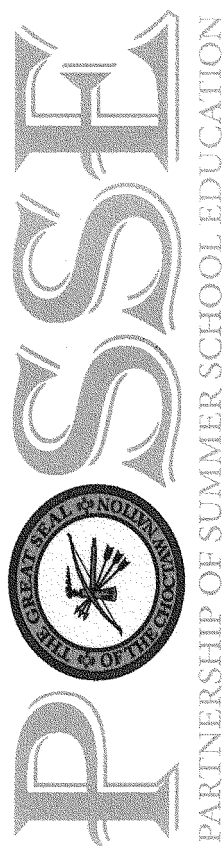
Distribution of Responsibilities

Choctaw Nation	School District
Salary	Facility
Supplies	Transportation
Trade Books	Child Nutrition
Summer School Shirts	Access to Computer Labs
Afternoon Snacks	Employees
Curriculum/Teacher Resources	Hire Choctaw Summer Workers
Professional Development	Copy Machine
Assessments	Paper Resources



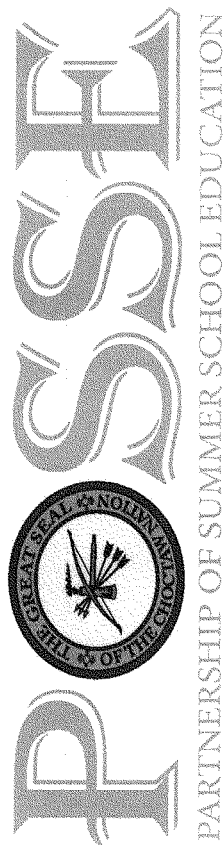
Student Selection

Selection of eligible students is based on the end of math and reading assessment benchmark scores or recommendation. POSSE serves **all** eligible students kindergarten through third grade who attend school the geographical boundaries of the Choctaw Nation Oklahoma.



Program Summary

- The session includes 24 days of learning
- Mornings are devoted to academic instruction in reading and math
- Afternoon provides enrichment opportunities for students STEM activities as well as art, music, and physical education
- Morning instruction is delivered in a small group setting with a maximum of 10 students per group



Typical Daily Schedule

7:30-8:15 a.m. Students arrive and eat breakfast in the cafeteria
8:15-8:30 a.m. Phonics Dance/Morning Exercise
8:30-10:10 a.m. Reading Instruction and Activities
*9:45-10:05 Kindergarten Recess and Restroom Break
*10:10-10:30 1/2/3 Recess and Restroom Break
10:30-11:00 Writing/Vocabulary Building Practice
11:00-12:00 Math Instruction and Activities
11:30-12:00 Lunch for any noon pick-ups
12:00-12:30 Lunch for those staying all day
12:30-1:00 Recess/DEAR time
1:00-4:30 Afternoon Enrichment Activities
4:30 Students are dismissed



Theme Based Curriculum

Year 1

Great Outdoor Adventure

Weeks 1 & 2: Camping

Book Studies:

K: Curious George Goes Camping

1: PJ Funnybunny Camps Out

2: Henry and Mudge and the Starry Night

Field trip

Weeks 2 & 3: Space

Book Studies:

K, 1: National Geographic Readers: Planets

2: Midnight on the Moon

Field trip

Weeks 3 & 4: Native American Heritage

Book Study:

K – 2: When Turtle Grew Feathers

Field trip

Year 2

Superhero's in Training

Weeks 1 & 2:

Book Studies:

K: Superhero ABC

1: The Bravest Cat- The True Story of Sc

2: Magic Treehouse

Field Trip

Weeks 3 & 4:

Book Studies:

K: Superhero ABC

1: Buzz Boy and Fly Guy #9

2: Magic Treehouse

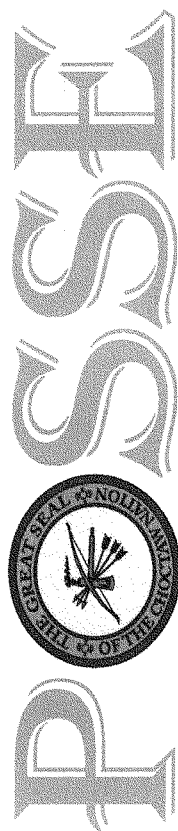
Field Trip

Weeks 5 & 6: Native American Heritage

Book Study:

K – 2: Sarah's Music

Field Trip



PARTNERSHIP OF SUMMER SCHOOL EDUCATION

Theme Based Curriculum

<http://choctaw.edu>

Year 3

Fun in The Sun

Weeks 1 & 2:

Book Studies:

K: Underwater Alphabet Book

1: Splat the Cat: Fishy Tales, Colorful Coral Reefs

2: Magic Tree House #9: Dolphins At Daybreak

Field trip

Weeks 2 & 3:

Book Studies:

K: Underwater Alphabet Book

1: One Fish, Two Fish, Red Fish, Blue Fish

2: Dolphins and Sharks: A Nonfiction Companion

Field trip

Weeks 3 & 4: Native American Heritage

Book Study:

K – 2: Chukfi Rabbit's Big, Bad Bellyache

Field trip

Year 4

TBD

Weeks 1 & 2:

Book Studies:

K:

1:

2:

Field Trip

Weeks 3 & 4:

Book Studies:

K:

1:

2:

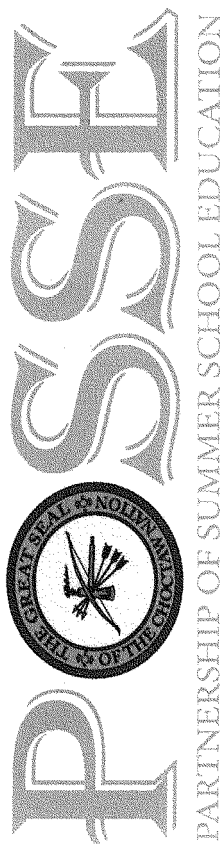
Field Trip

Weeks 5 & 6: Native American Heritage

Book Study:

K – 2:

Field Trip



Assessments: Assessments are to be given within the first couple of days of summer and at the end preferably just prior to the July 4th holidays.

Kindergarten Assessments:

Capital Letter Recognition (# correct out of 26)
Lower Case Letter Recognition (# correct out of 26)
Letter Sound Recognition (# correct out of 26)
Dolch Sight Word Recognition (# correct out of 40)
Number Recognition (0-20)

2nd Grade Assessments:

Dolch Sight Word Recognition (# correct out of 220)
Star Reading Assessment
Star Math Assessment

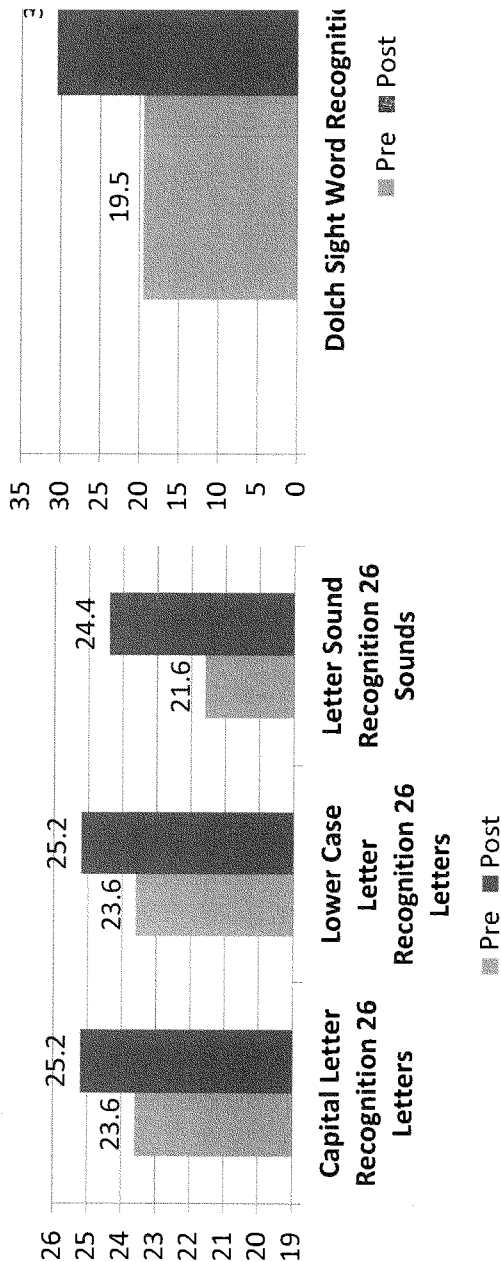
1st Grade Assessments:

Capital Letter Recognition (# correct c
Lower Case Letter Recognition (# corr
Letter Sound Recognition (# correct o
Dolch Sight Word Recognition (# corre
Star Reading Assessment

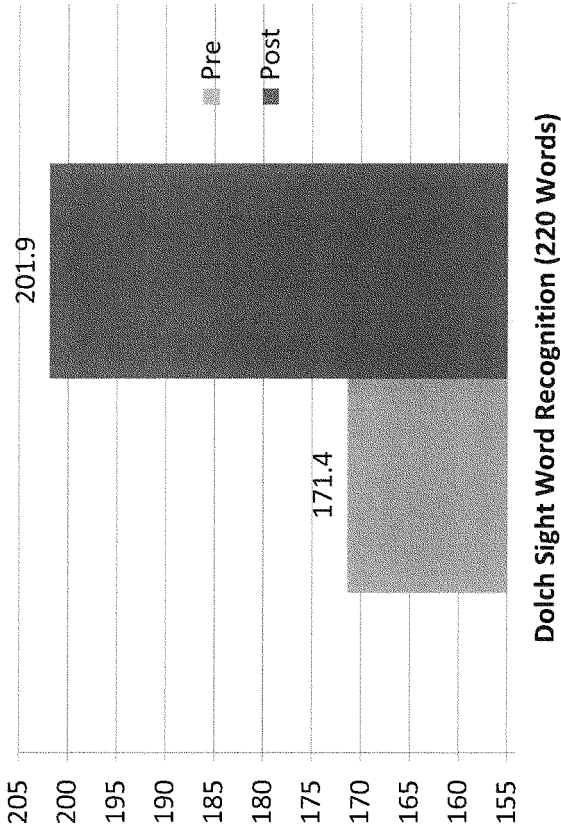
3rd Grade Assessments:

Dolch Sight Word Recognition (# corr
Star Reading Assessment
Star Math Assessment

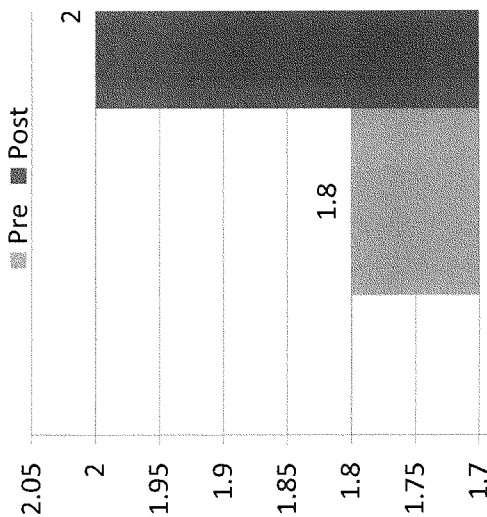
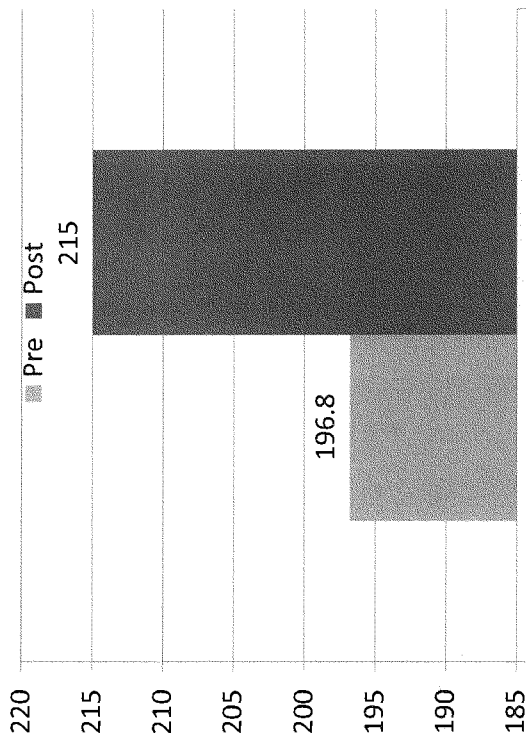
Kindergarten Assessments



1st Grade Assessments



2nd Grade Assessments

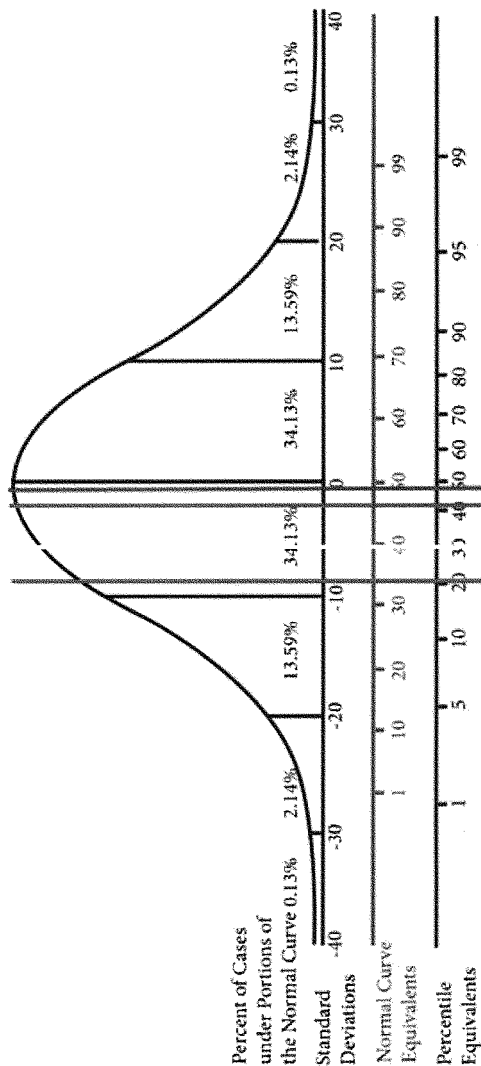




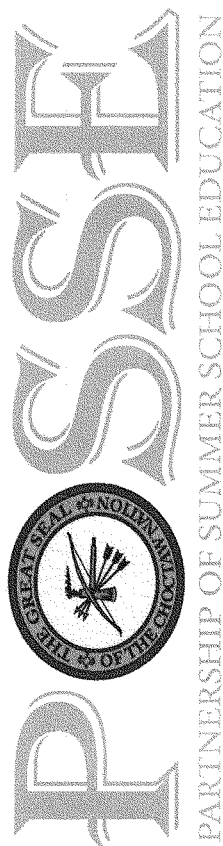
PARTNERSHIP OF SUMMER SCHOOL EDUCATION

Star Reading Assessment

Grade Level

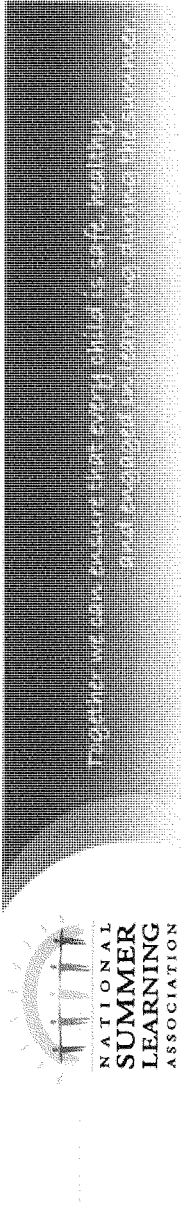


2014 Pre Summer Assessment	2014 Post Summer Assessment	2014-2015 Beginning of Year Assessment	2014-2015 Middle of Year Assessment	2014-2015 End of Year Assessment

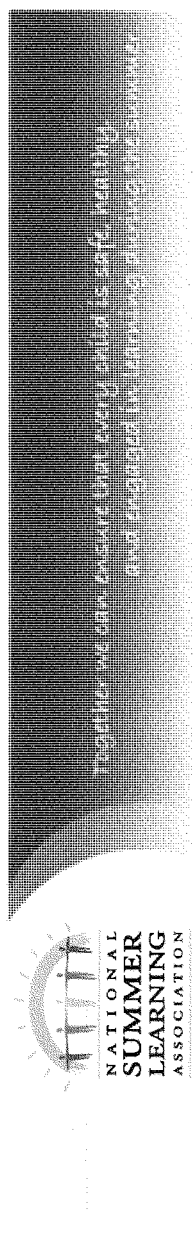


Partnerships

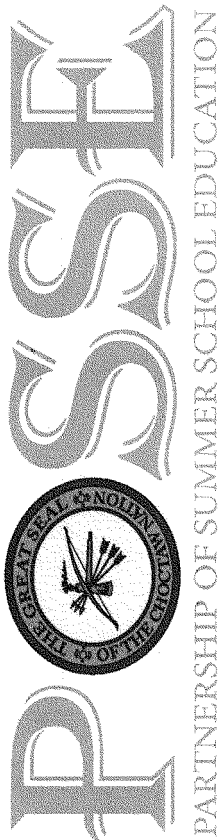
- Oklahoma State University
- Southeastern Oklahoma State University
- Eastern Oklahoma State College
- University of Oklahoma
- University of Oregon (DIB)
- Renaissance Learning (STA)
- Public Sector



1. Increase the duration, intensity, and scope of the traditional summer school model to a comprehensive week, full-day model that makes summer an essential component of district school reform strategy.
2. Expand participation to all students in school-wide Title I programs, not just those who are struggling and consider expanded year programs that include all students in participating schools.
3. Change the focus from narrow remediation and test preparation to a blended approach of both academic enrichment activities that provides hands-on, engaging programming that fosters critical 21st Century skills: collaboration, innovation, creativity, communication, and data analysis.
4. Strengthen and expand partnerships with community-based organizations and public agencies that provide to align and leverage existing resources, identify and meet gaps in service, improve program quality, and outcomes for summer success.
5. Include strategies to improve student attendance and engagement by providing healthy food, field trips, attendance policies, and comprehensive supports.
6. Provide innovative professional development for educators and ensure summer programs offer teacher models of teaching and gain valuable leadership experience.



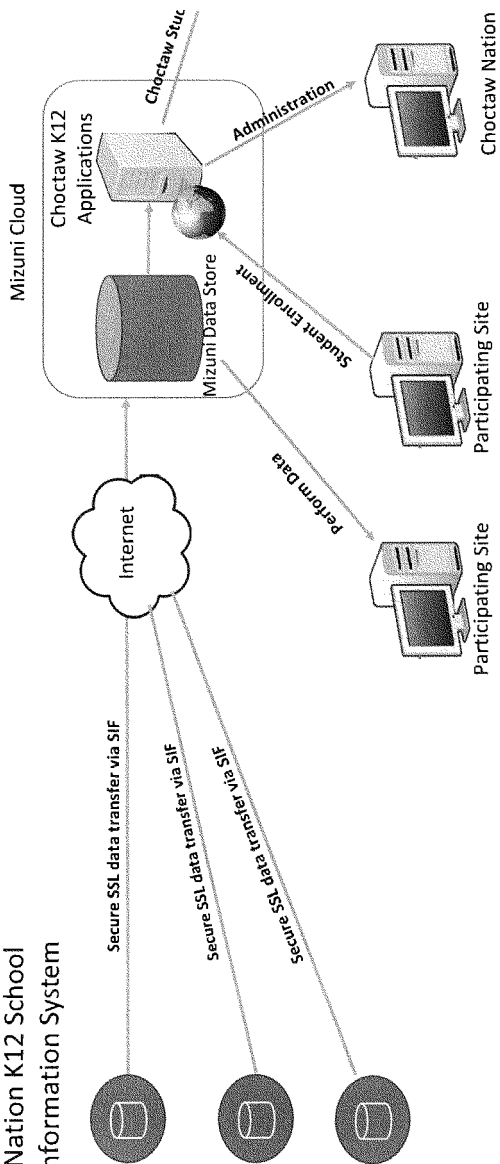
7. Include innovative approaches to learning for older students, including proficiency-based learning, flexible and acceleration, internships, college visits, and other college and career readiness opportunities that provide interventions and workforce development skills to prepare students for future success.
8. Target key transition periods such as the summers before kindergarten, middle school, high school, and college so that students are prepared for success in new environments.
9. Lastly, summers need to move from the periphery to the center of school reform strategies through sustained funding from Title I and other sources, long-term planning, robust assessment and evaluation, and improved data collection.



Technology Solution

Choctaw Nation K12 School
Student Information System

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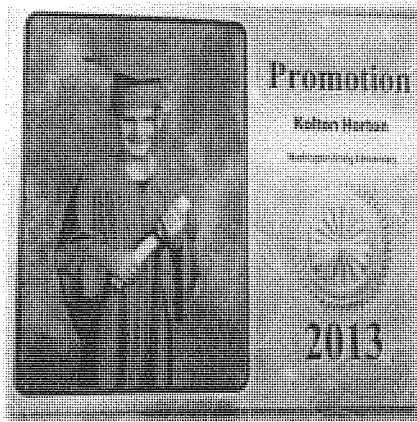


Kolton Horton

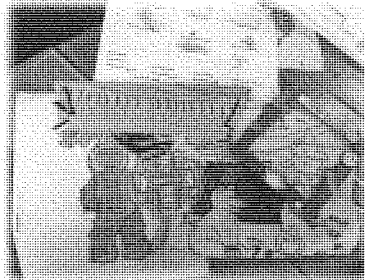
The summer school program provided by Choctaw Nation of Oklahoma brought a new, fun, and exciting way of learning for my son! Kolton was happy to be one of the first few students nominated to be a part of this wonderful program. The program was first launched as an introductory period and would provide strenuous curriculum while enhancing the knowledge of children in the area. While Kolton's testing scores were above average, the program allowed preselected students to enroll to continue to improve their learning skills during the summer. Kolton was not only able to learn the necessary academics while attending the program, he also learned a lot about his Choctaw heritage and was able to experience learning in a profound way.

I do feel that it is important to extend the program to students whom have a proven drive to learn and want to extend their knowledge beyond the yearly academic requirements. After completing the first grade, Kolton was even more excited than usual, about the upcoming summer months. He just knew that summer meant "summer school with the Choctaws". However, Kolton continued to thrive and actually excelled in the first grade academically and was not able to attend the summer school program because his testing scores were too high at the end of the year. This left Kolton wondering why he should go above the required levels if he would not be able to be a part of the cultural activities and learning exercises in the summer as well.

Kolton is now in the second grade and has successfully met and prospered the goals set for a second grade student. His reading level is 4.5-4.9, which translates into fourth grade, fifth month to fourth grade, ninth month. He has successfully made it halfway through the fourth grade math level and has a 101 average in spelling. His teachers continue to compliment him on his knowledge, drive, and overall willingness to learn new things. He treats every problem as if it were a competition or game and will do all he can to solve it! It is amazing what we can learn from a seven year old boy! No problem is too big when you have a mind that continues to grow!



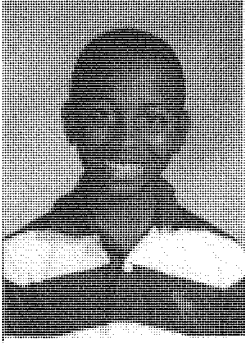
Kindergarten graduation 2013



Shown here, the students studied space and learned about astronauts and outer space. Also shown in the picture is a canoe, Native American necklace, and words they learned in the Choctaw language. After completing the camp, the students were able to color a camp bag and take all of the items they made during the summer home to show their parents.

Thank you,

Dana Horton

Lex Jestis

Lex was adopted in April of 2012 from Cali, Colombia. He had never been in a traditional school setting and only spoke Spanish. Beginning school at eight years old was a struggle for us as parents and almost impossible for him. He was trying to learn a new language and learn to read and write all at the same time. The one-on-one attention he received at the Choctaw Nation Summer School Program was a game changer for Lex. He came out of the summer program with more confidence and the understanding that he lacked. I am so thankful Lex had this opportunity.

Leandra Jestis

mother of Lex Jestis, 11 years old

Bokchito, OK



Paula Harp, Senior Director
Lori Wells, Director
 (800) 522-6170 Ext. 4105

Amanda Spencer, Admin. Asst. /Counselor
Amanda Gentry, Counselor
Padyn Hobgood, Counselor

Our Goal: To assist our students with academic information to promote education and/or career path beyond high school, thereby ensuring that our students become successful adults and leaders.

Requirements for eligibility:

Students must be tribal members of the Choctaw Nation of Oklahoma and verified by the Making A Difference staff.

Each student must have a parent permission form on file with the Choctaw Nation Making A Difference program. (one time application)

Any student, 9th-12th grade, attending an accredited high school within the 10 1/2 county service area of the Choctaw Nation of Oklahoma.

What services are available?

- *ACT Reimbursement*
- *ACT Workshop*
- *College Prep Study guides*
- *School Visits*
- *Parent-Teacher Conferences*
- *College Fair*
- *Notification of event dates*

Grade level folder with Choctaw Nation Education Program information which includes:

- *Higher Education*
- *Career Development*
- *CAB (Choctaw Asset Building)*
- *Talent Search-if available*
- *STAR*
- *Summer Youth work program*
- *YAB-Youth Advisory Board*
- *Chahta Foundation*
- *FAFSA*
- *Oklahoma's Promise Application*
- *Adult Tribal Membership application (16 and up)*

Choctaw Nation of Oklahoma
 Making A Difference Program
 P.O. Box 1210
 Durant, OK 74702-1210

Success Stories for MAD program

Student A

The Making A Difference staff received an email from a student who was a senior and attended one of the high schools in the 10 ½ county service area of the Choctaw Nation. This student needed assistance with finding a job. She was 18, in her senior year, and had moved from her home due to abuse and neglect. She was living with her best friend's parents. She had no income and needed a job to support herself but also needed money for upcoming expenses regarding her senior year. Without a job, she feared she would have to quit school and work full-time to make ends meet. This student did not have a vehicle.

The MAD counselor visited with the student the next day at the high school. During the visit she spoke with the student about her plans after high school. She wanted to attend culinary school at OSU Okmulgee Tech. She had toured the campus with her high school but was unsure if she would be able to attend. She had taken the ACT. The MAD counselor explained FAFSA guidelines and how to apply. Due to the abuse, the student was scared to ask her parents to fill out the FAFSA. Her counselor with Educational Talent Search was assisting her in filling out the FAFSA and had contacted the parents for them to fill out. The MAD counselor explained the services with the Choctaw Nation such as Higher Education and Career Development funding and how to apply. This student was a straight A student.

Due to the resources of the Choctaw Nation, a job was created at the Grant Casino the next day which was a few blocks from where she was staying. Since she was still in high school, the casino worked with her schedule. This student was able to save her money for the upcoming school year. She worked through the summer months and left for OSU Okmulgee in August to begin college. The Choctaw Nation was able to assist with funds through Higher Education and Career Development and she also received FAFSA and OkPromise.

Student B

The Making A Difference program helped a student who attended Durant High School. This student maintained good grades while in high school. His parents' income did not meet the guidelines for federal Pell grants. The Making A Difference staff assisted the student in filling out the OJ Harvey scholarship. This student was attending SOSU. He was chosen for the scholarship and was able to attend college and did not have to take out student loans.

Student C

One of the counselors for the Making A Difference (MAD) program was calling high school counselors to check on students' needs. One of the school counselors informed the MAD counselor of a senior who was very bright and had scored a 26 on her ACT but was experiencing great difficulty at home—the father actually offered to pay the girl (who is his biological daughter) to *move out* of his home.

The senior student had the opportunity to interview for a college scholarship but was involved in an auto accident on the way to the interview and totaled her family's vehicle. This left her with no transportation and as a result was unable to reschedule the interview for a later date. She was very upset because the scholarship could have allowed her to go to college with little to no out-of-pocket expense. She asked her school counselor how she could afford to pay for college if she couldn't even afford to have her braces removed.

This student had been wearing braces for the past six years. The braces had been ready to be removed for the last two years but her parents didn't have the money to have them removed or purchase the retainer. The school counselor had been trying to find an orthodontist who accepted our state insurance to have the braces removed, but kept running into roadblocks due to financial and legal issues. The Making A Difference counselor was able to work with Choctaw Nation's Patient Relations to acquire funding to have the student's braces removed and purchase the retainer.

In the meantime, the MAD counselor called the Native American Director for the college where the student had missed her scholarship interview to see if there was any chance of scheduling a make-up interview. As it happens, the school is planning to host a make-up interview the first week in May, and the student is currently waiting to hear the exact date and time of her interview.

Mr. COLE. Thank you all very much for your testimony and for the kinds words.

And I can't help but reflect just looking at the table, you see one of the big problems we have. As Chairman Allen said, he represents a tribe of 600 members, and Director Parrish represents a tribe of over 150,000, and how you tailor Federal programs to deal fairly.

But the citizens of both have exactly the same rights and trust obligations from the United States to them, and managing to put programs together that can deal with tribes of this kind of different size and, frankly, different historical circumstance, different geographic location, is a challenge. And you all mentioned areas where you have got concerns, but I want to go back to that because this is extremely helpful to the committee.

If you had to name—number one, just give us a gauge, and I am not trying to be critical in any way of the administration, how are we doing in terms of are we beginning to address these problems and moving in the right direction? What are the two or three things, if you could pick, that you would say this would be the most helpful thing for us to do?

And remember, on this committee, of course, we are a funding committee, not an authorizing committee. But the authorizing committees pay attention to what we have to say because they like to have their programs funded. So sometimes we can have some influence on what they are going to do legislatively as well.

So, but again, focus on two or three things that you would really like to see the Federal Government do better. If you have got a couple of success stories, that would be fine, too. Let us just go in reverse order. I will start with you, Director Parrish.

Mr. PARRISH. Well, one of our main concerns is when in the outstanding programs that we have, they are state-of-the-art programs. They are proven, and we have the data to back up what we do and how successful that they are. So, but when we look for help, and I will mention this again, with the grants and I have one in front of me that is 2014 that was the First in the World program and had to do with postsecondary education.

And when you look for the applicants on that, it says this regulation in 34 CFR Part 86 applied to institution of higher ed, and then the regulation in 34 CFR Part 79 applied to all application except federally recognized Indian tribes. So you know, we sometimes want to be able just to compete and come to the table and say we have researched-based programs, too, and that we can reach out to our schools directly, and we have direct partnerships with our schools. But sometimes we just don't get that opportunity to compete.

And all of our programs are research-based, state-of-the-art, and we would just—and one of our main deals is consider, too, for the Federal Government to understand that our tribal boundaries, okay, in our territory and boundaries, we deal with public schools, and we have 8,500 children that go just within the Choctaw tribal area. But within the State of Oklahoma, we have about 14,000.

So it is a unique situation that I just wish that Washington, D.C., could see our situation and understand our partnerships that

we have with the schools to help them with Title I and Title VII and IDEA programs that we have.

Mr. COLE. We can go next to you, if we can, Director Bohlen?

Ms. BOHLEN. Thank you.

Well, I mentioned what I think is one of the greatest successes of the funding that Congress has allotted for Indian Country. It is the Special Diabetes Program for Indians, I think. And thank you again for supporting the 2-year extension of that program, which should be a permanent program, frankly.

But the Special Diabetes Program for Indians works because has very little administrative clamps on how the funding can be used. There are objectives that need to be achieved, but the way those objectives are achieved really respects the fundamental differences that we are all articulating here between the various tribes.

That freedom can be expanded through allowing that funding to also be subject to 638, which is something the Tribal Self-Governance Advisory Committee is very supportive of. But as I stated, it not only saves money. It is saving money because there is a dramatic decline in the number of people who need dialysis because of it.

So saving money because it is working, and the hemoglobin A1C level that indicates your prevalence of diabetes, the seriousness of your diabetes, has gone down an entire percentage, 1 whole point. It has gone down an entire point.

Even the National Institutes of Health Special Diabetes Program cannot claim those kind of victories. And it works because the tribes are using the best that Western medicine has to offer and the best that their traditional healing practices and culture has to offer to have programs that work completely respectful of sovereignty, local control, and local tribal guidance of how those funds are used.

So that is my—what I think is one of the big success stories. Self-governance is a proven huge success in Indian Country, and I think SDPI is working because it is working on a model similar to self-governance where the funds are driven, directed, and managed by the tribes.

The tribes know what they need better than anybody. They know what they need, and they know how to allocate priorities in a way that will be the most beneficial. Despite very harrowing financial hardship, they will make the most out of what is right for their tribes.

So I think that three of the things that I think would really be helpful are extending self-governance to allow for the demonstration programs that we have talked about today because it works and it is going to work and it is going to be continually successful. It is just if past is prologue, we can expect total success.

The public health infrastructure for Indian Country needs to be invested in. We need a substantial investment. We know that every dollar spent in public health, disease prevention, and health promotion saves six in the direct provision of healthcare. And we have fought for the recognition of tribal epicenters as public health entities that can—we won that in the Indian Healthcare Improvement Act. Thank you all for supporting that.

But it is not working because the States are not sharing the data with the tribes, as the law requires them to, as they do with every other public health entity. So a substantial investment in the public health infrastructure and the tribal epicenters is really needed.

Structural changes that will alleviate funding barriers, administrative burden, and so forth on HHS funding reaching the tribes is another.

Thank you.

Mr. COLE. Thank you.

My time is expired. So, but don't worry. I will get back to you, Chairman Allen. If you would just—okay, please, your thoughts on things—

Mr. ALLEN. Well, thank you, Mr. Chairman.

Quickly, Stacy touched on one of the things that I was going to point out with regard to self-governance. Your first question is how well are you doing?

I have been a chairman for 38 years. I can tell you where we were 38 years ago versus where we are today, light-years. I mean, we made substantial progress. But the success has revealed how much more we need to do and how much more need there is.

I think if there is anything you can do that would help continue to make a difference is a point that Stacy was underscoring, whether it is self-governance legislation, allow us to take over more and more programs to serve our community as a whole, from the youth to the communities and family to the elders. And self-governance, 477 with regard to more focused employment assistance, those kinds of programs where you transfer Federal functions out to the tribes, let us do our job and let us have a little more flexibility, that works.

Mr. COLE. Thank you very much, and I thank the committee for its indulgence.

We will go to the ranking member, the gentlelady from Connecticut.

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

And thank you for your eloquent testimony. At some point, and I am not going to feign knowledge of all of these areas, and if I can say to you, Mr. Chairman, the whole issue of self-governance, which is more complicated and just as complex, I would love to have the opportunity to talk with you about that and get a sense of, in fact, how that—how that benefits folks.

I hear a lot from school districts and municipalities of wanting to have direct funding rather than money going through the States and so forth. So I don't know if it is a similar thing, but I understand where you may be coming from.

Let me just ask and let me just ask all of you, but particularly Director Bohlen, Chairman Allen, because in your testimony you talked about mental health and substance abuse issues. You talked about high suicide rates and high rates in these areas, and it is roughly about 23 percent, as I understand it, of Native American adults met the criteria for having a mental illness in the past year compared to 18 percent of all adults. And again, suicide is the second leading cause of death among Native American youth ages 8 to 24.

My understanding, again, is in 2014, Congress appropriated \$5,000,000 to SAMHSA to address this high incidence. SAMHSA awarded grants to 20 tribal organizations to promote mental health among tribal youth. Another \$5,000,000 was appropriated in 2015 to continue the effort.

The President has proposed an increase of \$25,000,000 for 2016. So that is about \$15,000,000 for mental health grants, \$15,000,000 for substance abuse programs, and I know that you all are interested in additional funds to that.

But what my question is, the funding has been modest, and there have been existing grants in the past 2 years. Tell us about what has been achieved with these efforts with mental health, substance abuse help potentially decreasing the suicide rate.

Are there lessons that you—that we can learn from what is going on in these areas? Or it may be too soon to tell. You know, we are talking 2014 and 2015 here. So, but I would like to know how these programs are working and what you see as what could be beneficial for the future in terms of making some real successful dents in the lives of youngsters particularly on the mental health side?

Mr. ALLEN. Yes, let me kick it off, Congresswoman. You know, this subject matter is a very complicated one in all our respective communities, and it is a subject matter that has a broad array of reasons that cause our youth or even adults to get so discouraged that they even contemplate suicide.

And so, so there is two aspects to these resources that we want flexibility to. One is just the obvious, treatment. When we experience a tribal citizen, whether it is a youth or not, that has issues, we are able to treat them. So that is the first issue.

But more importantly is to prevent it. And so, how do we—what can we do to prevent that? What is going on in their family life, in their own personal lives that we can address ahead of the game?

How can we elevate our community to rally around them? Whether is the family, the community, those that can be mentors and assist them so that life is not so discouraging that they would contemplate that idea.

So these resources are used for those two particular areas, and I think that we are seeing some semblance of success. But a lot of it is also driven by the economies. You know, if we don't have jobs, if we don't have employment opportunities, then they don't—then it gets into a despairing situation.

Ms. DELAURO. If you would also, Director Bohlen, just address the Circles of Care program, as well as what we were talking about, as a model, if you will, of trying to address some of the things that Mr. Allen was talking about as well?

Ms. BOHLEN. May I contextualize it just a little bit?

Ms. DELAURO. Please.

Ms. BOHLEN. Thank you.

In follow-up to what Chairman Allen said, there was a national research project over many years done in Canada by a man named Michael Chandler, and he was looking at suicide rates among first nations people, and they had similar rates to our issues in the United States. And he said that when you are looking at why this is happening, the first two indicators you throw out are poverty and depression because they are as common as the sand.

And what you look at are the communities where it is not happening for why something is working there. And he measured the presence of strong culture as the changing indicator for why youth and Native people are less likely to commit suicide. There are other social determinants of health, of course, are critical. There is no panacea. And this isn't an evangelical moment.

But the presence of culture and the strength of culture is a key indicator in the life expectancy of our youth and of our people. It would be great if a similar study could be done in the United States.

We also know that adverse childhood experiences truly have an unbelievably powerful impact on children and the adults that they become. And if a child is exposed to one of the four, the more adverse experiences they are exposed to, the more probable it is that their actual physiology will change in their bodies, and science has proven that they are more likely to be obese, which Native Americans suffer from in high disproportion to everybody else. The numbers are going down for youth in every other ethnicity in the United States, except ours are continuing to rise.

Substance abuse. Terrible self-image issues. Depression. Suicide. These are also tied to adverse childhood experiences. So that is one of the things that I believe Circles of Care really is successful in addressing, both from a cultural perspective and in providing healthy opportunities and environments and safe places to be a child and to extend care beyond just the therapeutic relationship, but to look at Indian people in the contextual reality of our culture, our families, the whole spectrum of who we are in our—that define us.

So I think Circles of Care is a highly successful program. It needs more time, and you know, there are other reasons as well, which we will be happy to provide remarks in writing to answer your question thoroughly.

Ms. DELAURO. My time is up, and I will come back to you, Mr. Parrish. But I would just say that I would love to know, if you can get back, about what the kinds of program that are engaged in—

Mr. COLE. You were kind enough to give me a little extra time. We will let you have a little extra time.

Ms. DELAURO. Thank you. But I would love to get that information as to what is included, and if you could just briefly comment?

Mr. PARRISH. Yes. In listening to the conversation that we have, education is obviously the key to all the problems that we have been talking about. So it begins at the very basis.

And then some of the programs that I described to you is if you can help them educationally, look what you can do. You know, reading, for example, is the greatest educational endeavor anybody will ever experience because that leads to other successes, bottom line.

And so, when I look at this, we also have the Making A Difference program, and we track that data that if our Choctaw student might be not coming to school or if they fall down on their grades or anything like that that might not be leading them to graduation, then when we see that, we get a hold of the administration or the counselor at the school, see what we can do.

And as a matter of fact, our counselors from Making A Difference go out to that student and say, "Do you need help? How do you need help? Do you need a ride home from school?" All those kinds of things to help you stay in the education system that might not lead to the health problems that we see with substance abuse and things like that.

So we know the key is education. We don't have the statistics for that. We are not that far along in the program. But we know, you know from your heart that is going to help keep young people out of trouble.

Ms. DELAURO. Thank you very much.

Thank you, Mr. Chairman.

Mr. COLE. Thank you.

I am going to go next to Mr. Simpson, but before I do, I would be—I am sorry? Oh, Mr. Fattah is next. So I apologize for that.

So the gentleman from Pennsylvania is recognized.

Mr. FATTAH. You will still be able to make a point, though, Mr. Chairman, whether you went to Simpson or me.

Mr. COLE. Well, I will make—I will hold and make the point.

Mr. FATTAH. All right. Let me say that at 11:00, I have to go. But I have to meet with Representative Kilmer about some treaty obligations we have in terms of fish hatcheries with Native American tribes in Washington State. So I want to be brief and concise. I am going to focus in on your point around education.

So I created the GEAR UP program, which has worked very well across the country and has particular success in terms of working with Native American students. I am going to be in South Dakota in a few weeks for a ceremony with hundreds of students who, as part of the Sioux Nation program there, have benefited through the GEAR UP program.

And I know, Jim, that you have had some experience with this in Oklahoma, and I have been out to Oklahoma. So if you could comment about college attainment and what kinds of—what has been the result and what more we could do in that space, that would be useful.

Mr. PARRISH. I hope I understood your question right. It is a very good question, and the Choctaw people tell me [speaking Native language] I talk a lot. [Laughter.]

So you have opened up that conversation that is really immense. And so, in our programs, with the program I mentioned, Making A Difference, is that what we are really aiming at is to—is to get you through that high school with that college and career readiness curriculum so that you will be ready, the same as GEAR UP was doing, okay?

And we also—we guide them along in that endeavor about the curriculum that they are taking. We are that involved in the schools, and school likes for us to partnership with them in that, okay? And go ahead.

Mr. FATTAH. You have had remarkable success across a number of districts. So I assume part of what you are doing is interacting with families also, right?

Mr. PARRISH. I didn't understand.

Mr. FATTAH. You operate in a variety of school districts?

Mr. PARRISH. Right.

Mr. FATTAH. In different schools, but with the same level of success. So are you also interacting with the families of these children?

Mr. PARRISH. Yes. One of the points of the Choctaw Nation of Oklahoma that we know to be successful for our Choctaw children, which are mostly in our 85 public schools, is that—is that personal relationship and that building a relationship with them, that they know that they can come to our education department and ask questions and get that help in that tough questions, which leads to education to the family also.

And so, it is very important what you say in building relations all the way not only just in the secondary or public school education, but also in postsecondary education. We are real concerned about our retention program. Why aren't we staying after we have—you have been through high school. You have taken the curriculum. Why aren't you staying in college?

So we are working on a new program for that, as you speak, because we know—and to be perfectly honest with you, in my public schools, we did involve the GEAR UP program. But one of the things about that is we became—we were personally involved with them in the high schools, obviously, but this GEAR UP gave us opportunity to be more involved with them to set that goal to attain a college and career readiness curriculum, okay?

Mr. FATTAH. Well, let me—

Mr. PARRISH. So, go ahead.

Mr. FATTAH. Yes, let me thank you, Jim.

Mr. PARRISH. Oh, okay.

Mr. FATTAH. Because I want to say to the chairman that your point about, you know, how we as a Federal Government interact better with the 500-plus tribes, you know, there is some opportunity.

I am ranking on CJS. So we deal with the tribes around law enforcement issues and support or lack of support, as it may go, on a variety of issues on tribal law enforcement issues, also in the Commerce Department around, you know, various treaties related to, for instance, fish hatcheries and fishing rights.

And so, you know, maybe there is some way for the Congress to engage this in a more comprehensive way because through the different committees, we are all kind of dealing with small pieces of if it was looked at more comprehensively maybe. And when I hear this Stacy say in respect to sovereignty of the nations, I assume what she means is it is almost like the majority's term, flexibility, right? That they want flexibility in terms of being able to apply these funds and not have a "one size fit all" circumstance.

But just like this committee has jurisdiction and other committees that have jurisdiction, and there may be ways where we could think about some focus to make some more disruptive improvement here sometime in our career, you know?

I heard Mr. Allen say he has been doing this for 38 years. Sometime like we want to make some quicker progress on some of these fronts.

So thank you, Mr. Chairman.

Mr. COLE. Well, I thank my friend very much for his contributions.

And just to make two points quickly, then I want to give Mr. Simpson a chance because we have votes, and we are going to have to leave shortly.

First, just to reinforce something that Director Bohlen said, the key to a lot of these issues are self-governance in one way or the other. I hear it over and over again, just let us have the resources, and we really will—do know what we are doing.

And I have seen how transformative that was in our own healthcare system as Chickasaws when we took it over and operated obviously under a contract system with the Bureau of Indian Health, and they are our partners. But it is our system, and everything from wait times to attention. If something goes wrong, when the patients can get their fingers around the neck of a tribal legislator as opposed to somebody over 1,000 miles away, it is amazing how quickly things work in the right direction.

So, but I want to next go to Mr. Simpson, and I would be remiss not to say this. Director Bohlen pointed out in her written testimony the tremendous disparity in dollars in what we spend on Native Americans versus the general population. But the person who has done more than anybody else to try and do something about it is the gentleman to my left.

His two predecessors as Chairman of Interior, Norm Dicks and Jim Moran, also worked. But under his leadership, in 4 years, we increased funding for Indian health by 39 percent at a time of budget austerity, and that was my friend from Idaho that got that done.

So, with that, I just want to thank him for his work and move to him for whatever questions he would care to submit.

Mr. SIMPSON. Thanks, Chairman, for those kind remarks.

It was really the whole Interior Subcommittee that did that. And as Chairman said, it was both under Republican and Democratic leadership. So even in decreasing budgets, as we have talked about, you can actually focus on things that are important and requirements and priorities, and we have done that in the Interior Committee.

And are we there yet? No. There is still a lot of work to do, both in healthcare and now we are starting to focus a little bit more on education and the need in education across Indian Country.

And, but I sit and I listen to your testimony, and you know, I could take the word “tribes” or “Indians” out of your testimony and put in the word “cities,” having been a former city councilman, and almost the same sort of thing exists in that you go to Boise, Idaho, which has about a third of the population of the State of Idaho. They have grant writers. They have all these things. They have access to everything that is available.

You go to Arco, Idaho, they don’t even know what programs are available to—and they can’t afford to have a full-time grant writer or someone who just follows what is available from the Federal Government or the State government or whatever. And that is the challenges that they face.

I have heard from several tribes that one of the challenges they have. You mentioned 700 different programs, that there will be a lot of different programs, maybe 4 or 5 programs that deal with job

training. They all have a little different direction and a little different requirements and all that kind of stuff.

And of course, we are really big on waste, fraud, and abuse. So we have reporting requirements for each of these. And that if we would give you a grant for all of these programs and let you decide which ones of these work best in your given area rather than us saying, well, you have got to spend this in this way and this in this way, and this in this way, that you would do a better job of it. Is that true?

Mr. ALLEN. That is the heart of the problem. Although what we have said, as we have been advancing the self-governance and the 477 initiative, that we are willing to sit down in a demonstration forum, asking to those programs what is your objective? And then, so what kind of data would you like back that gives you a comfort?

If we aggregate those resources and modify them in a way that better fits our community, what are you looking for? And so, we are okay with accountability. It is just a matter of you don't need to dissect it all up.

Mr. SIMPSON. See, my challenge is, is that I—and maybe I am—well, my challenge is, is that if I put money in a job training program, what I want to see is jobs coming out, and I don't really care how you get there. What I want to see is the results.

And frankly, in education, as we are focusing on education, we all know that Indian education around this country has to change. We can't change it. It is the tribes that have to change it. We are willing to help, but we need the help from the tribes to say what do we do to improve the quality of education?

I have been in some schools that are—we build schools, and I will tell you the President has done a great job this year in his budget request for school buildings and stuff, and we thank him for that, and we are going to try to match that in the Interior bill. It is going to be tough. We have lower allocation, but we are going to try to.

But we have got to change the very structure of it, but it has got to come from the tribes. And so, we need to listen to you more than us trying to impose what we think will work in tribes. Because as you said, it may work in Arco, Idaho, and not in Boise, Idaho, same sort of thing.

And one of the challenges that I face, that we see as we go around to different reservations, many of the reservations are in remote areas. You got a guy or a woman that goes to college, goes to dental school, goes to medical school, has \$300,000 or \$400,000 or \$500,000 debt when they get out. Where are they going to go practice and be able to pay off that debt?

Are they going to go to some reservation that has no housing? They can't even find a place to stay. And how are they going to make a payment on their debts and stuff? How do we change that so that we can get the doctors and dentists out on the reservations that need to be there, and how do we train more Native Americans?

How do we train more Indians to go to dental and medical school? Because that is really who will come back and help their own tribes. Anybody want to take that on, or I mean—

Mr. ALLEN. Well, what I—there is a couple of approaches that could be considered with regard to that challenge. One, we have a lot of our citizens who are moving into those fields of expertise.

So your point is well taken that at the end of the day, they have a debt load, and they have to be able to make sure that they are going to recover a reasonable salary for the new expertise they have. So more often than not, they don't go back to the reservation because our ability to be able to pay at the level they need, to be able to cover the debt load and take care of their family needs doesn't work for the most part, as a general observation.

So that is a bit of a challenge. But part of the solution, HRSA has a debt retirement program that enhances the opportunity to bring—bring that kind of expertise into various communities and to make those resources more available to tribes in remote areas that can create a better incentive. So they can go home or go to a tribal community and work and get the kind of assistance that they need in order to cover that debt load while they provide a service and may not get the salary level they are looking for that they could get in an urban setting, but well enough to give them a comfort level.

So it is a matter of these different little options and making them a little more available to the tribes.

Mr. SIMPSON. Well, thank you all for being here today. Appreciate it very much.

And thank you for holding this hearing, Chairman.

Mr. COLE. I thank you, Mr. Chairman.

If we can, we will go to my good friend from Maryland, Dr. Harris.

Mr. HARRIS. Thank you all. I will be very brief.

Thank you very much, and thanks for coming up to inform us on these issues.

I am going to just briefly address two areas. The first is with regards to education, and maybe, Mr. Parrish, you can answer. You know, charter schools have begun to appear. The Cherokee Nation, I understand, in 2012 became the first Native American tribe to actually authorize a charter school, but there are many other charters on reservations and near.

Is that one solution to help with education? And if it is, you know, again, you can respond in writing later, what are the things that we can do to make it easier to avail yourselves of the entire gamut of the education reform that we are doing elsewhere?

Mr. PARRISH. Yes, in addressing the issue of charter schools and how it affects tribes, Cherokee are the only ones that have a charter school at this time, an immersion school. However, there is a bill in legislation, as we speak, that is being talked about where tribes can administer their own charter schools, and I don't—honestly, I can't tell you where that is going to go. We just don't know.

But you know, as we are dealing with—right now we are dealing with what we have, and our children are in that public school. So I couldn't give you that statistics to say, well, this charter school served our Native American children better because it is not there.

So our concentration is on our public schools and how we work with them.

Mr. HARRIS. And I hope at some point that we have that kind of information, whether public charter schools may work better than the standard public schools that we have.

The other—and again, I will be brief. The other issue is, as we look toward healing disease in the future, pretty clearly we are going to need to expand the number of Native Americans who participate in medical research. Because as you look at genomics and personalized medicine, we need to understand a broad scope of all the individuals that are going to receive treatment in the United States, and Native Americans are traditionally underrepresented in medical research.

What are the techniques we can have—again, given the fact that it is going to be so clear that you need to make sure you have all groups represented in research as we go toward the new levels of treatment, the new methods of treatment—how are we going to overcome that, that problem with the low number of Native Americans who participate in research?

And any ideas? And again, you can respond if you think about them after you respond because we will submit a QFR on that. But that is a kind of a glaring problem.

Ms. BOHLEN. Dr. Harris, Congressman, thank you for the question.

We would like to follow up with more detail.

Mr. HARRIS. Okay.

Ms. BOHLEN. But one of the things you could expect that we will be talking about in our follow-up is that American Indians and Alaska Natives have experienced, have had very adverse experiences with some engagement in medical experimentation, sometimes not even aware that they were part of a medical experiment.

And while there have been improvements, I think that the history of that situation requires that there be a good engagement by American Indians in setting standards of ethics and human protections. And I think when American Indians/Alaska Natives will be engaged in that process and have human protections assured, they will be more likely to participate in such studies.

Mr. HARRIS. Yes, I agree. I mean, reestablishment of trust is essential, and you know, I did clinical research. And if your patient doesn't trust you or what you are doing, there is no way they are signing that paperwork to participate in research. And we have got to overcome that because the data is so critical, again, to the new generation of cures that we are going to be developing over the next couple of decades.

Mr. ALLEN. If I might, Congressman? STAC, the Secretarial Tribal Advisory Council, has engaged with NIH and SAMHSA with regard to research and analysis on what is going on in our Indian communities so that we become participants in that forum. So they are reaching out to us.

The challenge for us is to get our communities and our expertise engaged and working with them with regard to grant opportunities or institutions who are conducting studies to make sure that those studies are inclusive of Indian communities and the challenges that we have.

Mr. HARRIS. Okay. Oh.

Mr. PARRISH. I would like to address that on the educational issue. At this present time, we are working and collaborating with partners on the higher ed level to recruit more Choctaw students into the medical field. And I think that is very important as you look at it educationally is that we inform people about what our—and I am talking about our tribal members and students that things are out there available to be involved in the medical field.

And we are just—we started, just started working on a program with Oklahoma State University just for that purpose.

Mr. HARRIS. Well, very good. No, thank you very much. Thank you, Mr. Chairman.

Mr. COLE. Thank you for those very thoughtful questions.

And just to pick up quickly, you know, this is an area where some tribes that have a little more wherewithal are doing exactly what the Choctaws are doing. Literally, they are beginning to scholarship their own students with the idea that we can draw them back. But obviously, not every tribe has the ability to do that.

And the same thing, frankly, I have seen happen between Chickasaws and Choctaws in terms of directing research on diabetes, or we have a diabetes center at OU. Both of those tribes have been very generous in contributions because, obviously, we are dealing with that problem.

So they actually have picked the kind of research that they think is the most—and then they have backed it up because they have got the funds to do it. But again, that is a unique and favorable situation.

If I could, I am going to call on our ranking member to offer whatever closing thoughts and questions she has. I will do the same, and then we are going to adjourn the hearing because, again, we have to get to votes.

Ms. DELAURO. We do have to get to the votes, but I just want to, and I will submit these, if you will, for the record. I am very interested in the issue of early childhood education, zero to 3, Head Start. Mr. Parrish, I know that you are dealing with Head Start program in your area, but there is also the tribal-run schools, non-tribal-run schools. Want to get some sense of what is working.

I also co-chair, and it is a bipartisan effort, something called the Baby Caucus. I would love to focus one of the sessions that we do there on early childhood education and Native American children and be able to look at what some of the specific issues are there. But we will get this for the record with you and also to find out about the early Head Start childcare partnerships and the use of those efforts as well for all.

I also want to get follow-up from you on the impact of impact aid, or the elimination of impact aid and what that would mean to the Native lands. And because you are exempt from local taxes. If we cut out that impact aid effort, what happens to you?

An issue that this subcommittee does not undertake, which is the Supplemental Nutrition Assistance Program, and that is SNAP, something I sit on the Agriculture Subcommittee of Appropriations as well. I really want to gauge the importance of SNAP to your communities.

And if there is data with regard to the usage of free and reduced school lunch, et cetera, those are the kinds of efforts that would in-

form what we do in the Ag Subcommittee on child nutrition and what that means in terms of ability to succeed.

I will submit a question on job training and employment and what is available that you can—are taking advantage of or what you can't take advantage of, which is I keep asking the question why can't you access some of these programs? So I will take a look at that.

But I thank you so much for not just your testimony, but for your work. Appreciate it.

Mr. COLE. Thank you. The gentlelady has given you quite a homework assignment. [Laughter.]

And, but the difference is she will read your homework and try to do something about it, and which is why she is such a wonderful partner in this committee.

I want to join the gentlelady in thanking you all for your testimony, and we don't want this to be a one-shot hearing. We want this to be a continuing dialogue.

Director Bohlen, since you stole one of the smartest people that ever worked for me, and I know that dialogue will occur in her area because she will have a tremendous number of legislative suggestions and ideas and ways that we can follow up. But I invite all the rest of you to do the same.

We would like to—the complexity of these programs spread across such a vast jurisdiction as we have here, it does make coordination difficult, and I think the administration is trying to figure this out as well. I know my good friend Assistant Secretary Washburn is working on this, trying to break through these silos, trying to find ways in which we can focus the dollars, make them go further, and then trying to make up for some of the shortcomings of the past where the Federal Government is concerned.

And your appearance here and your testimony has been very, very helpful in that regard. So, again, thank all of you. We are sorry we have to cut this a little bit short, but they pay us to vote around here so we better go do that.

And just thanks again. Thanks for what you do for all of Indian Country and your respective tribes, and I am very, very appreciative you took the time to come and testify.

So, with that, we are adjourned.

TESTIMONY OF INTERESTED INDIVIDUALS AND
ORGANIZATIONS

WEDNESDAY, APRIL 29, 2015.

NATIONAL ALLIANCE FOR PUBLIC CHARTER SCHOOLS

WITNESS

NINA REES, PRESIDENT AND CEO, NATIONAL ALLIANCE FOR PUBLIC CHARTER SCHOOLS

Mr. COLE. Good morning. This is the Subcommittee, obviously, as all of you know, of Labor, Health, Human Services, and Education Appropriations Committee. This is our public witness day, so let me lay down a couple of procedures. We are going to try and move as quickly as we can. Those of you that are going to testify, I think we have 23, should feel fortunate because 157 people wanted to do this, and, of course, their testimony is all being submitted in written form for the record. But given the fact that we have the Japanese Prime Minister making a joint address to Congress today, we are going to try and, as much as we possibly can, stay on schedule. You might not get very many questions because we are going to try and move people, and we want to make sure everybody that has traveled such a long way, in many cases, has an opportunity to make their point.

Again, your written testimony is more than welcome and will be entered into the record, and we will be following up with a lot of you individually as we actually get into the position of writing the bill.

So my good friend, Mr. Fattah is here, so he is the ranking Democrat right now. I think Ms. DeLauro is on the way. Do you have any opening remarks you care to make?

Mr. FATTAH. No, I will second your comments.

Mr. COLE. Well, we have the ranking member here.

Ms. DELAURO. Happy birthday to you. Happy birthday to you.

Mr. COLE. Thank you.

Ms. DELAURO. Happy birthday, Mr. Chairman, happy birthday to you. This is my day job because I can't sing.

Mr. COLE. Actually yesterday, but I did become officially eligible for a full Social Security check, so very big day, and we are going to have more hearings on the health of that program going forward.

So if we can, Nina Rees who is president and chief executive officer of the National Alliance for Public Charter Schools will be our first witness. Welcome, and you are recognized for 5 minutes for whatever remarks you care to make. And again, your full testimony will be written into the record.

Ms. REES. Great. Thank you so much, Mr. Chairman and Ranking Member DeLauro, and Mr. Fattah. Thank you for having me before the committee. The charter school movement and the National Alliance for Public Charter Schools, in particular, is deeply appreciative of the strong bipartisan support for charter schools at this committee and before Congress. We strongly support the President's request for \$375,000,000 for the Federal charter school program. My goal this morning is to make a compelling case for the funding level as you grapple with sequestration and a very tight spending allocation.

As you know, today, we have nearly 3 million children attending public charter schools in 6,700 schools around the country. I am pleased to report that Oklahoma recently approved a bill that dramatically expands charter schools, and Alabama just recently became the 43rd State to enact a charter school law.

Charter schools offer students and parents high quality educational options because they have the flexibility to adopt innovative curricula and practices and are held accountable for their performance. Charter schools often address particular themes or instructional areas such as science, technology, engineering, and math, performing arts, language immersion, project-based learning, Native American tribal language and cultures.

Charter schools have also been at the forefront of serving disadvantaged and other special needs populations since the movement began. Nationally, public charter schools enroll higher percentages of minority students and students from low-income families than do traditional public schools, and their enrollment of English language learners and students with disabilities is comparable to those of other schools.

A 2015 review of data from Stanford University found that charter school students also outperformed their peers in traditional public schools and closing the achievement gap between student subgroups. These results are especially impressive for students from specific demographic backgrounds. African-American students from low income families enrolled in charter schools gained 59 additional instructional days in math, and 44 days in reading compared to their peers in the traditional public school system.

Hispanic English language learners gained 72 days in math and 79 days in reading by attending a public charter school, and students with disabilities gained the equivalent of 9 additional days of learning in math and 13 additional days in reading.

Although the number of charter schools has increased rapidly, the movement has not been able to expand quickly enough to meet the strong demand from parents and families. Last year, the National Alliance conducted a survey that demonstrated over a million names are currently on charter school wait lists. Accounting for the fact that many of these students apply to more than one school, we estimate that more than 586,000 students are currently on a charter school wait list.

I cannot overemphasize enough the importance of Federal support through the charter school program in helping charter schools get started and enabling the replication and expansion of high quality public charter schools as well as the support for a strong

authorizing and addressing the facilities challenges that charter schools face.

As the subcommittee gets down to the hard work of crafting the bill, I also encourage you to make funding for charter schools a priority by approving the President's request for \$375,000,000. Our Nation needs more schools that provide families with high quality public school options, but we also look forward to working with you on recommendations for the bill and report language to support expanding access to students in failing traditional schools to also be able to access charter schools, language around authorizer and charter school quality, and other issues related to the program.

Thanks again for the opportunity to testify this morning, and I am happy to answer any questions you may have.

[The information follows:]

**Testimony of Nina Rees
President and CEO, National Alliance for Public Charter Schools
Submitted to the House Appropriations Committee/
Subcommittee on Labor, Health and Human Services, and Education
April 29, 2015**

Mr. Chairman and Members of the Subcommittee, I am pleased to present the views of the National Alliance for Public Charter Schools (National Alliance) regarding significantly increasing fiscal year 2016 appropriations for the Charter Schools Program at the U.S. Department of Education to \$375 million. The National Alliance is the leading national organization committed to advancing the quality, growth, and sustainability of public charter schools. In what continues to be a very tight fiscal environment, with sequestration caps still in place and many urgent needs and priorities competing for Federal support, the National Alliance appreciates the bipartisan work that Congress has done to help meet the needs of the burgeoning and successful charter schools movement. We truly appreciate the bipartisan support that public charter schools have received, including the increase for the Charter Schools Program (CSP) in the final 2015 appropriation and the additional increase included in the President's 2016 budget request. Thank you for this opportunity to describe the growth of the charter school movement, the successful student outcomes achieved by charter schools, and the reasons why we believe it would be appropriate—even urgent—for the CSP to receive a significant appropriations increase for 2016.

The Growth and Performance of Public Charter Schools

In the 2014-2015 school year, nearly 3 million children are attending more than 6,700 public charter schools in 43 states and the District of Columbia. Most recently, Oklahoma passed a law in April 2015 to expand charter schools throughout the state significantly, and we anticipate the

Governor will be signing it very soon. In March, Alabama authorized charter schools for the first time, becoming the 43rd state with a charter school law. The growth in the charter movement during the 23 years since the first school opened in 1992 has been absolutely phenomenal.

Public charter schools are now a significant presence (more than 10 percent of enrollment) in some 150 communities, and enroll more than 30 percent of students in twelve school districts.

Charter schools have become a prominent component of the public school landscape in many communities because they offer students and parents high-quality educational options, have the flexibility to adopt innovative curricula and practices, and are held accountable for their performance. Charter schools often address particular themes or instructional areas, such as science, technology, engineering, and math (STEM), performing arts, language immersion, project-based learning, Native American tribal language and cultures.

Charter schools have also been at the forefront of serving disadvantaged and other special-needs populations since the movement began. Nationally, public charter schools enroll higher percentages of minority students and students from low-income families than do traditional public schools (and particularly high percentages in certain communities, such as New York City), and their enrollment of English language learners and students with disabilities is comparable to that of other schools.

Through their agreements with authorized public chartering agencies, charter schools are held accountable for results, and the penalty for repeated failure to educate students to state standards is closure. The data show that this model—greater flexibility in exchange for

accountability for student outcomes—is working. A 2015 review of 2006-07 through 2011-12 data by the Center for Research on Outcomes in Education at Stanford University found that charter school students are outperforming their peers in traditional public schools and closing the achievement gaps between student subgroups. Nearly half (43 percent) of urban charter schools post larger learning gains than traditional public schools in math. In reading, 38 percent of charter schools outperform traditional school peers, while 46 percent show equivalent learning gains. The academic gains charter students received equated to 40 additional learning days in math and 28 additional days in reading relative to their peers in traditional public schools.

These results are especially impressive for students from specific demographic backgrounds: black students from low-income families enrolled in charter schools gained 59 instructional days in math and 44 days in reading compared to their peers. Hispanic English language learners gained 72 days in math and 79 days in reading by attending a public charter school. Students with special needs showed learning gains equivalent to nine additional instructional days in math and 13 in reading.

The Need for Additional Resources

Although the number of charter schools has increased rapidly, the movement has not been able to expand quickly enough to meet strong parent and student demand. Last year, the National Alliance found that there were more than a million names on charter school waiting lists nationally in school year 2013-2014. Accounting for the fact that many students apply to more than one school, we estimated that more than 586,000 students wanted to attend a charter school but could not do so simply because there were not enough spaces. The number of

names on the waiting lists has grown annually: from 2008-2009 through 2013-2014 it increased by a staggering 186 percent. The message is clear—there is a great unmet demand for seats in charter schools, and public officials at all levels should be doing more to meet that demand.

Toward that end, I cannot overemphasize the importance of federal support, through the CSP, in helping charter schools get started and in enabling the replication and expansion of successful charter school models. Unfortunately, while 43 states and DC now have charter school laws, states and localities have underfunded their charter schools (relative to traditional public schools) and have not provided the seed money needed to plan and start new schools. It is inconceivable that the movement would have grown as quickly as it did without the CSP, particularly through the State Educational Agency (SEA) grants. And in recent years, the Replication and Expansion grants have been an essential tool for enabling our most effective models and schools to serve additional students, often in economically distressed areas where traditional public schools are failing.

Facilities are another area in which federal support is critical. State and local formulas and programs often do not provide charter schools with the same support for capital expenses as is available to traditional schools. In those cases, charter school operators typically have to scramble to find acceptable facilities. The CSP State Facilities Incentive Grants and the Credit Enhancement for Charter Schools program help to make up the difference. We look forward to working with the Committee on ensuring that both of these grant programs are meeting the needs of the charter school community.

The Fiscal Year 2016 Budget

As the Subcommittee begins its work on the appropriation for 2016, I encourage you to make funding for the CSP a key priority. As I have described, the nation needs more schools that can effectively serve diverse populations, particularly in neighborhoods that have not had high-quality options. And we must do more to meet the needs of parents and students who want charter schools but cannot gain access to them.

The National Alliance is pleased that the Administration's budget request includes \$375 million for the program, of which at least \$100 million would go for Replication and Expansion Grants, up to \$10 million for State Facilities Incentive Grants, at least \$13 million for Credit Enhancement, at least \$11 million for National Activities, and the remainder for Grants to SEAs and the "non-SEA" competition. We commend the Administration for including \$375 million for CSP in the budget request and ask that Congress support these funding levels for these important programs to ensure sufficient funding to open new charter schools in as many states as possible. In addition, we look forward to discussing our recommendations for bill and report language to support expanding access of students in failing schools to high-quality charter schools, authorizer and charter school quality, and other issues related to the program.

Thank you for the opportunity to present the views of the National Alliance and the charter school community on the fiscal year 2016 appropriations. If my organization can be of any assistance to the Subcommittee, please do not hesitate to contact me.

Mr. COLE. Any questions? Okay. Thank you very much.

I am going to quickly call on our ranking member, since I was pushing us a little rapidly this morning because we have the Japanese Prime Minister, because I think she had some opening remarks that she wanted to submit.

Ms. DELAURO. I will be brief, Mr. Chairman. I want to just say a thank you to you, to all who have gathered here this morning, and I thank you for all of your work that you do on behalf of hard-working American families. We have got 23 witnesses, as I understand it this morning, biomedical research, after-school programs, charter schools, Head Start, programs to assist Native Americans. I think the sheer number of requests that we were received by this committee are just as indicative of how important and what the importance is of this—attached to this subcommittee for Labor, Health, Education, and Human Services, the portfolio of this subcommittee.

When you spoke, Ms. Rees, about charter schools and the issue of sequester, I know my colleague, Mr. Fattah, I know the chairman is also concerned that having the wherewithal to be able to fund the needs, the needs. It is not the program. It is the needs. The program represents what the—you know, what the need is out there for these kinds of services.

This subcommittee, in terms of its allocation, has been cut by about \$3,700,000,000 from last year's numbers. My view is that that—that means that we are going to advocate our responsibility to the American people, but like the chairman, I hope that we can move toward a budget agreement that allows us to be able to address these needs.

So I look forward, again, to hearing the rest of the testimony, and I want to say thank you to the chairman.

Mr. COLE. Well, I thank the gentlelady. She is a terrific working partner, and if I could, we will move swiftly forward. Dr. Joseph Haywood, president of the Federation of American Societies for Experimental Biology. Welcome. It is good to have you here. You are recognized for 5 minutes.

WEDNESDAY, APRIL 29, 2015.

FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY

WITNESS

JOSEPH R. HAYWOOD, PH.D., PRESIDENT, FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY

Mr. HAYWOOD. Thank you. Good morning, Chairman Cole, Ranking Member DeLauro, Mr. Fattah, and other members of the subcommittee. Thank you for the opportunity to testify on behalf of funding for the National Institutes of Health. My name is Joseph Haywood, and I appear before you in my capacity as president of the Federation of American Societies for Experimental Biology, FASEB. The 27 scientific and engineering societies and more than 120,000 researchers represented by FASEB are profoundly grateful for the subcommittee's commitment to biomedical research.

It is abundantly clear that our progress in accelerating desperately needed therapies for the devastating diseases affected by my—affecting my fellow witnesses and their families—is dependent on a robust investment in biomedical research.

Families caring for loved ones with Alzheimer's disease and young people recovering from stroke, as well as millions of others with diabetes and other chronic diseases are counting on Congress and the biomedical research community to give them hope for a better future. We are all spouse, parent, child, dear friend, or acquaintance of someone who is relying on our Nation's scientists and physicians to develop tomorrow's treatments.

In my own family, we have experienced the heartbreak of cancer, meningitis, macular degeneration, and other health problems. In some cases, medical advances made it possible to mitigate the disease process. In others, the therapeutic successes have not yet occurred. However, throughout these potentially devastating health challenges, we have always known that research was ongoing, and maybe, just maybe, the next cure was around the corner. It is this hope that NIH-supported research offers to families like ours and everyone in the room.

Unfortunately, funding for NIH has failed to keep pace with inflation since 2003. This has reduced the agency's capacity to support research by nearly 23 percent, and over the last 10 years, has led to a 34 percent decrease in the number of RO1-equivalent awards, the primary mechanism for supporting investigator-initiated research.

Basic research discoveries and their subsequent translation to clinical applications can take many years. Budgets that are uncertain and variable from year to year make research planning difficult. There are long-term consequences of loss of personnel and scientific expertise as highly-trained researchers are forced to seek employment in other fields. Opportunities are lost. The future looks especially bleak if the Budget Control Act spending limits remain in place, and Congress does not eliminate sequestration.

To prevent further erosion of the Nation's capacity for biomedical research, and as a first installment of a multiyear program of sustainable increases, FASEB recommends an appropriation of at least \$32,000,000,000 for the National Institutes of Health in fiscal year 2016. A 5-year commitment to increases in Federal research funding of at least 5 percent annually would substantially bend the curve and ensure that our leadership in science and technology would not be eclipsed by other nations. It would also restore the constant dollar losses NIH has experienced since 2003.

We estimate that with a budget of \$32,000,000,000, NIH could support 522 new research project grants at current funding levels with commensurate growth for other vital agency programs. This investment is critical for developing innovative technologies and new global industries to sustain the Nation's continued economic recovery, and more importantly, to expedite progress towards the cures that are so desperately needed for all of our loved ones.

Thank you for the opportunity to offer FASEB support and funding recommendations for the NIH.

[The information follows:]



Representing Over 120,000 Researchers

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Testimony of Joseph R. Haywood, PhD

President of the

Federation of American Societies for Experimental Biology

Prepared for the

House Committee on Appropriations

**Subcommittee on Labor, Health and Human Services, Education, and
Related Agencies**

Representative Tom Cole, Chairman
Representative Rosa DeLauro, Ranking Member

On

FY 2016 Appropriations for the National Institutes of Health

Chairman Cole, Ranking Member DeLauro, and distinguished members of the Subcommittee, thank you for the opportunity to testify on behalf of the National Institutes of Health (NIH). My name is Joseph Haywood and I appear before you today in my capacity as the President the Federation of American Societies for Experimental Biology (FASEB), an umbrella organization representing 27 scientific societies, representing more than 120,000 life scientists and engineers. FASEB respectfully requests a minimum of \$32 billion in fiscal year (FY) 2016 for NIH within the Department of Health and Human Services. We estimate that with a budget of \$32 billion (an increase of \$1.69 billion), NIH could support 522 new research project grants at current funding levels with commensurate growth for other vital agency programs.

The American Physiological Society • American Society for Biochemistry and Molecular Biology • American Society for Pharmacology and Experimental Therapeutics
American Society for Investigative Pathology • American Society for Nutrition • The American Association of Immunologists • American Association of Anatomists
The Protein Society • Society for Developmental Biology • American Peptide Society • Association of Biomolecular Resource Facilities
The American Society for Bone and Mineral Research • American Society for Clinical Investigation • Society for the Study of Reproduction • The Teratology Society
The Endocrine Society • The American Society of Human Genetics • International Society for Computational Biology • American College of Sports Medicine
Biomedical Engineering Society • Genetics Society of America • American Federation for Medical Research • The Histochemical Society • Society for Pediatric Research
Society for Glycobiology • Association for Molecular Pathology • Society for Free Radical Biology and Medicine

NIH has produced an outstanding legacy of discoveries that have improved health, saved lives, and generated new knowledge. Many of these advances arose from scientists investigating questions designed to explain fundamental molecular, cellular, and biological mechanisms. Research supported by NIH has also expanded our understanding of the molecular roots of various cancers and led to important insights into how microbial communities affect a range of chronic diseases including obesity and diabetes. In addition, research supported by NIH led to the development of innovative technologies and created entirely new global industries that are a critical component of our nation's economic growth.

Investment in biomedical research funded by NIH has supported discoveries that lowered death and disability from polio, heart disease, and cancer, prolonging life and reducing suffering. New scientific breakthroughs have given us the opportunity to dramatically accelerate desperately needed progress on therapies for thousands of diseases and conditions. A study published by the National Academy of Sciences found that the key enabling discovery that led to the development of 16 out of 21 drugs with the highest therapeutic impacts was made as a result of federally supported research.

NIH-funded research is continuing to produce the insights that are needed for tomorrow's improvements in health and clinical care. Recent discoveries include:

- *Engineering Immune Cells to Improve Cancer Treatment Options:* Researchers funded by NIH continue to make progress on immunotherapy which uses the human immune system to fight cancer. Promising results have been reported from several small clinical trials testing adoptive cell transfer (ACT) on patients with acute lymphoblastic leukemia. ACT is a technique that engineers an individual's immune cells to identify and kill

tumors. Another form of ACT involves the addition of special receptors, chimeric antigen receptors, to T cells in order to change or improve their specificity.

- *Creating Organs on a Chip:* A new experimental technology supported through investigator-initiated research uses a series of micro-chambers, fluids, and human cells to simulate a person's internal organs. One example, lung-on-a-chip, mimics the site of oxygen exchange in the lungs, and is being developed to study lung inflammation and infection. Other organs-on-a-chip such as kidney, liver, and heart are also in development. An artery-on-a-chip was created that effectively imitates the molecular and flow conditions of early plaque development in coronary arteries. This chip was used to gauge the disease risk of individuals with high blood lipids and coronary artery plaque, and proved to be an accurate predictor of the extent of disease.
- *Developing an Artificial Pancreas:* NIH-funded researchers have developed an artificial pancreas that is capable of monitoring blood sugar and delivering appropriate amounts of hormones to control fluctuations in levels. A sensor implanted under an individual's skin measures his or her blood sugar and transmits the information to a smartphone application that determines the amount of insulin necessary. An implantable pump provides the insulin. This device is a critical tool for individuals with type-1 diabetes who must constantly monitor their blood sugar levels to prevent hypoglycemia and other life-threatening complications.

Stable, Predictable Funding Is Critical to Sustain Discovery

Stable and predictable increases in federal funding for research supported by NIH are necessary to take advantage of unprecedented opportunities to improve quality of life, address the rising costs of caring for our aging population, and protect us from new and emerging diseases. As NIH Director Francis S. Collins, MD, PhD, wrote in a recent viewpoint for the *Journal of the American Medical Association*, “The 21st century is the century of biology. The nation that invests in biomedical research will reap untold rewards in its economy and the health of its people.”¹

Appropriations for NIH have failed to keep up with inflation since 2003, reducing the agency’s capacity to support research by nearly 23 percent. The fact that the NIH budget has not kept pace with rising costs also led to a 34 percent decrease in the number of R01-equivalent awards – the primary mechanism for supporting investigator-initiated research – between 2003 and 2013. In addition, the number of investigators with NIH funding for six consecutive years declined from 10,030 in the FY 2000-2005 period to 9,127 in FY 2008-2013, a reduction of 11 percent.²

Basic research discoveries and their subsequent translation to clinical applications can take multiple years of collaboration. Budgets that are uncertain and vary in grant support from year to year make such planning difficult. The loss of personnel and scientific expertise may have long-term consequences as highly trained researchers seek employment in other fields.

Congress took an important step in the right direction by providing desperately needed increases for NIH in the FY 2014 and FY 2015 omnibus appropriations bills. However, the additional

¹ Collins, F. (2015, January 13). Exceptional Opportunities in Medical Science: A View From the National Institutes of Health. *Journal of the American Medical Association*.

² Data Hound (Berg J). Minding the Gap. *Data Hound Blog, Sciencetopia*. May 15, 2014.

funding did not restore the lost purchasing power or fully replace money that was cut in 2013 due to sequestration.

To prevent further erosion of the nation's capacity for biomedical research, and as a first installment of a multi-year program of sustainable increases, FASEB recommends an appropriation of at least \$32.0 billion for NIH in FY 2016. Beyond next year, a five year commitment to increases in federal investment in research and development of at least five percent annually would substantially "bend the curve" and ensure that our leadership in science and technology would not be eclipsed in the next four years. This goal is roughly similar to the recommendation of the American Academy of Arts and Sciences which called for the U.S. to strive to exceed "a sustainable real growth rate of at least 4 percent in the federal investment in basic research, approximating the average growth rate sustained between 1975 and 1992."³ It would also restore the constant dollar losses in NIH funding that the agency has experienced since 2003.

Thank you for the opportunity to offer FASEB's support and funding recommendation for NIH.

³ American Academy of Arts and Sciences, *Restoring the Foundation: The Vital Role of Research in Preserving the American Dream*, Cambridge, Mass, 2014.

Mr. COLE. Thank you very much, Doctor. And I don't have a question, but I do want to make a quick comment. I couldn't agree more with much of what you had to say, and I do think this committee is extremely interested, and you can just tell by the questioning in the meetings we have had and the number of members that went out to NIH to try and address some of this, and I have had some discussions with my counterpart in the Senate, Senator Blunt to—I think is also very interested in trying, so we are going to have our differences in this committee, and as the ranking member pointed out, we have got a very difficult allocation.

But, there will be areas where we come together, and I hope this is one of them because I think it actually—this is not a partisan issue. I think you make the point very well about how much all of us have at stake in the work that goes on at NIH, so thank you for being here.

Are there other questions or comments?

Ms. DELAURO. Again, I don't have a question. I would like to make a comment because I couldn't agree with you more, Dr. Haywood. And the chairman and my colleague, Mr. Fattah have heard me say this before. I am here by the grace of God and biomedical research. I am a survivor of ovarian cancer, diagnosed almost 30 years ago. I understand the power of biomedical research. I also understand the power that we have here to make a difference in terms of allowing people to have the gift of life.

You categorize sequestration. I would characterize it as truly mindless austerity, and it is our responsibility to do it in, and I commit to you that we will—and this committee is interested in this on a bipartisan basis, which has been the history of this committee. We doubled the amount of money for NIH a number of years ago in a bipartisan way. I believe we can do it again. Thank you so much.

Mr. HAYWOOD. And thanks to both of you and the subcommittee. This has been an extremely supportive subcommittee for biomedical research.

Mr. COLE. Any other comments or questions?

Okay. With that, we will move on. Danielle Leach, director of government relations, the Alliance for Childhood Cancer and St. Baldrick's Foundation. Welcome. Good to have you here.

WEDNESDAY, APRIL 29, 2015.

**ALLIANCE FOR CHILDHOOD CANCER AND ST.
BALDRICK'S FOUNDATION**

WITNESS

**DANIELLE LEACH, DIRECTOR, GOVERNMENT RELATIONS, ST.
BALDRICK'S FOUNDATION**

Ms. LEACH. Good morning. Good morning. Thank you for the opportunity to share my story with you today. My name is Danielle Leach. I am the director of government relations for the St. Baldrick's Foundation based in California. St. Baldrick's donors and volunteers have enabled the Foundation to fund over \$154,000,000 in dollars and grants, making St. Baldrick's the larg-

est funder of childhood cancer research outside of the U.S. Government.

I am pleased to join the United Cancer Community in formally requesting that in the coming year, Congress provide \$33,000,000,000 for the National Institutes of Health and \$5,400,000,000 for the National Cancer Institute. I am also the co-chair for the Alliance for Childhood Cancer. The Alliance represents 29 national patient advocacy groups, healthcare professionals, and scientific organizations committed to representing over 10 million Americans who care deeply about childhood cancer. Most importantly, I come to you today as an advocate. My sister Noel is a childhood cancer survivor, and my son, my middle son Mason died from brain cancer.

I was only 9 when my sister Noel was diagnosed with aggressive rhabdomyosarcoma. The doctors told my parents that she might survive 2 months. Luckily, she qualified for a clinical trial, and I am happy to report she is still with us 35 years later.

My son Mason was not so lucky. What can I tell you about our little boy? Mason was a fighter, a super hero, an artist, a soccer player, a baseball player, and a cancer survivor. Our 3-year-old Mason was diagnosed with a brain tumor, medulloblastoma, in 2006. His only symptom, 4 days of vomiting. I was shocked to discover that the recommended treatment had not really changed for over 30 years. The doctors offered surgery, radiation, chemotherapy. We also learned that if he survived, the treatment would probably leave him disabled for life.

Within days of diagnosis, we had a little boy with a surgery scar who could not walk or talk, and we did not know if we would ever get him back. Mason, despite his age, was curious about what was happening to his body. He wanted to know why we were giving him this drug or doing this test. How do you tell a child that you are going to take him to the brink of death to save his life. As we navigated the childhood cancer journey, I learned most of the arsenal of the drugs being used on children were not specifically made for them. We bombarded Mason's body with adult drugs, some so old that they were part of my sister's arsenal 30 years before.

They were also incredibly toxic. Imagine the terror of watching a nurse put on gloves and protective gear and hang an IV bag that says "poison" and they are putting it into your child. You know full well that it could kill him before it cures him, but you do it because you have no other choice. There is no worse feeling than not being able to take away your child's suffering and pain. These children suffer.

The treatment decisions we parents have to make have lifelong consequences for our kids with cancer. We have to fund the research to find a better way to save these kids' lives. We are not able to do so for Mason. He died on October 13, 2007. He did not get the miracle. Despite Mason's death, we have made significant progress in some types of childhood cancer because of government investment in research. In many ways, childhood cancer represents one of the greatest successes in our investment in medical research. In the 1950s, almost all kids died from cancer. Today, one in five will die. Better but not good enough.

Cancer remains the number one reason children die from disease in this country. And for many types, there are few, if any, effective treatments. Only funding for more research can change that. For those that do survive, most will have a chronic health problem or severe life-threatening conditions. My sister Noel has endured multiple surgeries to repair her face. Every time she looks in the mirror, she sees what childhood cancer did to her. I know a child wheelchair-bound from a radiation-induced stroke 15 years after her treatment and another that has a 50-year-old heart in an 8-year-old body. Survival comes at a price that is too high to pay. Here lies our challenge. We have come far but not far enough.

Our childhood cancer community stands ready to work with Congress and the NIH to make childhood cancer a top priority. I would ask that you address this problem much like Mason approached life. Mason was creative. He needed to find—we need to find ways so that we can support cancer research, in childhood cancer, in particular. It may be a messy process, but we need to be creative in our thinking to save our Nation's children. Mason was persistent. We need to be persistent in this difficult political environment and fund research to save children's lives with less toxic treatments.

Mason liked being part of a team. A coordinated effort with everyone in the fight: Congress, government agencies, nonprofits, pharma companies, and the public is key to conquering childhood cancers.

And lastly, Mason was a super hero. He loved to dress as Batman and other super heroes. We need more super heroes for research and funding needed that will change kids' lives. In honor and in memory and in defense of all kids with cancer, I ask you to become super heroes for kids with cancer. Our Nation's children deserve nothing less. Thank you.

[The information follows:]

**Danielle Leach
Director of Government Relations
St. Baldrick's Foundation**

**Testimony before the
House Committee on Appropriations
Subcommittee on Labor, Health & Human Services,
Education and Related Services**

April 29, 2015

Good morning. Thank you for the opportunity to share my story with you today. My name is Danielle Leach. I am the Director of Government Relations for the St Baldrick's Foundation, based in California. St. Baldrick's donors and volunteers have enabled the foundation to fund over \$154 million in grants, making St. Baldrick's the largest private funder of childhood cancer research other than the U.S. government. I am pleased to join with the united cancer community in formally requesting that in the coming year, Congress provide **\$33 billion for the National Institutes of Health (NIH)** and **\$5.4 billion for the National Cancer Institute (NCI)**.

I am also the Co-Chair for the Alliance for Childhood Cancer. The Alliance represents 29 national patient advocacy groups, healthcare professional and scientific organizations, committed to representing over 10 million Americans who care deeply about childhood cancer.

Most importantly, I come to you today as an advocate. My sister, Noel, survived childhood cancer and my middle son, Mason, died from brain cancer.

I was only 9 when my sister, Noel, was diagnosed with aggressive rhabdomyosarcoma . The doctors told my parents she might survive two months. Luckily, she qualified for a clinical trial and I am happy to report she is still with us, 35 years later. My son Mason wasn't so lucky.

What can I tell you about our little boy? Our Mason was a fighter, a superhero, an artist, a soccer player, a baseball player and a cancer survivor. Our three-year old Mason was diagnosed with a brain tumor — medulloblastoma, in 2006. His only symptoms? Four days of vomiting.

I was shocked to discover that the recommended treatment had really not changed for 30 years. The doctors offered surgery, radiation, and chemotherapy. We also learned that the treatment would probably leave him disabled for life if he survived. Within days of diagnosis, we had a little boy with a surgery scar who could no longer talk or walk and we did not know if we would ever get him back.

Mason, lived his life as a force of nature. He was sweet and loved to give hugs and kisses but he was also stubborn as an ox and very vocal about what he wanted. We truly believe it was that stubbornness and his determination that helped him regain his speech and mobility after his surgery.

All our little boy wanted to do was to play with his brother, wear his soccer jerseys and be with his family. Mason, despite his age, was curious about what was happening with his body. Even at his young age, he demanded to be heard. He wanted to know why we were giving him this test or this medicine and what it would do to him.

How do you tell a child that you need to take him to the brink of death to save his life? As we navigated the childhood cancer journey, I learned that most of the arsenal of drugs being used on children were not made specifically for them. We bombarded Mason's body with adult drugs, some so old that they had been part of my sister's arsenal thirty years before.

They were also incredibly toxic. Imagine the terror of watching a nurse don protective gloves and gear to hang IV bags that say "poison" on them and knowing those drugs were going into your child. You know full well that it could kill him before it cured him. But you do it because you have no other choice.

There is no worse feeling than not being able to take away your child's suffering and pain. These children suffer. The treatment decisions we parents have to make have lifelong consequences for our kids with cancer. We have to fund the research to find a better way to save these kid's lives.

Mason continued to live his life despite what was happening to his body. He taught us that despite all the horrible things, the hospitalizations, the medicines, the shots, etc., that life was meant to be lived. We have had to remind ourselves of his fortitude and his example as we mourn his loss. He died on October 13, 2007. He did not get the miracle.

In many ways, childhood cancer represents one of the great successes of our investment in medical research. In the 1950s, almost all kids diagnosed with cancer died. Because of **government investment** in research, today about 90% of kids with the most common type of cancer will live. But this statistic does not tell the whole story. For many other types, progress is limited, and for some kids there is no hope for a cure. Our job is not done and to be satisfied with the status quo is not acceptable. I repeat, **our job is not done**, and we have so much more to do to find better, less damaging treatments for our children. I work every day so no mother will have to tell their son like I did that he will go to heaven because we can't help him with another medicine. **Only funding for more research can change that.**

Even for kids who survive, the battle is not over when treatment ends. My sister Noel has endured multiple plastic surgeries to repair her face – every time she looks in the mirror she sees what childhood cancer did to her. Most survivors will have a chronic health problem or severe life-threatening conditions. I know a child wheelchair-bound for life after a radiation-induced stroke and another who has the heart of a 50 year old in his 8-year-old body. For our children, survival comes at a price that is too high to pay. We can and have the capacity to do better by making cancer research a priority.

Here lies our challenge. We have come far – but not far enough. **Clearly, there is a great deal that needs to be done better for our pediatric cancer patients.**

I have been encouraged by recent meetings we have had with the NCI about childhood cancer. We all agree more needs to be done. But that promise and hope for childhood cancer will not happen if NIH as a whole does not get the money it needs to accomplish its work.

Speaking as a mother, and as an advocate representing tens of millions of other parents and citizens, we stand ready to work with Congress and the NIH to make childhood cancer a top priority so we can give hope to all children and families.

I would ask that you address this problem much like Mason approached life.

Be creative. Mason loved to make a mess and then create something beautiful. We need to find ways we can support cancer research and childhood cancer in particular. It may be a messy process but we need to be creative in our thinking to save our nation's children.

Mason was persistent. The tenacity of his spirit is something I aspire to everyday as I fight for children with cancer and their families. We need to be persistent in this difficult political environment and fund research to save children's lives with less toxic treatments.

Mason liked being a part of a team. He loved projects and constructing things and being a part of a team on the soccer field. "A coordinated effort" should be our mantra. We need everyone in the fight - Congress, government agencies, non-profits, companies & the public to conquer childhood cancer. But we need Congress to give us the funding to launch those efforts to create solutions.

Lastly, Mason was a superhero- he loved to dress as Batman and other superheroes. He fought the bad guys and saved the world. We need more superheroes for research and the funding needed that will change these kids' lives. In honor, in memory and in defense of all children with cancer, I ask you to become superheroes for kids with cancer. Our nation's children deserve nothing less.

Mr. COLE. Thank you very much. I have no questions, but I want to thank you for exceptionally compelling and meaningful testimony and just to express how much I admire how you turned grief and challenge into an advocacy that helps other people. So thank you for being here.

Other comments or questions? Mr. Fattah.

Mr. FATTAH. Just briefly, Mr. Chairman. This—you are right that about 80 percent of these cancers have—young people now live, but we still have a little work to do. I know many members, including myself have worked with Hope With Wheels, a Hyundai effort which has generated \$100,000,000-plus. We are going to work very hard to make sure that the National Cancer Institute and NIH funding is in place. So thank you for your work in this regard.

Mr. COLE. Gentlelady, I didn't mean to move by you there. I apologize.

Ms. DELAURO. No, no. Just thank you for your courage, and I hope that we live up to your expectations.

Ms. LEACH. Thank you. Appreciate it.

Mr. COLE. And gentleman from Virginia.

Mr. RIGELL. Thank you, Mr. Chairman, and thank you, Ms. Leach for just what the chairman said, taking something so—just so deeply troubling and turning it into something constructive for others. I admire that. I have a question for you.

Is the incidence of childhood cancer, is it, over time, has it changed? I mean, the percent of children getting cancer? And if so, how much of your effort is directed toward understanding the causes like perhaps, and I am not a scientist or a physician or a researcher, but the environmental—some of the chemicals we brought into our homes and things like this, could you just comment on that briefly for us? Thank you.

Ms. LEACH. Sure. The incidence rate for childhood cancer is actually increasing, but they do not know that environmental factor is a part of it. Part of the research that is being done and some of the research that is being looked at, that is part of the portfolio for many organizations that are in the fight and also for the—but there is nothing conclusive. You know, the unique part of pediatric cancer and its value in research is that there are, you know, many—in many cases, it is an embryonic genetic piece to it, and they are investigating those reasons and what changes are happening in that space.

Mr. RIGELL. Thank you. That is helpful.

Thank you, Mr. Chairman.

Mr. COLE. Thank you again. Thank you very much.

If we could next, we will move to Mark Wolfe. He is representing the National Energy Assistance Directors' Association. Mr. Wolfe, welcome. You are recognized for 5 minutes.

WEDNESDAY, APRIL 29, 2015.

**NATIONAL ENERGY ASSISTANCE DIRECTORS'
ASSOCIATION****WITNESS****MARK WOLFE, EXECUTIVE DIRECTOR, NATIONAL ENERGY ASSISTANCE DIRECTORS' ASSOCIATION**

Mr. WOLFE. Thank you. Good morning, Mr. Cole, Ranking Member DeLauro, and members of this committee. I am the executive director of the National Energy Assistance Directors' Association. I represent the State grantees or managers of a low-income home energy assistance program, or LIHEAP. I would first like to take this opportunity to thank the members of the subcommittee for considering our funding request for fiscal year 2016. For this fiscal year 2016, we are requesting the committee restore program funding for LIHEAP to the 2011 level of \$4,700,000,000, up from \$3,300,000,000 in the current year. Additional funding would allow States to increase program services to a level provided in 2011, which would allow us to increase the number of households served by 1,300,000 to 8,000,000, and the percent of households served from 19 percent in the current year to 22 percent.

More importantly, it will allow us to raise the average cost of home heating and cooling to 50 percent of the cost, which we believe is kind of a tipping point in the program where you start to see arrearages go down, you see shutoffs go down, and also allows families to pay the differential.

Energy assistance is different than, say, the SNAP program where a family can, to some extent, plan ahead for the cost of food.

For energy, it is more difficult because you have to factor weather as well as price. So with this year, the cost of home heating oil dropped considerably, it was also very cold, so that offset a lot of the potential savings. So for a family, it is very difficult to plan for the cost of home energy. Even if they try, they can get blindsighted by shortages, by price spikes. And so what LIHEAP does is help them get through. It doesn't cover the whole cost of home energy, but it does allow families to pay a differential. And also, we only have sufficient funds right now to cover about 19 percent of the eligible households, so there are many, many families that are not being helped.

So what States have done is target. We target the most vulnerable of the low-income families, we target families who are elderly, disabled, and those with young children. Those are the ones that, while all of low-income families are of course needing—families with these special conditions we are most concerned about because they are less able to get a second job, less able to work more. They are more likely to be homebound or living on fixed incomes.

LIHEAP is also in a period of transition. Along with the Administration For Children and Families, the Department that oversees the program, LIHEAP offices are working diligently to enhance current program integrity, measures including developing modernized Web-based intake systems, improving program controls, and instituting external verification of applicant submitted data. In other words, we are trying to make sure we use the funds as well

as possible and not lose funds to waste and fraud, and I think LIHEAP does a great job at that. We only use 10 percent for administration, so most of the money goes to families in need.

The President's budget. We would like to address some of our concerns about the President's budget. While the President's budget maintained the overall funding for LIHEAP at the 2015 level, they would add two provisions that we are very concerned about that would reduce State flexibility and grant amounts by requiring a minimum set-aside of 10 percent of each State's grant for weatherization and also set aside \$200,000,000 from the overall State grant from a new competitive grant program that would test, according to the administration's budget, innovative strategies to serve LIHEAP households, including reducing energy use, supporting fuel switching, reducing energy bills, and smoothing energy costs to avoid large spikes during some parts of the year.

While this is a great idea, these are very important issues in LIHEAP, because of the cutbacks in the program, we don't think the program can afford to take \$200,000,000 out for an innovative grant program. It would reduce State grants by about an average of 8 percent, and we are very concerned about that.

So we are recommending that both programs, both recommendations be rejected. In addition, the administration has called to increase the ceiling that could be set aside for the weatherization program from 25 percent to 40 percent. Again, while that is a laudable goal, weatherization is a very important program, the base program needs to remain payment assistance, and our concern is that moving funds into other areas or increasing so-called flexibility so we can pay for other kinds of services undermines the core goal of LIHEAP, which is to help people pay their energy bills. And because of the terms of cutback, \$3,300,000,000, there is not enough flexibility to take on new responsibilities.

One thing the administration did recommend that we do think is a good idea, they recommended a contingency fund that would help to cover price spikes. I know it is an additional, I think, \$1,500,000,000 they requested, but right now, what happens is that the administration's hands are tied. If prices spike, there is no possibility to address those costs. Like last year, when it was very cold and we were running out of money in a number of States, there was no supplemental funding available. So giving the administration some flexibility to provide emergency funds could make a significant difference, especially for those using delivered fuels. Delivery fuels are extremely difficult for States to manage because we don't have the kind of control we have with regular utilities.

With regular utilities, you can put in shutoff controls, we can mandate discounts, and other kinds of services to help families with delivered fuels, because they are independent vendors; we don't have that kind of flexibility, so for those families using propane or heating oil, our hands are tied. So having that kind of flexibility to provide additional funds could make a very significant difference, especially in the Northeast and Midwestern States, or in States with rural areas like Oklahoma, for example, where propane is used a lot.

[The information follows:]

Mark Wolfe, Executive Director, National Energy Assistance Directors' Association

The members of National Energy Assistance Directors' Association (NEADA), representing the state directors of the Low Income Home Energy Assistance Program (LIHEAP) would like to first take this opportunity to thank the members of the Subcommittee for considering our funding request for FY 2016. For FY 2016 we are requesting the Committee restore program funding to the FY 2011 level of \$4.7 billion.

The funding request would allow states to increase program services to the level provided in FY 2011 and allow us to increase the number of households served by 1.3 million to 8 million and the percentage of households served from about 19 percent in FY 2015 to about 22 percent and fund about 50 percent of the cost of home heating for eligible households.

In addition, the lack of a final program appropriation prior to the beginning of the fiscal year creates significant administrative problems for states in setting their program eligibility guidelines. We are concerned that states will be hampered in their ability to administer their programs efficiently due to the lack of advanced funding. In order to address this concern, we are requesting advance appropriations of \$4.7 billion for FY 2017.

LIHEAP is the primary source of heating and cooling assistance for some of the poorest families in the United States. In FY 2015, the number of households receiving heating assistance is expected to remain at about 6.7 million or about 19 percent of eligible households, with an average grant size of about \$425. In addition, the program is expected to reach about 1 million households for cooling assistance, the same level that received assistance in FY 2014.

Program funding for LIHEAP has been significantly cut from \$5.1 billion in FY 2010 to the current level of \$3.3 billion. As a result, states have had to reduce the number of households receiving assistance from 8 million to the current level of 6.7 million. Program cuts have hurt

the ability of states to help the nation's poorest households pay their energy bills.

At the same time, LIHEAP is in a period of transition. Along with the Administration for Children and Families, the Department that oversees the program, LIHEAP offices are working to enhance current program integrity measures including developing modernized web-based intake systems, and instituting external verification of applicant-submitted data. In addition, they are in the final stages of developing nationwide performance measures that will give Congress and the public a clear picture of the effectiveness of LIHEAP in helping low income households. NEADA believes these efforts will lead to a more responsive and more cost-effective program.

LIHEAP in the President's Budget

The President's Budget would maintain the overall funding level for LIHEAP at 2015 levels but would add two new provisions that would reduce state flexibility and grant amounts by requiring a minimum set-aside of 10 percent of each state's grant for weatherization and set-aside \$200 million from the overall state grant to implement a new competitive grant program that would test "innovative strategies to serve LIHEAP households, including reducing energy use, supporting fuel switching, reducing energy bills, and smoothing energy costs to avoid large spikes during some parts of the year." Our concern is the negative impact these provisions would have on state grants and state flexibility in administering LIHEAP.

Weatherization. Current law allows states to set aside up to 15 percent of their allocation for Weatherization and up to 25 percent with a waiver. The Administration's proposal would require a minimum set-aside of 10 percent and allow states to set-aside up to 40 percent without a waiver. We are recommending that the Committee reject both proposals. The current law provides states with sufficient flexibility to design their weatherization programs in context of other resource that might be available for this purpose, allowing states to strike the proper

balance between bill payment assistance and efficiency. In addition, we believe that increasing the ceiling for Weatherization within the block grant would undermine the primary purpose of LIHEAP which is to help poor families pay their home energy bills.

Competitive Grant Program. The proposed program would be funded by reducing the formula grant program by \$200 million. The funding level for the block grant has been cut significantly in the last few years from \$5.1 billion in FY 2010 to the current level of \$3.4 billion. We do not believe the program has any flexibility to absorb additional cuts without corresponding cuts to program services. If approved, the states would have no choice but to reduce the number of grants by about 47,000 households to pay for this initiative.

The Administration has also proposed to establish a contingency fund providing additional funds to respond to increases in the number of low-income households, spikes in energy prices, and extreme cold at the beginning of winter. We support this additional program authority. It would help to address concerns about weather conditions that we cannot control and that have the potential to undermine the effectiveness of the program on very short notice. The need for such a contingency fund was demonstrated during the winter of 2014 as propane prices nearly doubled, forcing state LIHEAP offices to increase propane benefits in the middle of the year.

What is the Impact of Declining Federal Funds?

Surveys of families receiving federal assistance have been consistent over the years. Poor families struggle to pay their home energy bills. When they fall behind, they risk shut-off of energy services or they are not able to afford the purchase of delivered fuels. In FY 2011, NEADA conducted a survey of approximately 1,800 households that received LIHEAP benefits. The results show that LIHEAP households are among the most vulnerable in the country.

- 40 percent have someone age 60 or older
- 72 percent have a family member with a serious medical condition

- 26 percent use medical equipment that requires electricity
- 37 percent went without medical or dental care
- 34 percent did not fill a prescription
- 85 percent of people with a medical condition are seniors

LIHEAP's impact in many cases goes beyond providing bill payment assistance by playing a crucial role in maintaining family stability. It enables elderly citizens to live independently and ensures that young children have safe, warm homes to live in.

Faces of LIHEAP

Alabama: A single mother in Alabama supporting three children on minimum wage was often forced to decide whether to pay utility bills or rent. She received LIHEAP to help pay her bill and was enrolled in an energy education class to help manage her energy usage. In addition to the LIHEAP benefit, she was able to bring down her energy bill from about \$570 a month to \$495 month, a savings of \$75, as a result of the class.

Oklahoma: A young single woman with medical issues was working part time as a cashier and taking care of her elderly grandmother. She was able to use LIHEAP to maintain service while she was between jobs, preventing her and her mother from entering a shelter. She was also able to use LIHEAP emergency assistance to prevent disconnect of her electricity when her new salary was not enough to cover the bill.

Pennsylvania: A disabled cancer patient lost her home through foreclosure but was still in the residence pending eviction. Her furnace was shut down for safety reasons after the state weatherization team discovered it was leaking carbon monoxide. The property was acquired by an out-of-state corporation that refused to allow the weatherization team to repair the furnace. The state LIHEAP office was able to use LIHEAP weatherization funds to provide space heaters for the woman until she was able to make other living arrangements, saving her from making the choice of living in a house made hazardous from carbon monoxide or in freezing temperatures.

Tennessee: A woman who is bed ridden and paralyzed from the waist down had to cut back on other necessities to pay her medical bills. At the beginning of last winter, she saved energy by only turning on the lights when her nurse came to visit. She also kept her thermostat on 60 degrees and asked her nurse to layer her clothing and put extra blankets on her before she left. Since receiving LIHEAP, she has been able to leave a light on at night to make her feel more secure and to keep the home a comfortable temperature.

Idaho: A 90-year-old woman in rural Idaho was referred by LIHEAP to Weatherization after she indicated that she had a broken furnace. Weatherization staff found that she was using a coffee can to carry wood pellets from an outdoor shed to a pellet stove in her living room, because she was not able to carry an entire bag. With no other backup heat source, she would have to leave her home if the unreliable stove broke. Because of the referral from LIHEAP, the Weatherization program was able to install a new high efficiency furnace and weatherize her home. This saved her money on her monthly heating bill and allowed her to stay in her home.

California: A young mother of three lived in an older all-electric home and had their electricity shut off due to a past-due bill of about \$800. She worked full time making minimum wage and her husband worked as a seasonal laborer. With no electricity, the family could not heat their home, access hot water, or operate appliances. LIHEAP was able to assist the family by paying their past due bill to get the electricity turned back on. She was also referred to the County's Weatherization Program, which assists families in making their homes more energy efficient.

Connecticut: A single mother of two facing the challenges of being homeless came to the state for help. Through Connecticut's connected services, she received a housing subsidy, \$505.00 in LIHEAP funds, and was enrolled in the utility company's Matching Payment Program.

Mr. COLE. I am going to——

Mr. WOLFE. I am sorry?

Mr. COLE. The remainder of your testimony will have to go in the record. We are going to have to really be strict with this clock given the number of people that we have, so I apologize for that.

Are there any comments or questions anybody care to make.

Ms. DeLAURO. Only one comment. I would just tell Mr. Wolfe, I am personally prepared to oppose both a 10 percent set-aside in the competitive grant program.

Mr. WOLFE. Thank you.

Mr. COLE. Again, I am sorry to have had to be brutal with the gavel.

Mr. WOLFE. I understand.

Mr. COLE. But in the interest of all the rest that are here, I am going to have to do that. Thank you very much for your testimony.

Next, if we could move to Mr. Robert Egge, the executive vice president of the Alzheimer's Association. Welcome. It is good to have you here.

Mr. EGGE. Thank you very much.

Mr. COLE. And you are recognized for 5 minutes.

WEDNESDAY, APRIL 29, 2015.

ALZHEIMER'S ASSOCIATION

WITNESS

ROBERT EGGE, EXECUTIVE VICE PRESIDENT OF GOVERNMENT AFFAIRS OF THE ALZHEIMER'S ASSOCIATION

Mr. EGGE. Good morning, Chairman Cole, Ranking Member DeLauro, members of the committee. On behalf of the more than 5,000,000 Americans with Alzheimer's disease and their 50,000,000 caregivers, thank you for the opportunity to testify before you today.

Alzheimer's is a terminal disease with no survivors. Almost two-thirds of Americans with Alzheimer's disease are women, and it disproportionately affects racial and ethnic minorities. Alzheimer's is also very costly. According to an NIH-funded study conducted by RAND economists and published in the New England Journal of Medicine, Alzheimer's is now the most expensive disease in America. More than two-thirds of this cost is paid by Medicare and Medicaid. It should be no surprise then that Alzheimer's has become a top priority for Americans. In fact, American seniors routinely identify Alzheimer's by a significant margin as the disease they fear most.

As if this were not enough to justify an urgent response, the crisis today is said to grow much worse in the years ahead. Because Alzheimer's is predominantly a disease associated with aging and America is predominantly an aging society, these numbers will skyrocket between now and 2050. By 2050, those with Alzheimer's will as much as triple, and the associated costs will quadruple to over \$1,000,000,000,000 per year, unless, that is, we change this trajectory through the development of effective treatments and means of prevention.

So what are the prospects for us of changing this trajectory? That answer depends to a significant extent on the choices made by Congress. Looking over the past 20 years, Alzheimer's research has held relatively steady at never more than 1.8 percent of NIH annual outlays. This low relative prioritization was set in the early 1990s and has remained frozen in place over the past generation despite Alzheimer's steadily mounting impact over this same period and the repeated independent confirmation of its alarming trajectory for the years ahead. This is crucially important because it points to an immense opportunity.

NIH has the power to change this future. NIH research has yielded tremendous results as exemplified by very encouraging progress over the past several decades against cancer, heart disease, HIV, and many other major diseases, progress that must continue. The failure over this same period to develop Alzheimer's treatments aligns with its prioritization, and so we have now arrived at the point where the top 10 causes of death in the United States, Alzheimer's stands as the only one of them without a way to cure, prevent, or even slow its progression.

Today, Congress has rightly committed to letting researchers establish a scientific agenda and to providing funding increases only where these resources are ready to be used productively, and only where the results can be evaluated over time. Wholeheartedly agreeing with this over the past 5 years, the Alzheimer's Association has collaborated extensively with Congress and with the administration to create an unprecedented pathway. This pathway is now available to Congress to bring Alzheimer's research funding up to an appropriate level while simultaneously adhering to these principles of scientific rigor, discipline, transparency.

To briefly sketch this pathway, in 2011, the bipartisan National Alzheimer's Project Act became law requiring the creation of a comprehensive national Alzheimer's plan. The U.S. Department of Health and Human Services released its plan in 2012 containing the lead goal to prevent and effectively treat Alzheimer's disease by 2025. In support of this effort, NIH scientists have undertaken a systematic planning process to specify the scientific milestones that must be accomplished year by year to achieve this 2025 goal.

Thanks to critical leadership in Congress, first steps have been taken towards completing early milestones due to the direction of an additional \$125,000,000 in Alzheimer's research. These increases in the fiscal year 2014 and fiscal year 2015 funding bills have enabled very important projects to move ahead, but much more remains to be done.

The Alzheimer's Association is the world's largest provider of nonprofit funder of Alzheimer's research in the world. To prepare our appropriations request, our same scientific team that leads this international program has consulted with leading scientists at NIH and around the world on these fiscal year 2016 milestones. These are milestones the NIH itself, not the Association, has identified as required to achieve the 2025 goals set in the congressionally-mandated national Alzheimer's plan.

Based on these consultations and subsequent evaluation, the Association estimates that NIH will require an increase of \$300,000,000 over current levels to remain on pace to reach the

2025 goal. Further increases will certainly be required in subsequent years, but this resource commitment would enable a much-needed acceleration of progress and can be productively deployed in fiscal year 2016 to fund the scientific work required to complete current milestones.

If the NIH were asked to comment based on their professional judgment, we expect the NIH would concur with the milestone cost estimates of the Alzheimer's Association's scientific team from which we derived in the bottom-up process, our requested increase of \$300,000,000 in Alzheimer's research.

Thank you again for the opportunity to testify this morning. We look forward to continuing to work with you and with the subcommittee. With this requested increase, Congress can bring us much closer to the day when you can hear testimony from our Nation's first Alzheimer's survivor. Thank you.

[The information follows:]

Testimony of Robert Egge, Executive Vice President of Government Affairs of the Alzheimer's Association
Fiscal Year 2016 Appropriations for Alzheimer's-related Activities
at the U.S. Department of Health and Human Services

Subcommittee on Labor, Health and Human Services, Education and Related Agencies
Committee on Appropriations
United States Senate

April 29, 2015

The Alzheimer's Association appreciates the opportunity to comment on the Fiscal Year (FY) 2016 appropriations for Alzheimer's disease research, education, outreach and support at the U.S. Department of Health and Human Services.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support and research. Our mission is to eliminate Alzheimer's disease and other dementias through the advancement of research; to provide and enhance care and support for all affected; and to reduce the risk of dementia through the promotion of brain health. As the world's largest nonprofit funder of Alzheimer's research, the Association is committed to accelerating progress of new treatments, preventions and, ultimately, a cure. Through our funded projects and partnerships, we have been part of every major research advancement over the past 30 years. Likewise, the Association works to enhance care and provide support for all those affected by Alzheimer's and reaches millions of people affected by Alzheimer's and their caregivers.

Alzheimer's Impact on the American People and the Economy

In addition to the human suffering caused by the disease, Alzheimer's is creating an enormous strain on the health care system, families and federal and state budgets. Alzheimer's is a progressive brain disorder that damages and eventually destroys brain cells, leading to a loss of memory, thinking and other brain functions. Ultimately, Alzheimer's is fatal. Currently, Alzheimer's is the sixth leading cause of death in

the United States and the only one of the top ten without a means to prevent, cure or slow its progression. Over five million Americans are living with Alzheimer's, with 200,000 under the age of 65.

Alzheimer's is the most expensive disease in America. In fact, a study funded by the National Institutes of Health (NIH) in the *New England Journal of Medicine* confirmed that Alzheimer's is the most costly disease in America, with costs set to skyrocket at unprecedented rates. If nothing is done, as many as 16 million Americans will have Alzheimer's disease by 2050 and costs will exceed \$1.1 trillion (not adjusted for inflation), creating an enormous strain on the healthcare system, families and the federal budget.¹ As the current generation of baby boomers age, near-term costs for caring for those with Alzheimer's will balloon, as Medicare and Medicaid will cover more than two-thirds of the costs for their care.

Caring for people with Alzheimer's will cost all payers - Medicare, Medicaid, individuals, private insurance and HMOs -- \$20 trillion over the next 40 years. In 2015, America will spend an estimated \$226 billion in direct costs for those with Alzheimer's, including \$153 billion in costs to Medicare and Medicaid. Average per person Medicare costs for those with Alzheimer's and other dementias are three times higher than those without these conditions. Average per senior Medicaid spending is 19 times higher.²

A primary reason for these costs is that Alzheimer's makes treating other diseases more expensive, as most individuals with Alzheimer's have one or more co-morbidity that complicate the management of the condition(s) and increase costs. For example, a senior with diabetes and Alzheimer's costs Medicare 81 percent more than a senior who only has diabetes. Nearly 30 percent of people with Alzheimer's or another dementia who have Medicare also have Medicaid coverage, compared with 11 percent of individuals without Alzheimer's or dementia. Alzheimer's disease is also extremely prevalent in nursing homes, where 64 percent of Medicare residents live with the disease.

¹ 2015 Alzheimer's Disease Facts and Figures: http://www.alz.org/facts/downloads/facts_figures_2015.pdf

² Ibid

With Alzheimer's, it is not just those with the disease who suffer - it is also their caregivers and families. In 2014, 15.7 million family members and friends provided unpaid care valued at over \$217 billion. Caring for a person with Alzheimer's takes longer, lasts longer, is more personal and intrusive, and takes a heavy toll on the health of the caregivers themselves. Nearly 60 percent of Alzheimer's and dementia caregivers rate the emotional stress of caregiving as high or very high, with nearly 40 percent reporting symptoms of depression. Caregiving may also have a negative impact on health, employment, income and family finances. Due to the physical and emotional toll of caregiving on their own health, Alzheimer's and dementia caregivers had \$9.7 billion in additional health costs in 2014.³

Changing the Trajectory of Alzheimer's

Until recently, there was no federal government strategy to address this looming crisis. In 2010, thanks to bipartisan support in Congress, the National Alzheimer's Project Act (NAPA) (P.L. 111-375) passed unanimously, requiring the creation of an annually-updated strategic National Alzheimer's Plan (Plan) to help those with the disease and their families today and to change the trajectory of the disease for the future. The Plan must include an evaluation of all federally-funded efforts in Alzheimer's research, care and services - along with their outcomes. In addition, the Plan must outline priority actions to reduce the financial impact of Alzheimer's on federal programs and on families; improve health outcomes for all Americans living with Alzheimer's; and improve the prevention, diagnosis, treatment, care, institutional-, home-, and community-based Alzheimer's programs for individuals with Alzheimer's and their caregivers. . Through its annual review process, NAPA has enabled, for the first time, Congress and the American people to assess whether the nation is meeting the challenges of this disease for families, communities and the economy.

³ ibid

As mandated by NAPA, the Secretary of Health and Human Services, in collaboration with the Advisory Council on Alzheimer's Research, Care and Services, released the first-ever *National Plan to Address Alzheimer's Disease* in May of 2012 and released annual updates in 2013 and 2014. The Advisory Council, composed of both federal members and expert non-federal members, is an integral part of the planning process as it advises the Secretary in developing and evaluating the annual Plan, makes recommendations to the Secretary and Congress, and assists in coordinating the work of federal agencies involved in Alzheimer's research, care, and services.

In keeping with the National Plan, NIH convened a research summit in 2012, which resulted in the development of research milestones and timelines for meeting the goal of effectively treating and preventing Alzheimer's disease by 2025. NIH held a second summit in February of this year to review the progress being made on those milestones and to develop updates on them. Having a plan with measurable outcomes is important. But unless there are resources to implement the plan and the will to abide by it, we cannot hope to make adequate progress. If we are going to succeed in the fight against Alzheimer's, Congress must provide the resources the scientists need. Understanding this and following the recommendation of scientists at NIH, Congress passed the *Consolidated and Further Continuing Appropriations Act of 2015* (P.L. 113-235) which included a \$25 million increase for Alzheimer's research. The law also included the *Alzheimer's Accountability Act* (S.2192/H.R. 4351), which requires NIH to develop a professional judgment budget focused on the milestones established by the National Plan. This will provide Congress with an account of the necessary resources that NIH believes are needed to reach the critical goal of the National Plan, to effectively treat and prevent Alzheimer's disease by 2025.

A disease-modifying or preventive therapy would not only save millions of lives but would save billions of dollars in health care costs. Specifically, if a treatment became available in 2025 that delayed onset of Alzheimer's for five years (a treatment similar in effect to anti-cholesterol drugs), savings would be

seen almost immediately, with Medicare and Medicaid saving a cumulative \$535 billion in the first ten years.⁴

Today, despite the federal investment in Alzheimer's research, for every \$26,000 Medicare and Medicaid spend caring for individuals with Alzheimer's, NIH spends only \$100 on Alzheimer's research. Scientists fundamentally believe that we have the ideas, the technology and the will to develop new Alzheimer's interventions, but that progress depends on a prioritized scientific agenda and on the resources necessary to carry out the scientific strategy for both discovery and translation for therapeutic development.

The Alzheimer's Association urges Congress to support an additional \$300 million for research activities and priorities included in the National Alzheimer's Plan required under P.L. 111-375.

Conclusion

The Association appreciates the steadfast support of the Subcommittee and its priority setting activities. We look forward to continuing to work with Congress in order to address the Alzheimer's crisis. We ask Congress to address Alzheimer's with the same bipartisan collaboration demonstrated in the passage of the National Alzheimer's Project Act (P.L. 111-375) and enactment of the Alzheimer's Accountability Act (P.L. 113-235), and with a commitment equal to the scale of the crisis.

⁴ *Changing the Trajectory of Alzheimer's Disease: How a Treatment by 2025 Saves Lives and Dollars:*
http://www.alz.org/documents_custom/trajectory.pdf

Mr. COLE. Thank you. Again, no questions, but I want to thank you very much for your work and your testimony. I lost my father to Alzheimer's and had to spend the last 12 years of his life in an institution, so I have seen firsthand just how debilitating and how difficult this is for the families as they go through it. I very much appreciate all the good work that the Alzheimer's Association has done over the years to, frankly, educate the broader public and to move us toward a cure, so thanks again.

Any additional comments or questions? Okay. Thank you.

If we can, Kelly Buckland, the executive director of National Council on Independent Living will be our next witness.

Thank you very much, and again, apologize. Our quarters are so cramped, but we appreciate it very much you being here and look forward to your testimony.

WEDNESDAY, APRIL 29, 2015.

NATIONAL COUNCIL ON INDEPENDENT LIVING

WITNESS

KELLY BUCKLAND, EXECUTIVE DIRECTOR, NATIONAL COUNCIL ON INDEPENDENT LIVING

Mr. BUCKLAND. Good morning, Mr. Chairman. Happy birthday. Mr. COLE. Thank you very much.

Mr. BUCKLAND. My birthday is tomorrow, so we are both Taurus.

Mr. COLE. Tauruses have got to hang together.

Mr. BUCKLAND. That is exactly right. Thank you again, Mr. Chairman, and good morning, and members of the committee. My name is Kelly Buckland, and I am the executive director of the National Council on Independent Living, and it is an honor to appear before you today on behalf of the Nation's Centers For Independent Living. I would like to start by thanking you for your commitment to enabling people with disabilities to participate fully in their communities by investing in an independent living program.

Today I appear before the subcommittee to ask that you reaffirm your commitment to more than 57,000,000 Americans with disabilities by increasing the funding for Centers For Independent Living by \$200,000,000. The National Council on Independent Living is the oldest. We go by NCIL. It is the oldest cross-disability, national grassroots organization run by and for people with disabilities, and we envision a world in which people with disabilities are valued equally and participate fully.

Centers For Independent Living are nonresidential, community-based, nonprofit organizations that are designed and operated by individuals with disabilities and provide five core services: Advocacy, information referral, peer support, independent living skills training, and transition services that facilitate individuals with disabilities moving from nursing homes and other institutions into community and home-based—or community-based—home- and community-based residences or keeping people with disabilities from entering institutions so that they can remain in the community.

Centers For Independent Living are unique in that they operate according to a strict philosophy of consumer control in which people

with disabilities directly govern and staff the centers. Centers For Independent Living address discrimination and barriers that exist in society through direct advocacy. As my own life experience has proven, with increased opportunities, individuals with disabilities can claim our civil rights and participate in our communities in ways our nondisabled counterparts often take for granted.

NCIL estimates that to meet the current demand, including the additional fifth core service, which was the transition service added by the Workforce, Innovation, and Opportunity Act and overcome years of devastating funding cuts, an appropriation of \$200,000,000 will be needed for the IL program. Funding in fiscal year 2015 is approximately \$3,000,000 less than it was in the Federal fiscal year 2010.

In Federal fiscal years 2012 through 2014, Centers For Independent Living attracted over 2,260,000,000 through private, State, local, and other sources, moved 13,030 people out of nursing homes and institutions, saving States and the Federal Government over \$500,000,000, and provided the four core services to approximately 5,000,000 people with disabilities.

Beyond the direct services they provide, the Center seek ways to broadly change traditional service deliveries in their communities and throughout the Nation, including reform of the long-term care system for over 40 years. Centers For Independent Living have sought community-based programs to assist people with all types of disabilities across the lifespan to remain in or return to their family and friends in their homes and communities.

When services are delivered in an individual's home rather than a costly nursing facility or institution, the result is tremendous cost savings to Medicaid and Medicare, and States, while enabling people with disabilities to become more independent, financially self-sufficient, and less reliant on long-term government support.

In 2014 alone, centers have had major successes increasing access for people with disabilities. In my home State of Idaho, Living Independence Network Corporation in Boise helped 190 individuals access no cost assistive technology and medical equipment, helping them remain independent in their communities. The Center for Accessible Living in Louisville celebrated the completion of the 100th ramp built with volunteers from Ford and United Auto Workers, Local 862, have been building ramps for Kentucky residents since 2012.

The Arizona Bridge for Independent Living, or ABIL, in Phoenix collaborated with the Arizona Center for Disability Law to host the 4th Annual African-American Symposium on Disabilities, which included an estimated 200 participants and 35 vendors. REACH Resource Center for Independent Living in Fort Worth, Dallas, Denton, and Plano transitioned 25 nursing home residents into community living saving the State of Texas and the Federal Government approximately \$1,180,000, while the Center for Independent Living options in Cincinnati, Ohio accepted their 800th consumer in the HOME Choice program.

And, Mr. Chairman, with that, I will just—I see the light is red, so I will skip to the end and close by just saying that there is a Center for Independent Living in each congressional district, and we would hope that the committee members and other Members of

Congress would go visit the local Center for Independent Living and see what one really looks like. And our good friend in Norman, Oklahoma, Jeff Hughes, is the former chair of the rehabilitation committee on NCIL and sends his best to you. Thank you, Mr. Chairman.

[The information follows:]

Kelly Buckland
Executive Director
National Council on Independent Living

NCIL Testimony to the House Appropriations Subcommittee

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Kelly Buckland and I am the Executive Director of the National Council on Independent Living and it is my honor to appear before you today on behalf of the nation's Centers for Independent Living. I would like to start by thanking you for your commitment to enabling people with disabilities to participate fully in their communities by investing in the Independent Living Program.

Today, I appear before your Subcommittee to ask that you reaffirm your commitment to more than 57 million Americans with disabilities by increasing funding for Centers for Independent Living (CILs) by \$200 million, for a total of \$306 million for the Independent Living line item in FY 2016. NCIL is dedicated to increasing the availability of the invaluable and extremely cost-effective services Centers for Independent Living provide. NCIL is the oldest cross-disability, national grassroots organization run by and for people with disabilities. NCIL's membership includes people with disabilities, Centers for Independent Living, Statewide Independent living Councils, and other disability rights organizations. NCIL advances independent living and the rights of people with disabilities. NCIL envisions a world in which people with disabilities are valued equally and participate fully.

Centers for Independent Living are non-residential, community-based, non-profit organizations that are designed and operated by individuals with disabilities and provide five core services: advocacy, information and referral, peer support, independent living skills training and transition services that facilitate the transition of individuals with significant disabilities from nursing homes and other institutions to home and community-based residences with appropriate supports and services. Also included are assistance to individuals with significant disabilities

who are at risk of entering institutions so that the individuals may remain in the community, and the transition of youth who are individuals with significant disabilities to postsecondary life.

CILs are unique in that they operate according to a strict philosophy of consumer control, in which people with any type of disability, including people with mental, physical, sensory, cognitive, and developmental disabilities, of any age, directly govern and staff the Center. Each of the 356 federally funded Centers are unique because they are run by people with disabilities and reflect the best interest of each community individually.

Centers for Independent Living address discrimination and barriers that exist in society through direct advocacy. These barriers are sometimes architectural, but more often reflect attitudes and prejudices that have been reinforced for generations. They have deterred people with disabilities from working, leaving many in poverty and unjustly detained in institutions. As my own life experience has proven, with increased opportunities, individuals with disabilities can claim their civil rights and participate in their communities in ways their non-disabled counterparts often take for granted.

NCIL estimates that to meet the current demand- including the addition of a fifth core service as authorized by WIOA- and overcome years of devastating funding cuts, appropriations for the IL Program will need to increase by \$200 million. In FY 2010 funding for the IL Program was \$103,716,000, and in FY 2015 funding for the IL Program is \$100,932,487. That equals a loss of \$2,783,573, not including adjusting for inflation. Increased funding should be reinvested from the billions currently spent to keep people with disabilities in costly Medicaid nursing homes and institutions and out of mainstream of society.

According to data collected by the Rehabilitation Services Administration, during Fiscal Years 2012-2014, Centers for Independent Living:

- Attracted over \$2.26 Billion through private, state, local, and other sources;
- Moved 13,030 people out of nursing homes and institutions, saving states and the Federal government over \$500 million, not to mention improving people's quality of life, and;
- Provided the four core services, including: advocacy to 233,230 consumers, information and referral to 4,189,922 consumers, peer support to 172,287 consumers, and independent living skills training to 274,991 consumers.

In that same period, Centers provided other services to hundreds of thousands of individuals with disabilities in their respective communities that included:

- Services to 35,137 youth with disabilities;
- Assistance to 145,937 people in securing accessible, affordable, and integrated housing;
- Transportation services to 103,175 people with disabilities;
- Personal assistance services to 184,240 people with disabilities;
- Vocational and employment services to 96,492 people with disabilities; and
- Assistance with Assistive Technology for 171,441 people with disabilities.

Beyond the direct services they provide, CILs seek ways to broadly change traditional service delivery in their communities and throughout the nation, including reform of the long-term care system. For over 40 years, Centers for Independent Living have sought community-based programs to assist people with all types of disabilities, across the lifespan, to remain in or return to their family and friends, in their homes and communities. When such services are delivered in an individual's home, rather than a costly nursing facility or other institution, the result is tremendous cost savings to Medicaid, Medicare and states, while enabling people with disabilities to become more independent, financially self-sufficient, and less reliant on long term

government supports. And research has found that community-based services are significantly less expensive than nursing home placements.

In 2014 alone, CILs have had major successes in increasing access for people with disabilities. In my home state of Idaho, Living Independence Network Corporation in Boise helped 190 individuals access no cost assistive technology and medical equipment, helping them remain independent in their communities. The Independence Center in Colorado Springs, Colorado led a coalition that resulted in an increase of \$471,000 to the City's transit services budget. Access Living, in Chicago launched the Home and Community Ombudsman Program, where advocates assist individuals with disabilities with matters related to benefits and rights, and the program has already helped Illinoisans get their benefits reinstated, retrieve security deposits from landlords, and secure in-home services to prevent nursing home placement. The Center for Accessible Living in Louisville celebrated the completion of the 100th ramp built with volunteers from Ford and UAW Local 862, who have been building ramps for Kentucky residents since 2012. The Vermont Statewide Independent Living Council published a comprehensive k-12 online curriculum that promotes inclusion for students with disabilities in Vermont schools. This curriculum meets national and state standards and is available to Vermont teachers and students free of charge. And Arizona Bridge to Independent Living in Phoenix collaborated with Arizona Center for Disability Law to host the 4th Annual African American Symposium on Disabilities, which included an estimated 200 participants and 35 vendors.

Additionally, CILs have been extremely effective in helping people remain in or transition back into the community. REACH Resource Centers on Independent Living in Fort Worth, Dallas, Denton & Plano, transitioned 25 nursing homes residents into community living saving the State of Texas and federal government approximately \$1,180,000, while the Center

for Independent Living Options in Cincinnati, Ohio accepted their 800th consumer in the HOME Choice program, which assists people with disabilities transition from nursing facilities back to community based living. Access II Independent Living Center in Gallatin, Missouri provided Consumer Directed Services for 134 individuals with disabilities, keeping them at home and in their communities and saving the state \$6,365,400.

As I previously mentioned, the Workforce Innovation and Opportunity Act created a fifth core service for Centers: transition. NCIL strongly supported the addition of this fifth core service, but additional funding is sorely needed to effectively carry it out. Funding these transition services will be critical to promoting effective employment outcomes, successful nursing home transition, and increased community participation for transitioning students.

Current funding levels barely sustain day-to-day operations. Centers struggle to meet the demands of the community and provide leadership and common sense solutions. Without increased funds our vision to achieve full integration of people with disabilities in society will be undercut and taxpayers will continue to pay for costly Medicaid nursing homes and bear the economic impact of negative employment outcomes and continued dependence on programs that disincentivize work and community involvement. Centers for Independent Living are an excellent service and a bargain for America. They keep people active and engaged in their communities, and they save taxpayer money.

Thank you again for this opportunity, Mr. Chairman and Subcommittee members. We will follow up with each of you to invite you to visit your local Center for Independent Living so you can see first-hand their contributions to your Congressional Districts. We look forward to working with you to ensure that Americans with disabilities have the opportunity become active members of society.

Mr. COLE. Thank you very much, and appreciate your testimony. Appreciate very much your work on behalf of Americans with disabilities, and so we look forward—are there any comments or questions?

Thank you again. Appreciate that.

If we could, our next witness, and forgive me if I mispronounce the name. I think they have tried to get—spell it out phonetically for me. It is Stephanie Vander—is it Meulen? Meulen?

Ms. VANDERMEULEN. VanderMeulen.

Mr. COLE. I knew I was not going to get this well. I apologize.

Ms. VANDERMEULEN. People get it wrong more than they get it right, so it is okay.

Mr. COLE. You are kind. Thank you. And you are recognized for 5 minutes. Good to have you here.

WEDNESDAY, APRIL 29, 2015.

PHYSICIAN ASSISTANT EDUCATION ASSOCIATION

WITNESS

STEPHANE VANDERMEULEN, MSPAC, PA-C, PRESIDENT, PHYSICIAN ASSISTANT EDUCATION ASSOCIATION

Ms. VANDERMEULEN. Thank you. Chairman Cole, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to speak to you today. My name is Stephane VanderMeulen, and I am president of the Physician Assistant Education Association. I am deeply honored that PAEA has been invited to testify for the very first time.

I am a practicing PA and an educator at the University of Nebraska's PA program. I would also like to introduce PAEA's chief executive officer, Timmy Agar Barwick, who is over in the side of the room today, too.

And it is my pleasure today to testify on behalf of the 196 accredited PA programs in the United States to underscore the importance of PA education and how PAs work to enhance interprofessional teams. Today we ask for your continued support of \$12,000,000 in funding for PA education. \$12,000,000 is a relatively small amount of funding, but to us, this investment would benefit our program significantly. Title VII programs, and in particular, the primary care, training, and enhancement grant program provide funding for physician assistant curricular innovations, faculty development, increased access to care for underserved areas, and increased PA workforce diversity.

PAs are primary care providers, and I am confident that at some point, each of you or a family member has seen a PA for care at some point along the way. PAs are licensed in every State and the District of Columbia to practice medicine that includes performing physical exams, ordering tests, and prescribing medications. We have a unique relationship with both patients and physicians unlike that of any other health profession.

PAs complete their graduate education in about 26 months, which lessens the financial impact of student debt and allows PAs to enter the workforce more quickly. The current demand for PAs by hospitals, clinics, physician practices, and other medical settings

exceeds our capacity to educate and graduate new PAs. Fortunately, colleges and universities across the country are responding to that demand and establishing new PA programs. Our PA accrediting agency reports that there are currently 77 new PA programs at various stages of development, which will lead to approximately 270 PA programs by the year 2020.

And Congressman Fattah, you will be proud to know that your district has—there is only one district in the Nation that has more PA programs in its district than yours. You have four. There is one with five.

Despite the continued demand for a robust PA workforce, Federal funding has not kept pace with the growth and the needs. With the increasing number of PA programs—while increasing the number of PA programs will help alleviate the provider shortage, PA education still requires assistance in critical areas such as encouraging students to specialize in primary care, work in underserved communities, and to address the critical shortage of critical training sites.

PAs are educationally prepared to address the primary care needs of our Nation, with more PAs choosing to enter primary care than any other specialty. The effectiveness of PAs is well documented. Multiple studies has known that PAs—multiple studies of PA show improved access, especially for Medicare patients and Medicaid patients, more frequent patient education and healthcare outcomes that are comparable to physician care. Additionally, 93 percent of patients who have interacted with a PA agree that PAs add value to healthcare teams.

Title VII is the only Federal funding source that directly supports PA programs, and it plays a crucial role in supporting our education system's ability to produce the next generation of healthcare providers. My PA program at the University of Nebraska benefits from a PA training grant that seeks to address the rural healthcare needs of our State. Of the 93 counties in Nebraska, 80 of them are designated as either all or partially medically underserved areas. Our grant funded by Title VII focused on the areas of recruitment, education, and delivery models that encourage PAs to assume careers in primary care medicine, particularly in rural and underserved areas.

In closing, Federal support is vital to the continued success of the PA profession. Investments in PA education not only strengthen the PA community, but also allow PA programs to increase the number of opportunities for students to work in team-based primary care settings. Doctors need and want our help. The Alzheimer's patients, cancer patients, and cardiac patients that you heard from or will hear from here today, their care is better with PAs on their team.

The funding that we request will help ensure that the next generation of providers are equipped to work together to provide the highest quality care. Again, PAEA recommends \$12,000,000 in funding to maintain and expand the capacity of PA education in the United States. We are grateful to this subcommittee for your commitment to strengthening health profession's education and your longstanding support of primary care medicine. Thank you.

[The information follows:]

TESTIMONY OF STEPHANE P. VANDERMEULEN, MSPAC, PA- C
PRESIDENT, PHYSICIAN ASSISTANT EDUCATION ASSOCIATION

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES COMMITTEE ON
APPROPRIATIONS U.S. HOUSE OF REPRESENTATIVES

APRIL 29, 2015

Chairman Cole, Ranking Member DeLauro, and members of the subcommittee, thank you for the opportunity to speak to you today. I am here to ask for your continued support of Title VII programs, and in particular the Primary Care Training and Enhancement grant program, which provides funding for physician assistant curricular innovations, faculty development, increased access to care for underserved areas, and increased PA workforce diversity.

My name is Stephane VanderMeulen, and I am President of the Physician Assistant Education Association (PAEA), a practicing PA, and an educator from the University of Nebraska PA program. It is my pleasure to testify today on behalf of the 196 accredited PA programs in the United States to underscore both the importance of PA education and how PAs work to enhance interprofessional teams in our evolving health care system. We recommend \$12 million in funding to support PA education in FY2016 to bolster innovation and the recruitment, training, and development of both students and faculty at PA programs nationwide.

PAs are educated to practice medicine as generalists. This allows us the flexibility to fill in the gaps of access to primary care as well as to specialize based on local and regional needs. PAs possess the knowledge, demeanor, and skills that allow them to adapt and meet patient care needs. After obtaining a bachelor's degree, a PA completes their graduate education in about 26 months, lessening the financial impact of student debt. PAs are

licensed in every state and the District of Columbia and practice medicine that includes performing physical examinations, ordering tests, and prescribing medications.

The current demand for PAs by hospitals, clinics, physician practices, and others exceeds our capacity for educating and graduating new PAs. Fortunately, colleges and universities across the country are responding to the demand and establishing new PA programs. According to the Accreditation Review Commission on Education for the Physician Assistant, Inc. --the accrediting agency that defines the standards for and evaluates PA educational programs in the US--, there are currently 77 PA programs at various stages of development. The growth rate in the applicant pool is even more pronounced. In the 2014–2015 application cycle, there were almost 23,000 applicants to PA education programs, representing a 35 percent increase over the past five years. At the same time, the current rate of graduate PAs entering the workforce is growing an estimated 5 percent per year. A recent study by the Association of American Medical Colleges found that, even with the increase in PAs, there will still be a significant primary care provider shortage by 2025. Despite the continued demand for a robust PA workforce, federal funding has not kept pace with program growth and needs. In FY2010, there were 142 PA programs, and PAs received just over \$3 million in Title VII funding. Today, there are 196 PA programs, yet the most recent Primary Care Training and Enhancement competition designates only \$1 million in funding for PA education. With an estimated 77 programs in development, we will have approximately 270 programs by 2020. This is a critical time for our profession and for the patients we serve. While the increasing number of PA programs will help alleviate the provider shortage, PA education still requires assistance in critical areas, such as: encouraging students to specialize in primary care and work in underserved

communities; addressing the critical shortage of clinical training sites; increasing diversity among providers; and addressing faculty shortages.

PAEA believes that PAs are well-suited to help our nation's health care system meet the triple aim of: improving the experience of care, improving the health of the population, and reducing per capita costs of health care.

Since its inception in the 1960s, PA education has been based on the concept of an integrated, interprofessional, team-based approach to patient-centered care. This approach is uniquely suited to the outcome-based care models that are transforming the U.S. health care system. While the PA profession is well-established, it is nimble enough to embrace new models of care, adopt innovative approaches to training and education, and adapt to health system challenges. For example, when restrictions were placed on physician residency hours in the 1990s, the PA profession responded to the increased need for more in-patient providers.

Primary care has been clearly identified as the critical entry point into our health care system. Today, PAs are educationally prepared to address the challenges our nation faces in primary care, with more PAs choosing to enter primary care than any other specialty. Although the PA profession is relatively young, the effectiveness of PAs is well-documented. Multiple studies of PAs in medical practice show: improved patient access, especially for Medicaid patients; high patient satisfaction; more frequent patient education; and health care outcomes comparable to physician care. According to a Harris Poll conducted by the American Academy of Physician Assistants, 93 percent of patients who have interacted with a PA agree that PAs add value to health care teams.

Title VII is the only designated federal funding source that directly supports PA programs, and it plays a crucial role in supporting our education system's ability to produce the next generation of health care providers. Title VII funding fills a critical need in curriculum development, recruitment, faculty development, clinical site expansion, and diversification of the primary care workforce — areas that, if appropriately supported, can help ensure the PA profession realizes its full potential to meet the nation's health care needs.

My PA program at the University of Nebraska benefits from a PA training grant that seeks to address the rural health needs of our state. 80 of the 93 counties in Nebraska are designated as all or partially Medically Underserved Areas. A portion of our training grant dollars went toward convening a conference focused on best practices in the areas of recruitment, education, and delivery models that promote PA graduates to assume careers in primary care for rural populations, including those underserved. Another PA program used its grant funding to support remote travel expenses for 267 students, who trained at rural primary care clinical sites and in medically underserved communities. Another program used its funding to purchase equipment to train its students to effectively use telemedicine technology. Several other programs used funding to increase access to PA education for veterans.

Funding, however, is only one part of the solution. Ensuring the necessary clinical training is crucial to health professions education. Last year, PAEA partnered with the Association of American Medical Colleges, the Association of Colleges of Nursing, and the American Association of Colleges of Osteopathic Medicine to launch a clerkship survey. This survey found that 80 percent of respondents from across the four health professions

are concerned about the number of clinical training sites — and reported the greatest difficulty in securing clinical opportunities for their students at primary care sites. With a growing patient population and expanded access to health care, it is essential that our students are given clinical education opportunities that prepare them to practice in areas of need. Federal support can help enhance students' experiences in primary care settings, particularly those in rural and inner city settings, increasing the likelihood that they will practice in medically underserved communities.

In closing, federal support is vital to the continued success of the PA profession. Investments in PA education not only strengthen the PA community, but also allow PA programs to increase the number of opportunities for students to work in team-based primary care settings, helping them prepare for clinical settings and meet the needs of our nation. Investment in this kind of team-based education will ensure that the next generations of providers are equipped to work together to provide the highest quality care. PAEA recommends \$12 million to maintain and expand the capacity of PA education in the United States. I know that this funding will go a long way toward enhancing our programs' effectiveness. We also unite with the health professions community to express our concern for the eroding level of funding for Labor HHS programs, and advocate increased funding for public health, research, education, and the workforce. We recognize the need to lower the federal debt while addressing the many priorities of our nation but strongly believe that the relatively minor investment in PA education will reap major benefits of lower cost, quality care for our nation. We are grateful to the subcommittee for your commitment to strengthening health professions education, and for your longstanding support of primary care medicine. Thank you.

Mr. COLE. Thank you very much. I very much appreciate your testimony, your advocacy. I would be remiss on a totally unrelated matter, but as somebody who graduated from the University of Oklahoma and represents—we want Nebraska back in the Big 12, and we want to play you guys again.

Ms. VANDERMEULEN. I knew we would talk football at some point.

Mr. COLE. You have the best football fans in America. I have been to Nebraska many times. I have never seen a more hospitable and knowledgeable group of fans. They are the best. They really are amazing.

Ms. VANDERMEULEN. Thank you. I would say that Oklahoma probably rivals them, but thank you very much.

Mr. COLE. Well, we do actually. Well, with that, any other comment?

Ms. DELAURO. God, this is like the Yankees and the Red Sox here, I mean, so. Anyway, a quick question. The breakdown in PAs. Mostly female? What is the breakdown?

Ms. VANDERMEULEN. That—the feminization of medicine is being seen across medicine. It is approximately 65 females to 35 males, percentage-wise

Ms. DELAURO. And tell me about the wages. Is there a wage gap?

Ms. VANDERMEULEN. Between males and females?

Ms. DELAURO. Females?

Ms. VANDERMEULEN. There is a slight wage gap. It is probably not quite as great as we see, you know, on the nationwide average, but there is a wage gap between male and females.

Ms. DELAURO. Okay. And so that is the same job—it is—men and women same job, but not same pay.

Ms. VANDERMEULEN. Same job. Uh-huh.

Ms. DELAURO. Thank you very much.

Ms. VANDERMEULEN. You are welcome.

Mr. COLE. Any other comments or questions? Thank you again for your testimony.

If we could now, we will move to Dr. Daniel Carr, professor of ophthalmology, microbiology, and immunology, representing the Association for Research in Vision Ophthalmology. Doctor, good to have you here.

WEDNESDAY, APRIL 29, 2015

ASSOCIATION FOR RESEARCH IN VISION OPHTHALMOLOGY

WITNESS

DANIEL J. CARR, PH.D., PROFESSOR OF OPHTHALMOLOGY, MICROBIOLOGY AND IMMUNOLOGY, UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER, ON BEHALF OF ASSOCIATION FOR RESEARCH IN VISION OPHTHALMOLOGY AND THE NATIONAL ALLIANCE FOR EYE AND VISION RESEARCH

Mr. CARR. Thank you. Good morning, Chairman Cole, Ranking Member DeLauro, and distinguished members of the subcommittee. My name is Dan Carr. I am a professor of ophthalmology, microbiology, and immunology at the University of Oklahoma Health

Sciences Center and the Dean McGee Eye Institute, the largest research and healthcare center in Oklahoma.

It is an honor to appear before you today on behalf of two organizations, the Association for Research in Vision and Ophthalmology, and the National Alliance for Eye and Vision Research. My goal in the next few minutes is to describe how taxpayer investment and vision researchers like me has yielded remarkable returns in people and products, patient outcomes, and private industries.

First, though, I have to answer the question what is vision research? Simply, it is efforts into understanding, preserving, and restoring sight. Americans value vision research because Americans value their sight. A recent public opinion poll asked which of the following diseases or ailments is the worst that could happen to you. The results were a three-way tie between cancer, Alzheimer's, and blindness.

I am a vision researcher whose work has been supported by the National Eye Institute for 17 years. During that time, my students, fellows, and I have focused on discovering how the body responds when viruses, like herpes, infect the eye. Once the eye is infected, it is almost impossible to eliminate the virus. Current treatment simply tries to push it into remission. Every time the infection recurs, the eye is damaged further as the body's immune response causes potentially blinding inflammation and scarring.

We recently created an experimental vaccine against herpes that shows much better results than a previous vaccine used in clinical trials. With more work and more funding, we can halt the spread of herpes. Beyond people in the lab, a taxpayer's investment in vision research is clearly evident when he or she visits an eye care provider. A powerful technology initially discovered over 20 years ago with NIH support has matured to become the standard of care used by ophthalmologists and optometrists today known as optical coherence tomography, or OCT, it provides doctors a three-dimensional image of the back of the eye.

This technology has proven especially valuable in diagnosing diseases such as glaucoma and diabetic retinopathy early in their development. As a result of such early detection, eye care providers have a cost-effective means in minimizing vision loss in populations where these conditions are disproportionately prevalent, such as the Native Americans and African Americans.

Taxpayer-supported advancement in vision and healthcare technology supports companies and jobs. For example, the private OCT manufacturing industry hit \$350,000,000 in 2012. OCT has spread to other medical disciplines as well with an estimated market value of over \$60,000,000 in 2012.

These people and products, patient outcomes and private industries represent success in a longstanding model of American-led innovation, public supported efforts into research leading to discoveries that grow into new products which benefit the same public that made it all possible.

Today is among the greatest eras for scientific discovery. You are familiar with the NIH-led BRAIN and precision medicine initiatives. The National Eye Institute is also pursuing its own high-level project called the "Audacious Goals Initiative." This project is focused on one objective, restoring vision by regenerating the ret-

ina, the tissue at the back of the eye that allows us to see, and the same tissue that begins to fail in patients with diabetic retinopathy. The Audacious Goals Initiative is well-named because it will take the entire vision research community working together with adequate funding to reach this goal.

We all know that these past successes and future opportunities in vision research are not enough to overcome the intense budget restraints facing the Federal Government today, but just as scientists are at their best when they think creatively, I urge you, members of this subcommittee, to be creative in your search for a policy that enables growth for the NIH. If it is not possible to fund NIH and NEI at \$32,000,000,000 and \$730,000,000 respectively, then perhaps you can find a way to waive NIH from the sequester cuts and Budget Control Act caps in fiscal year 2016 because there are few agencies that deliver a greater return on top taxpayer dollars in companies and jobs, industries and profits, therapies and healthy citizens than the National Institutes of Health. Thank you very much.

[The information follows:]



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Testimony in Support of Increased Investment
 in the National Institutes of Health (NIH)
 and the National Eye Institute (NEI)

Subcommittee on Labor, Health and Human Services, Education and Related Agencies of the
 House Committee on Appropriations
 April 29, 2015

Testimony by Daniel J. Carr, PhD
 Professor of Ophthalmology, Microbiology and Immunology
 University of Oklahoma Health Sciences Center, Oklahoma City, OK
 On behalf of the Association for Research in Vision and Ophthalmology
 and the National Alliance for Eye and Vision Research

Good morning, Chairman Cole, Ranking Member DeLauro and distinguished Members of the Subcommittee. My name is Dan Carr, PhD, and I am a professor of Ophthalmology, Microbiology and Immunology at the University of Oklahoma Health Sciences Center, the largest research and health care center in Oklahoma. It is an honor to appear before you today on behalf of two organizations, the Association for Research in Vision and Ophthalmology (ARVO) and the National Alliance for Eye and Vision Research (NAEVR). My goal in the next few minutes is to describe how taxpayer investment in vision researchers – like me – has yielded remarkable returns in people and products, patient outcomes and private industries.

First, though, I have to answer the question: “What is vision research?” Simply, it is efforts into understanding, preserving and restoring sight. Americans value vision research because Americans value their sight. A recent public opinion poll asked “Which of the following diseases or ailments is the worst that could happen to you?” The results were a three way tie – between cancer, Alzheimer’s and blindness.



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I am a vision researcher whose work has been supported by the National Eye Institute

(NEI) for 17 years. During that time, my students and I have focused on discovering how the body responds when viruses, like herpes, infect the eye. Once the eye is infected, it is almost impossible to eliminate the virus; current treatments simply try to push it into remission. Every time the infection recurs, the eye is damaged further as the body's immune response causes potentially blinding inflammation and scarring. We recently created an experimental vaccine against herpes in the eye that showed much better results than a previous vaccine used in clinical trials. With more work – and a little luck – we could halt the spread of eye infections from herpes.

Beyond people in the lab, a taxpayer's investment in vision research is clearly evident when he or she visits an eye care provider. A powerful technology initially discovered over 20 years ago — with NIH support — has matured to become the standard of care used by ophthalmologists and optometrists today. Known as optical coherence tomography (OCT), it provides doctors a three-dimensional image of the back of the eye. This technology has proven especially valuable in diagnosing diseases, such as glaucoma and diabetic retinopathy, early in their development. As a result of such early detection, eye care providers can minimize vision loss in populations where these conditions are disproportionately prevalent, such as Native Americans and African Americans.

Taxpayer-supported advancement in vision and health care technology supports companies and jobs. For example, the private OCT manufacturing industry (responsible for



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making the instruments used by eye care providers) hit \$350 million in 2012. OCT has spread to other medical disciplines as well, with an estimated market value of over \$60 million in 2012.

These people and products, patient outcomes and private industries represent success in the longstanding model of American-led innovation: public-supported efforts into research leading to discoveries that grow into new products which benefit the same public that made it all possible.

Since 2004, appropriations for NIH have essentially flat lined, which is equivalent to the U.S. hitting the “pause” button on taxpayer investment in research. Yet during that time, other countries have hit “fast forward.” China, for example, has tripled its support for researchers in the past 10 years. I learned that fact this February when I had the chance to visit the Oklahoma Congressional delegation here in Washington, D.C. Accompanying me on my visits was another vision researcher, Dr. Qingjiong Zhang, a professor in Guangzhou, China. He said:

“It is important to discuss how different the research climate is in China compared to the U.S. In the past 10 years, our [research] grants have tripled in value, and my institution has recruited several scientists directly from the National Eye Institute.”

I was shocked to hear this, but in hindsight I shouldn’t have been. When investment dries up in one country, smart and ambitious people move to another, taking their future ideas, companies and the accompanying jobs and profits with them.

Yet, today is among the greatest eras for scientific discovery. You are familiar with the NIH-led BRAIN and Precision Medicine Initiatives. The National Eye Institute is also pursuing its own high-level project, called the Audacious Goals Initiative. This project is focused on one objective: restoring vision by regenerating the retina, the tissue at the back of the eye that



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allows us to see, and the same tissue that begins to fail in patients with diabetic retinopathy.

The Audacious Goals Initiative is well-named because it will take the entire vision research community working together – with adequate funding – to reach this goal.

We all know that these past successes and future opportunities in vision research are not enough to overcome the intense budget restraints facing the federal government today. But just as scientists are at their best when they think creatively, I urge you, Members of the Subcommittee, to be creative in your search for a policy that enables growth for the NIH. If it is not possible to fund NIH and NEI at \$32 billion and \$730 million, respectively, then perhaps you can find a way to waive NIH from the sequester cuts and Budget Control Act caps in Fiscal Year 2016. Because there are few agencies that deliver a greater return on taxpayer dollars – in companies and jobs, industries and profits, therapies and healthy citizens – than The National Institutes of Health.

Thank you very much. I am happy to answer any questions.

Mr. COLE. Thank you, Doctor. I appreciate your testimony very much. Thanks for coming all the way from Oklahoma, our home, so good to have you here. And ranking member has a question or comment.

Ms. DELAURO. Go ahead. Go ahead.

Mr. FATTAH. Go ahead.

Ms. DELAURO. Just, first of all, I am very, you know, pleased that I have introduced legislation on NIH to lift the cap on NIH for increased funding. Two quick questions on macular degeneration. Increase in—

Mr. CARR. The incidents will be increasing as the aging population increases.

Ms. DELAURO. And the level of research with regard to macular degeneration, what is—

Mr. CARR. I don't know the dollar amount. There is investment, but I don't know the dollar amount. I am sorry.

Ms. DELAURO. Uh-huh. Uh-huh. And that is something that you take up—you are researching and dealing with as well? Is that—

Mr. CARR. The NEI is very heavily vested—

Ms. DELAURO. Vested in—

Mr. CARR [continuing]. In that research as well.

Ms. DELAURO. Okay. Thank you.

Mr. COLE. Mr. Fattah, did you have a question or point you care to make?

Mr. FATTAH. No. I'm a big supporter of the Audacious Goals Initiative, and I just want to thank you for your testimony. I actually truly believe that this is going to bring to so many people—we have 3 million or so, you know, the opportunity to see, so this is—I can't think of anything more important for us to be doing. Thank you.

Mr. COLE. Thank you again, Dr. Carr. Thank you very much for your testimony.

Mr. CARR. Thank you so much.

Mr. COLE. And if we can, we will move to Dr. Maxine Feinberg, president of the American Dental Association. Good to have you here.

WEDNESDAY, APRIL 29, 2015.

AMERICAN DENTAL ASSOCIATION

WITNESS

MAXINE FEINBERG, PRESIDENT, AMERICAN DENTAL ASSOCIATION

Dr. FEINBERG. Thank you. Good morning, Chairman Cole, Ranking Member DeLauro, and members of the subcommittee. I am Dr. Maxine Feinberg, president of the American Dental Association and practicing periodontist in Cranford, New Jersey. The American Dental Association is requesting \$425,000,000 for the National Institute of Dental and Cranial Facial Research for fiscal year 2016. We are urging the NIDCR to use a portion of its resources to conduct more research on the effects of added sugars, sweeteners, and artificial sweeteners on oral health.

Additionally, we are urging other Federal research agencies to carve out a role for oral health when conducting any nutrition-re-

lated research. Eating patterns and food choices play an important role in maintaining oral health. From a dental perspective, a steady diet of sugary foods and drinks, including natural fruit juices, sport drinks, natural fruit juices can damage teeth. A lack of certain nutrients can also make it more difficult for tissues in the mouth to resist infection.

Mr. Chairman, we recognize and share the national concerns about obesity. We also recognize the growing popularity of taxing sugar-sweetened beverages and pursuing other measures to tackle the epidemic on obesity. Of course the ADA is primarily concerned with whether and how these policies would reduce the prevalence of dental caries. Compared to the available data on obesity, however, the available research on dental caries is lacking.

On January 28, the 2015 Dietary Guidelines Advisory Committee, DGAC, submitted its scientific report to the U.S. Departments of Agriculture and Health and Human Services. The report, which is advisory only, will serve as the basis for developing the next iteration of dietary guidelines for American policy.

In its report, DGAC concluded that there was a high degree of consistent evidence associating the consumption of added sugars with excess body weight and type 2 diabetes. Comparatively, the DGAC found only a moderate degree of consistent evidence supporting a relationship between the consumption of added sugars and the development of caries. The dental caries finding was based largely on systematic review commissioned by the World Health Organization for its 2015 guideline on sugars intake for adults and children. That review is perhaps the most thorough and reliable evidence review on the topic to date.

Mr. Chairman, considering how much money the Federal Government has already spent on nutrition research, examining the relationship between dietary sugars and obesity and the associations with cardiovascular disease, type 2 diabetes, and other health conditions, why is there still only a moderate degree of consistent evidence addressing the volume of added sugars and artificial sweeteners consumed in the development of dental caries?

Surely we can do better than that. For many years, the ADA has pursued a “carrot” approach to encourage people to adopt healthier diets. Our mission has been to empower consumers to achieve optimal oral health by being food-wise. We have been a strong advocate for including oral health education in Team Nutrition, SNAP-Ed, and WIC, and other Federal food assistance programs. We have pushed the USDA to adopt nutrition standards that promote optimal oral health for all foods offered in schools and to include oral health education in local schools and wellness policies. We have even pressed the Federal Trade Commission to develop basic industry standards for marketing foods and beverages to children.

I would also note we strongly support the recent Federal Drug Administration’s proposal to require a separate line for added sugars on nutrition and supplement fact labels. Doing so will help consumers monitor the added sugar intake simply by reading the nutrition label. There is no doubt that Congress will continue investing in research examining the relationship between diet and obesity and corresponding health conditions. So what do we need? Among other things, the American Dental Association would like to

see a high degree of consistent evidence on whether and how dental caries rates fluctuate on the volume of added sugars and sweeteners consumed. We would like to see demonstration products evaluating whether sugar-sweetened beverages taxes and other disincentive pricing strategies will lower caries consumption.

Dr. FEINBERG. I would like to thank the committee for this opportunity to testify, and we appreciate your ongoing support for NIDCR and committed to working with you and other Federal nutrition agencies to better understand the association between diet, nutrition, and oral health.

Thank you for your time.

[The information follows:]

ADA American Dental Association®

STATEMENT OF THE

AMERICAN DENTAL ASSOCIATION

TO THE

**SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION, AND RELATED AGENCIES**

COMMITTEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

ON

**THE NEED FOR MORE RESEARCH ON RELATIONSHIPS BETWEEN
DIET, NUTRITION, AND ORAL HEALTH**

SUBMITTED BY

DR. MAXINE FEINBERG

PRESIDENT OF THE AMERICAN DENTAL ASSOCIATION

April 29, 2015

Good morning, Chairman Cole, Ranking Member DeLauro, and Members of the Subcommittee. I am Dr. Maxine Feinberg, President of the American Dental Association and a practicing periodontist in Cranford, New Jersey.

The American Dental Association is requesting \$425 million for the National Institute of Dental and Craniofacial Research for fiscal year 2016. We are urging NIDCR to use a portion of its resources to conduct more research on the effects of added sugars, sweeteners, and artificial sweeteners on oral health.

Additionally, we are urging other federal research agencies to carve out a role for oral health when conducting any nutrition-related research.

Eating patterns and food choices play an important role in maintaining good oral health. From a dental perspective, a steady diet of sugary foods and drinks, including natural fruit juices and sports drinks, can damage teeth. A lack of certain nutrients can also make it more difficult for tissues in the mouth to resist infection.

Mr. Chairman, we recognize—and share—the national concern about obesity. We also recognize the growing popularity of taxing sugar-sweetened beverages and pursuing other measures to tackle the epidemic of obesity. Of course, the ADA is primarily concerned with whether and how these policies would reduce the prevalence of dental caries. Compared to the available data on obesity, however, the available research on dental caries is lacking.

On January 28, the 2015 Dietary Guidelines Advisory Committee (DGAC) submitted its scientific report to the U.S. Departments of Agriculture and Health and Human Services. The report, which is advisory only, will serve as the basis for developing the next iteration of Dietary Guidelines for Americans policy.

In its report, the DGAC concluded there was a high degree of consistent evidence associating the consumption of added sugars with excess body weight and type 2 diabetes. Comparatively, the DGAC found only a *moderate* degree of consistent evidence supporting a relationship between the consumption of added sugar(s) and the development of dental caries.

The dental caries finding was based largely on a systematic review commissioned by the World Health Organization for its 2015 guideline on sugars intake for adults and children. That review is perhaps the most thorough and reliable evidence review of the topic to date.

Mr. Chairman, considering how much money the federal government has already spent on nutrition research examining the relationship between dietary sugars and obesity—and associations with cardiovascular disease, type 2 diabetes, and other health conditions—why is there still only a *moderate* degree of consistent evidence addressing the volume of added sugar(s) and artificial sweeteners consumed and the development of dental caries? Surely we can do better than that.

For many years, the ADA has pursued a “carrot” approach to encourage people to adopt healthier diets. Our mission has been to empower consumers to achieve optimal oral health by being food wise.

We have been a strong advocate for including oral health education in Team Nutrition, SNAP-Ed, WIC, and other federal food assistance programs. We have pushed the USDA to adopt nutrition standards that promote optimal oral health for all foods offered in schools, and to include oral health education in local school wellness policies. We have even pressed the Federal Trade Commission to develop basic industry standards for marketing foods and beverages to children.

I would also note that we *strongly* support the recent Food and Drug Administration proposal to require a separate line for added sugar(s) on the Nutrition and Supplement Facts labels. Doing so will help consumers monitor their added sugar intake simply by reading a nutrition label.

There is no doubt that Congress will continue investing in research examining the relationships between diet, obesity, and its corresponding health conditions. Similar research on the effect of diet on oral health should be part of that agenda.

So, what do we need? Among other things, the American Dental Association would like to see a high degree of consistent evidence about whether and how dental caries rates fluctuate based on the volume of added sugar(s) and sweeteners consumed. We would like to see demonstration projects evaluating whether sugar-sweetened beverage taxes and other disincentive pricing strategies will lower dental caries rates over the life span,

or whether consumers will simply switch other foods that may further increase the risk for dental caries. We would also like to know the synergistic effect of acids and sugars on dental caries incidence, and how we can better leverage nutrition counseling in dental settings to improve oral health outcomes.

Oral health is inextricably linked to overall health and well-being. Any strategy to improve the dietary habits of Americans can and must include an oral health component. It is an agenda worth embracing.

Again, the American Dental Association is requesting \$425 million for the National Institute of Dental and Craniofacial Research for fiscal year 2016. We are urging NIDCR to use a portion of its resources to conduct more research on the effects of added sugars, sweeteners, and artificial sweeteners on oral health.

Additionally, we are urging other research agencies to carve out a role for oral health when conducting any nutrition-related research.

I would like to thank the committee for this opportunity to testify. We appreciate your ongoing support of NIDCR and are committed to working with you, NIDCR, and other federal nutrition research agencies to better understand associations between diet, nutrition, and oral health.

Mr. COLE. Thank you very much. And I don't have any questions, but I do want you to know you are probably the smartest person here because you have an insider at the committee with Mr. Simpson here, who is a dentist. So all things dental get attention here.

Dr. FEINBERG. And we appreciate his support.

Mr. COLE. He is your ferocious put unpaid advocate, I can assure you.

Dr. FEINBERG. Thank you.

Mr. COLE. Any comments or questions?

Ms. DELAURO. I will just make a comment. I want to go on the road with you with regard to the SWEET Act. And I thank you for what you have said in that area and about taxing sugar-sweetened beverages, the dietary guidelines, and are paying attention to that. So let's just figure out a road show. I would love to partner with the American Dental Association because you certainly have a lot of clout and you are going to be listened to more than I will be listened to in this area.

So thank you very, very much for your testimony and for your advocacy.

Dr. FEINBERG. Thank you for your time.

Ms. DELAURO. Thank you.

Mr. COLE. It is good to have you here.

Ms. LEE. Mr. Chairman, may I just ask one question very quickly.

Mr. COLE. Oh. Absolutely.

Ms. LEE. Fluoridated water, good for teeth or not?

Dr. FEINBERG. It is very good for teeth, and we support it wholeheartedly, and we hope you do too. Thank you.

Mr. COLE. Thank you very much.

If we could, next we will have an old friend of mine, Aurene Martin, board member for the National Indian Child Welfare Association, but also former acting assistant secretary, Department of Interior, and well-known advocate for Native Americans.

Great to see you.

Ms. MARTIN. Thank you.

Mr. COLE. You are recognized.

WEDNESDAY, APRIL 29, 2015.

NATIONAL INDIAN CHILD WELFARE ASSOCIATION

WITNESS

AURENE MARTIN, BOARD MEMBER, NATIONAL INDIAN CHILD WELFARE ASSOCIATION

Ms. MARTIN. Good morning. As the chairman said, my name is Aurene Martin. I am a member of the Bad River Band of Lake Superior Chippewa Indians, and I am also a member of the National Indian Child Welfare Association Board of Directors.

Thank you for the opportunity to testify today. NICWA, National Indian Child Welfare Association, is a national American Indian and Alaska Native organization with over 30 years experience in public policy development based on Native children and families.

Our mission is twofold. First, to address the issues of Indian child abuse and neglect through training, research, policy and com-

munity development, and also to support compliance with the Indian Child Welfare Act. I appreciate the opportunity today, and I would like to talk about three things, three priority issues for our organization.

First, our support for the administration's proposed \$20,000,000 increase for tribal child welfare capacity building through the Promoting Safe and Stable Families discretionary fund. Second, our support for funding the administration's \$27,000,000 set-aside under the Payments for Foster Care and Permanency program to provide tribes with Title IV-E foster care, adoption assistance, and startup support. And finally, a request for increased funding for the SAMHSA Tribal Behavioral Health Program.

In a report issued last November by the Attorney General's Advisory Committee on American Indian and Alaska Native Children Exposed to Violence, the task force found that Native children are exposed to violence at a rate that is three times that of the general population. They also found that Native children suffer from post-traumatic stress disorder at a rate that is equal to Iraq and Afghan veterans returning from the war. Yet, tribal governments have the most limited access to Federal funds to treat these kinds of issues, and in many cases they don't have direct access to this funding at all.

So our first recommendation is to provide full funding for the President's program to promote safe and stable families. This program provides flexible funds for tribes for vital coordinated child welfare services that include family preservation, family reunification, and adoption support services. There is a 3 percent set-aside for tribes based on a formula, but if a tribe doesn't reach or is not eligible for \$10,000 in the formula, then they don't get any funding at all.

This means that smaller tribes located in very rural areas aren't able to access this funding at all and they probably most need it. They are either forced to find other funds to fund these services or not provide them at all. The proposed \$20,000,000 increase to specifically build this capacity will provide vital services on the ground.

Our second recommendation supports funding the Payments for Foster Care and Permanency line item. In 2008, the Fostering Connections to Success and Increasing Adoptions Act provided tribal governments with new opportunities to access foster care and permanency funding under the Title IV-E program. These funds support tribal recruitment and retention of foster, adoptive, and guardianship homes, and ensure that children have safe places to be and that those placements have resources that they need to care for those children.

Earlier this year, the GAO reported that there aren't more tribes accessing this program because they don't have the money available to start up the program in the first place. That is, they don't have the infrastructure already to provide these services. So even though they might be eligible for the funds, they can't implement the program.

The President's proposed increase would allow tribes to apply for startup funding if they have an approved plan, and so it would provide access to those tribes that can't currently access it.

Finally, as the National Indian Health Board and tribal leaders—I believe, Ron Allen testified last week—they recommended to this committee that they fund the SAMHSA Tribal Behavioral Health Program at a level of \$50,000,000, and we agree with that recommendation. This program, as I understand it, is the only program that allows tribes the flexibility to provide these kinds of services on the ground. They are able to coordinate disparate services and put them together, and there is no other Federal funding available to do that. This is extremely important because the suicide epidemic, it is an extreme problem in Indian country, and these funds really address that issue.

In closing, I would like to thank you again for your efforts to protect Native children and for your continued support. Thank you.

[The information follows:]

Aurene Martin—NICWA Board Member, National Indian Child Welfare Association

**United States House of Representatives
Labor, Health and Human Services, Education, and Related Agencies
Department of Health and Human Services Recommendations
National Indian Child Welfare Association FY 2016 Testimony**

The National Indian Child Welfare Association (NICWA) has over 35 years of experience advocating on behalf of American Indian and Alaska Native (AI/AN) children in child welfare and children's mental health systems. Thank you for the opportunity to provide FY 2016 budget recommendations for child welfare and children's mental health programs administered by the Department of Health and Human Services (DHHS) (ACF, Payments for Foster Care and Permanency: +\$27m for tribal start up; ACF, Promoting Safe and Stable Families Discretionary: +20m for tribal capacity; SAMHSA, Tribal Behavioral Health Program, +25m).

Child Welfare Recommendations

A recent report from the Attorney General's Advisory Committee on American Indian/Alaska Native (AI/AN) Children Exposed to Violence provided the following recommendation:

Congress and the executive branch shall direct sufficient funds to AI/AN tribes to bring funding for tribal criminal and civil justice systems and tribal protection systems into parity with the rest of the United States (U. S. Department of Justice [USDOJ], 2014, p. 51).

Tribes, like states, rely on the federal government for the majority of their child welfare funding. Child safety and family stability are tribal governments' highest priorities, yet their programs remain drastically underfunded by the federal government. This underfunding has contributed to the increased risk for child maltreatment of AI/AN children and has stymied efforts to heal victims of child maltreatment and rehabilitate their families. Congress must prioritize the safety and well-being of these children and families in the budget process. NICWA provides the following recommendations:

Agency	Program	President's FY 2016 Budget	FY 2016 Rec.
DHHS	Promoting Safe and Stable Families-Disc.	\$89.7m	\$89.7m
ACF/CB	(tribal)	(\$31.8m)	(\$31.8m)
DHHS	Child Abuse Discretionary Activities	\$48.7m	\$48.7m
ACF/CB	(tribal)	(unknown)	(unknown)
DHHS	Community-Based Child Abuse Prevention	\$39.7m	\$60m
ACF/CB	(tribal)	(\$416k)	(\$600k)
DHHS	Child Welfare Services	\$268.7m	\$280m
ACF/CB	(tribal)	(\$6.3m)	(~\$7.1m)
DHHS	Payments for Foster Care and Permanency	+\$27m for tribal start-	+\$27m for tribal
ACF/CB		up funds	start-up funds
DHHS	Maternal Infant & Early Childhood Home	\$500m	\$500m
HRSA	Visiting Program (tribal)	(\$15m)	(\$15m)

Priority Recommendations

Payments for Foster Care and Permanency

DHHS, Administration for Children and Families

Budget Recommendation: Increase this program's funding by \$27 million to specifically support tribal Title IV-E program start-up for tribes with approved Title IV-E plans.

The Fostering Connections to Success and Increasing Adoptions Act (2008) provided tribal governments with historic new opportunities to access foster care and permanency funding and technical assistance under the Title IV-E program—an area of child welfare services where tribes are woefully underfunded.

As described in a recent GAO report (2015) more tribes are not running Title IV-E programs because Title IV-E does not provide the funding or support needed by many tribes to actually begin implementation of the program. Essential to Title IV-E implementation is the ability to provide a substantial non-federal match and support initial caregiver payments and program costs with tribal funds. Yet, tribes interested in operating IV-E do not have the same access to general revenue as states. Also essential to Title IV-E implementation is the staffing and infrastructure necessary to support expanded services, additional requirements, and new accounting systems. Tribes—who have been chronically underfunded and only reassumed

control over their child welfare services in 1978—do not have the same child welfare infrastructure or capacity as states.

The President's FY 2016 budget requests an increase of \$27 million to the Payments for Adoption and Permanency Program to allow for tribes that have approved Title IV-E plans to apply for start-up funding. For tribes to successfully access Title IV-E and children to have safe and supported foster homes this program must be funded.

Promoting Safe and Stable Families (Social Security Act Title IV-B, Subpart 2)

DHHS, Administration for Children and Families

Budget Recommendation: Increase discretionary funding in this program to \$89.75 million to support the President's \$20 million initiative to increase tribal capacity and rural child welfare.

The Promoting Safe and Stable Families (PSSF) Program provides funds to tribes for coordinated child welfare services that include family preservation, family support, family reunification, and adoption support services. There is a 3% set-aside for tribes based on a formula, however if a tribe would qualify for less than \$10,000 then it is not eligible to receive any funding under this program. This means that many tribes, typically those tribes who are most in need, cannot access PSSF funding because the overall appropriation is currently too low and affects the individual tribal allocation. This means that tribes are providing intensive family preservation and family reunification services in spite of inadequate funding and insufficient staffing. This puts incredible strain on individual workers and programs. This strain stands in the way of tribes' ability to build capacity, expand programs, and coordinate services.

The President's FY 2016 budget includes a \$20 million increase to PSSF Program discretionary funds for a tribal child welfare capacity building initiative. This initiative would provide tribes with the resources necessary to support the staff time, infrastructure, and

development of child welfare departments and services. NICWA recommends that this initiative be funded.

Children's Mental Health

The Attorney General's Advisory Committee on American Indian/Alaska Native Children Exposed to Violence provided the following recommendation:

The Secretary of Health and Human Services should increase and support access to culturally appropriate behavioral health services in all AI/AN communities (USDOJ, 2014, p. 88).

In order to effectively serve AI/AN children and communities, funding must provide flexible opportunities that allow tribes to integrate culturally appropriate comprehensive mental and behavioral health services. NICWA provides the following recommendations:

Agency	Program	President's FY 2016 Budget	NICWA FY 2016 Rec.
DHHS SAMHSA	Programs of Regional and National Significance— Children and Family Programs (includes Circles of Care)	\$6.5m	\$8.5m (Reserve \$6.5m for Circles of Care)
DHHS SAMHSA	Children's Mental Health Services Program— Systems of Care	\$117m	\$117m
DHHS SAMHSA	GLS State/Tribal Youth Suicide Prevention	\$40.5m	\$40.5m
DHHS SAMHSA	GLS Campus Suicide Prevention Program	\$8.9m	\$9.5m
DHHS SAMHSA	AI/AN Suicide Prevention	\$2.9m	\$3m
DHHS SAMHSA	Tribal Behavioral Health Grant	\$30m	\$50m
DHHS SAMHSA	Project LAUNCH	\$34.5m	\$34.5m

Priority Recommendations

Tribal Behavioral Health Program

DHHS, Substance Abuse Mental Health Services Administration

Budget Recommendation: Increase funding of this program to \$50 million to make this funding available across Indian Country.

The Consolidated Appropriations Act of 2015 recommended that \$5 million be allocated to Tribal Behavioral Health Grants in the form of the Native Connections grant program appropriating this funding for the first time. These are competitive grants designed to target tribal entities with the highest rates of suicide per capita over the last 10 years. These funds must be used for effective and promising strategies to address the problems of substance abuse and suicide, and to promote mental health and well-being among AI/AN young people.

As originally conceptualized, the FY 2012 budget request sought \$50 million for a new Behavioral Health-Tribal Prevention Grant. Approximately half of the funding was to be allocated as a “base level” to federally recognized tribes that applied for these funds. Originally, the base amount that each tribe would be eligible for was at least \$50,000. As eventually passed by Congress in the 2015 budget, funding for what is now known as the Native Connections grant program, focuses more specifically on youth and, due to the level of funding, are competitive grants available to approximately 20 tribes. The President’s FY 2016 budget request includes a \$25 million increase, \$10 million additional dollars in the Mental Health Services appropriations and \$15 million new dollars in the Substance Abuse appropriations. This additional funding is still not enough to provide the program with adequate support to fulfill its initial conceptualization. To make it available across Indian Country NICWA recommends this program be funded at \$50 million, as suggested by the initial conceptualization of the program.

If you have any questions about this testimony please contact NICWA Government Affairs Associate Addie Smith at addie@nicwa.org or (503) 222-4044 ext. 134.

References:

U. S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. (2014). *Attorney General’s Advisory Committee on American Indian Alaska Native Children Exposed to Violence: finding violence so children can thrive*. Retrieved from <http://www.justice.gov/sites/default/files/defendingchildhood/pages/attachments/2014/11/18/finalaianreport.pdf>

Mr. COLE. Thank you very much.

Any questions or comments? Gentlelady is recognized.

Ms. DELAURO. Yes. First of all, many, many thanks. And we did see Mr. Allen last week. And I just want to reiterate something I said at that juncture. I have the opportunity to co-chair the bipartisan Baby Caucus.

Mr. Chairman, I would love to work with you and with Ms. Martin and Mr. Allen and others so that we can have a forum specifically about the welfare of Indian children. I think we have to raise the education level to what is happening and what are the circumstances and focus some time and attention on that issue.

So I would love to work with you.

And again with you, Ms. Martin, because you have got all the information and the data. We focus on infants and toddlers, but we can certainly broaden that mission in terms of putting the spotlight on this effort. So I thank you very, very much for your compelling testimony. Thank you.

Mr. COLE. I certainly look forward to working with my friend on that issue. Thank you very much.

Any other comments or questions?

Thank you very much. Appreciate it.

Ms. MARTIN. Thank you.

Mr. COLE. If we can, next, Mr. Chuck Mills, who is president and CEO of Salera Employee Benefits and Solutions, and he is here to testify on behalf of the National Head Start Association.

Good to have you here.

WEDNESDAY, APRIL 29, 2015.

**SALERA EMPLOYEE BENEFITS SOLUTIONS LLC,
NATIONAL HEAD START ASSOCIATION**

WITNESS

CHUCK MILLS, PRESIDENT AND CEO, SALERA EMPLOYEE BENEFITS SOLUTIONS LLC, NATIONAL HEAD START ASSOCIATION

Mr. MILLS. Chairman Cole, Ranking Member DeLauro, and distinguished members of the subcommittee, thank you for inviting me to present public witness testimony this morning.

I am here representing Head Start, and I am a proud Head Start alumnus, one of 32 million alumni across our Nation. Amongst our alumni ranks are Harvard professors, doctors, authors, and many leaders within their discipline, like Secretary Burwell, comedian Chris Rock, and NBA star Shaquille O'Neal.

This year, Head Start is celebrating its 50th anniversary, 50 years of changing the lives of at-risk children and families. I would like to share my personal story of how Head Start changed my life and then encourage the subcommittee to continue its strong bipartisan support for Head Start in fiscal year 2016.

I am an example of how Head Start helps individuals achieve success in life and produces a clear return on investment to society. As a direct result of Head Start, I have served my country as a military officer, a state agency head, and a speaker for the U.S. Department of State. In addition, I have contributed to society as a

taxpayer through my 20-year career in finance and economic development, having started three businesses.

You may ask how I know Head Start was the defining factor in my success. I know this because I am the youngest of six children, and while Head Start did not exist for my four oldest siblings in my family, it did exist for me and my sister just above me. My sister Lisa and I attended Head Start with the support and engagement of our single parent mother, and Lisa and I have led stable and productive lives while my four other siblings, who did not attend Head Start, were not so fortunate.

Lisa is one of the most successful court reporters in Houston, Texas. She has been a court reporter for almost 30 years, and she owns numerous investment properties. In contrast, my oldest brother led a life of crime and spent much of his adulthood incarcerated. My oldest sister struggled with drug addiction and, like my oldest brother, passed away before her 35th birthday. Of the two middle siblings, one led a life of drugs and dependance on government support and also passed away early. The other one has had some success, however, struggles to maintain a consistent job.

So if one were to use my family as a control group, so to speak, it is clear that six children raised by the same mother with the same family values, but ended up in very different places. What was the discriminating factor, we must ask? I will contend it was Head Start. Arguably, there were other conditions that contributed to Lisa and my accomplishments, but there is no denying that we were the only ones in my family who attended Head Start and we are the only ones that would go on to one day fly for Presidents and one day become the foremost court reporter.

And with over 32 million alumni in mind, alumni that in many cases are just like me and Lisa, I urge the subcommittee to build upon their investments made in recent years in Head Start and Early Head Start.

My written statement outlines specific recommended funding levels for each one of the programs. If appropriated, these funds will allow Head Start centers to continue services from birth to age 5 for approximately 1 million children and families living in poverty. These funds will support continued strengthening of the critical Head Start workforce, which is comprised of 200,000 dedicated individuals. These funds, if appropriated, will support Head Start's ongoing efforts in continuous quality improvement and program assessment.

Chairman Cole, I understand you are a new member of the subcommittee. I also understand this subcommittee has responsibility and oversight for funding many worthy programs, including Head Start. Lastly, I understand the subcommittee has been providing funding allocation that will make it difficult to fund increases in any program, regardless of its worth or value.

All I can say is for 50 years, Congress has supported Head Start on a bipartisan basis, and, in my view, every dollar invested by the Federal Government should seek the highest possible impact and should be used accountably.

So my story is one concrete example of how Head Start delivers results in the form of return for the taxpayers' investment. As the

subcommittee sets funding priorities throughout the year, I hope you will consider Head Start a worthy investment.

Thank you for the opportunity to testify. I would be pleased to answer any of your questions.

[The information follows:]

Charlie “Chuck” Mills III
Head Start Alum
National Head Start Association
Subcommittee on Labor, Health & Human Services and Education
House Appropriations Committee

Chairman Cole, Ranking Member DeLauro and members of the Subcommittee, thank you for inviting the National Head Start Association (NHSA) to present public witness testimony this morning. 2015 marks the 50th anniversary of Head Start centers creating opportunities for at-risk children and families. As a proud Head Start alum, and on behalf of the 32 million Head Start alumni across our nation, it is my honor to represent NHSA today. We respectfully urge the Subcommittee to continue Congress’ enduring bipartisan support for this effective intervention by allocating **\$10,117,706,000 for the Administration for Children & Families’ Head Start and Early Head Start** programs in Fiscal Year 2016 (FY16.)

There is no doubt in my mind that Head Start was my chance to achieve success in life and that the return on the investment is clear. I have served our country as a military officer, a state agency head, and a speaker for the US State Department. I have gone on to have an over 20 year career in finance and economic development. I understand the need to examine the economic impact of human service programs such as Head Start – not just their clear social value.

My experiences as a member of our military, a successful entrepreneur who has hired employees, as a board member on public and private organizations, and as a parent volunteer are evidence of my contributions to the social and economic strength of our country and my community. I

would also bet that this significant multiplier of return on the Head Start investment is similar for my sister – herself a Head Start student - through her work as a court reporter in our country's judicial system and through her private investments.

Why am I so convinced of Head Start's impact that I volunteered to be here today? Please indulge me in a closer look at my family – which included a single mom and six siblings. Only the two youngest, my sister and me, attended Head Start. The four oldest, who did not have the benefit of a Head Start experience, have unfortunately traveled tough and sometimes tragic paths. My brother, the oldest, led a life of crime and spent much of his adulthood incarcerated. My oldest sister also led a very difficult life, struggling with drug addiction and passed away to a massive stroke prior to her 35th birthday. Four months after my oldest sister passed away, my oldest brother also passed away prior to his 35th birthday and while in jail. His official cause of death has never been uncovered. Of the two middle siblings, one has led a life of drugs and a dependence on government support. The other one has had some success however struggles to maintain a consistent job.

My youngest sister, herself a proud Head Start alumna, is one of the most successful court reporters in Houston, TX. She has been a court reporter for almost 30 years, owns numerous properties, and without a doubt has made the most of her Head Start experience. If one were to use my family as a “control group” so to speak, it is clear that six children were raised by the same mother, with the same family values, but ultimately ended up in very different places. What was the discriminating factor? I would contend that it was Head Start. Arguably there are other

conditions that contributed to my sister's and my accomplishments, but there is no denying that we were the only ones who attended Head Start and that one day I would fly for Presidents and my sister would become one of the foremost court reporters. Over the last decade or so I've met authors, mayors, entrepreneurs, Harvard professors and so on - all of whom are former Head Start students and making contributions to our society.

With these 32 million alumni stories in mind, we urge the Subcommittee in FY16 to continue and build on investments made in recent years by allocating \$10,117,706,000 for Head Start and Early Head Start. This funding will allow Head Start centers to continue services to 959,828 children and their families from birth through age five, continue supporting the recently awarded Early Head Start expansion grants and child care partnerships, support the critical Head Start workforce and enable a special focus on improving program quality. Specifically, NHSA is recommending a \$1.228 billion allocation for Quality Improvement funds which, as outlined in the Head Start Act of 2007, may be used for increasing the duration of instruction time, staff training, improving community-wide planning, improving classroom environments, strengthening transportation safety, and increasing hours of program operation. NHSA is also urging the Subcommittee to join it in asking the Administration to honor its promise to release, this spring, a long-overdue set of revised Head Start Program Performance Standards, aligned to the Head Start Act of 2007.

It is well known that one of the hallmarks of excellence in any early learning program is the caliber of its teachers. More than 70% of Head Start teachers have a bachelor's degree or higher in early learning or related fields, which significantly exceeds the 50% minimum mandated by

Congress in the 2007 reauthorization and enables the program to have one of the best-trained early childhood workforces in the country. However, the average salary for these degreed teachers is \$30,086 – lower than what schools pay teachers, and much lower than salaries for many other jobs with comparable education requirements.

Examples of programs losing their best staff to higher paying schools or other providers are plentiful across the country and focusing any increased investment toward workforce quality improvements will help enable programs to hold on to dedicated teachers, and provide a solid foundation for the good of students and families. To that end, NHSA supports the Administration's request of \$284,482,375 for workforce investments.

Recognizing the need for programs to retain staff, improve facilities, expand transportation services, and increase program duration, NHSA recommends providing \$1.228 billion to the Quality Improvement fund. Investing in the Quality Improvement fund, rather than mandating that funds be used solely to expand hours of service as the President's budget does, enables local programs to determine their area of greatest need and improve services in their community. This is especially true for rural programs and NHSA believes that this allocation of funding will still accomplish the Administration's goal of increasing the duration of instruction time to meet the needs of working families. NHSA encourages the dissemination of these funds, as well as all other funds in the Head Start base, in accordance with the process described in the Head Start Act - specifically that no less than 4.5 percent of the funds be made available to Migrant and Seasonal Head Start programs and no less than 3 percent for American Indian/Alaska Native Head Start programs.

NHSA is pleased that the first round of Early Head Start-Child Care Partnership grants have been awarded, resulting in an additional 32,000 vulnerable infants and toddlers now able to access high quality early learning. NHSA encourages the Subcommittee to include \$500,000,000 in FY16 to continue to support this emerging program. Given the challenges expressed by providers in the field and the collective desire to expand access to high-quality programs immediately, NHSA encourages the keeping of the option that allows these funds to be available for straight Early Head Start expansion. Mandating or incentivizing only one model of service, such as the child care partnership, eliminates the opportunity for many providers to compete for these funds, especially in rural and frontier communities that have few available partner options. The grants, whether for expansion, conversion, or partnerships, should be awarded based on how effectively the model design fits the needs of the community in question, versus an adherence to a partnership model that may be inappropriate to that locality.

For 50 years Congress has supported Head Start on a bipartisan basis. Every dollar invested by the federal government should seek a high yield impact and be used accountably. I trust that my story is proof positive that Head Start delivers these very results in return for the taxpayers' investment.

Mr. COLE. First of all, I want to thank you very much for your testimony. Not quite a new member. I am a returning member.

Mr. MILLS. Returning member.

Mr. COLE. I used to sit where Mr. Rigell back when I first got on Approps, and it is wonderful to be back on this particular subcommittee, particularly with my good friend, the ranking member from Connecticut, who has done such yeoman's service here over so many years.

And just for the record, I want to say I couldn't agree with you more about Head Start. And thank you for your testimony. I know there must have been elements of that that are a little bit difficult, but it is compelling testimony because it does make exactly the point that you care to make.

And getting involved in children's lives early is a huge difference maker. So this has been a good program for many, many years and you are certainly a distinguished example of that. Thank you for bringing that to our attention.

Are there other questions or comments?

Ms. LEE. Yeah.

Mr. COLE. The gentelady from California.

Ms. LEE. Mr. Chairman, I just would like to first thank you and just say my former district director also is a graduate of Head Start. My district office ran very smoothly under his leadership.

And, Mr. Chairman, I think we talked earlier about how young African American boys are twice as likely to be expelled actually from Head Start than their White counterparts based on the studies that have been done in terms of expulsions and suspensions. And at some point, if we do a hearing or a forum on this, I am wondering if you would be willing to invite our witness back to talk about what factors could, at this point, lead to young 3- and 4-year olds being expelled, young Black boys being expelled at such an alarming rate from Head Start and from early childhood education programs.

Mr. COLE. I certainly would look forward to working with the gentelady on that. She has brought this issue up before, and it is an important issue. She is precisely right about this. So look forward to working with you, yes.

Mr. MILLS. My pleasure.

Ms. LEE. Thank you.

Mr. COLE. Gentelady from Connecticut.

Ms. DELAURO. Amen, Head Start. The founder of Head Start is a constituent, Dr. Ed Zigler, in New Haven, Connecticut. And it really is a foundational program for youngsters, as is all of preschool.

Mr. MILLS. Thank you.

Ms. DELAURO. And we need to increase the opportunity for it to all of our youngsters.

Thank you. Thank you for your testimony.

Mr. MILLS. My pleasure.

Mr. COLE. Thank you very much.

Mr. MILLS. Sure.

Mr. COLE. And next if we could go to—this is actually somebody that is an old friend of mine too, Dr. Pam Deering, who is the superintendent of schools in Midwest City, Oklahoma, a tireless advo-

cate for Impact Aid. But actually she is one half of one of our more distinguished families. Her husband recently finished a 30-odd-year career in the Oklahoma National Guard, but more importantly he was our adjutant general and now is our secretary for veterans affairs in Oklahoma.

So, Pam, great to have you here.

WEDNESDAY, APRIL 29, 2015.

MIDWEST CITY-DEL CITY PUBLIC SCHOOLS

WITNESS

PAM DEERING, SUPERINTENDENT, MIDWEST CITY-DEL CITY PUBLIC SCHOOLS

Ms. DEERING. Thank you, sir. It is great to be here this morning.

Thank you, Mr. Chairman, Ranking Member DeLauro, and members of the subcommittee. I appreciate the opportunity to testify before you in support of the Impact Aid program. Again, my name is Pam Deering. I am the superintendent of the Midwest City-Del City Public School in Midwest City, Oklahoma, the home of Tinker Air Force Base.

The 25 schools in Mid-Del schools serve 14,600 students; 2,275 of those students are federally connected. My students and my community depend on the continued financial support that is represented by the Impact Aid programs for the moneys that we receive in the place of property tax income for the Federal presence. For Mid-Del schools, the story of appropriations not keeping up is very evident from my school district.

The Impact Aid maximum payment level, based on the current formula, is \$2,900,000, but my district only receives \$600,000 of what is owed to the district. In 2010, the payment as a percentage of this maximum payment was 24.9 percent. In fiscal year 2012, the payment was 21 percent. In fiscal year 2015, the payment could be 18.7 percent, for a drop of 6.2 percent.

Lawton Public Schools, home of Fort Sill, the largest recipient of Impact Aid in the State, is facing the same losses. In fiscal year 2010, the payment as a percent of the maximum payment was 56.6 percent. In 2012, the final payment was 49.9 percent. In 2015, the final payment could be as low as 41.4 percent, for a drop of 15.2 percent for Lawton schools. The nationwide average between fiscal year 2010 and 2015 is approximately 9 percent.

Appropriations continue to slip each year as the cost of education increases, thus further reducing the amount owed to federally connected districts. How can we explain to our communities that the Federal Government is not paying its part and that, in turn, forces school districts to depend more heavily on a State or reduce programs and services when State resources fail as well.

In Mid-Del, we have worked to consolidate our expenses by closing three schools, combining two remodeled schools and into two new schools. We are doing our part to manage our resources, as are many school districts in the Impact Aid program. We understand that budget constraints are now a way of life at the local and State and Federal level. We must continue to urge Congress to continue funding the entire Impact Aid program.

We accept our responsibility for due diligence with our resources, making tough decisions that could mean losing teachers, closing buildings, and reducing programs to maintain just the basic education.

Expectations for education have increased. The public, according to most polls, supports its schools. But funding continues to lag behind, leaving dashed hopes for adding programs that prepare our students for the workforce of the future. The need, Mr. Chairman, is evident that Impact Aid payments must at a minimum be maintained when compared to the percentage of the maximum.

Both NCIS and NAFIS estimate that a 4 percent increase in basic support payments would put payments on a path that would bring the percentage of those payments to the maximum, almost back to where it was in 2010. The Impact Aid basic support program is funded at 55 percent of what is needed to fully fund the program.

We also request that you do not give any consideration to the administration's proposed budget that eliminates payments for Federal Property, Section 8002.

In closing, Congress must continue to meet its obligations to fund schools that have lost their tax base due to the Federal presence and who have additional students as a result of the Federal presence. We see it as an obligation and respectfully urge you to take the lead to support your federally connected schools and the over 900,000 federally collected students served.

Thank you very much.

[The information follows:]

Dr. Pam Deering, Superintendent
Midwest City-Del City Public Schools,
Home of Tinker Air Force Base
Midwest City, Oklahoma

April 29, 2015

Good Morning Chairman Cole, Ranking Member DeLauro and members of the Subcommittee.

My name is Pam Deering. I am the Superintendent of the Midwest City-Del City School District in Midwest City, Oklahoma. I also serve as the President of the National Council for Impacted Schools (NCIS). I have been in education for over 40 years as a special education teacher, Assistant State Superintendent for School Finance, District Deputy Superintendent for Human Resources and Finance, and now as the Superintendent. Impact Aid is critical to my school district and to the other 1,300 districts nationwide. My students and community depend on the continued financial support that is represented by the Impact Aid program for the monies that we receive in the place of property tax income for the federal presence. Our mission is clear—when students enter our schools they will be safe, challenged and ready! These monies ensure that our schools will continue to prepare our students for the world of work and as responsible citizens—the cornerstone of our democracy!

It is vitally important that this Subcommittee recognize the importance of Impact Aid for the 908,300 federally-connected students served and that Impact Aid must be a Congressional priority for the FY 16 funding levels.

Mid-Del Schools serve the men, women, and families of Tinker Air Force Base, located in the heart of Oklahoma. Today, I will speak specifically about the importance of Impact Aid in our community and in the State of Oklahoma. Many other school administrators, parents, and

teachers can tell their stories and document the need for Impact Aid funds and how vital the monies are to the education of our students. From a national perspective, school districts that have a federal presence, serve students on and around military installations, federal property and Indian lands. While most school districts receive property tax collections to support schools, our federally-connected schools must depend far more heavily on Impact Aid support that is there to replace those collections lost due to the federal presence in the communities. Inadequate resources continue to impede the progress that we strive to make for our students to achieve the 21st Century education that they deserve.

Oscar Rose, former Mid-Del Schools Superintendent, led the charge to Congress to create a federal funding source to act as an in lieu of tax to local school districts for lost revenue as a result of tax-exempt federal property and to assist schools with the impact of increased expenditures due to the enrollment of federally-connected children. In 1950, Congress recognized the need to accept this responsibility in these areas impacted by a federal presence by partnering with local taxpayers to help meet the local responsibility of financing public education. The program provides direct, flexible funding to the impacted school districts. Impact Aid funds a range of programs, including programs to retain highly qualified teachers, adequate technology, STEM initiatives, facilities renovation, and maintenance of transportation vehicles. For many school districts, Impact Aid is the one source that allows the school systems to remain operational.

Indian Land school districts face the same need for Impact Aid. They serve a Native American population of over 93%, often in rural areas, with fewer tax payers and where everyone “pitches in” to support the educational program—administer the schools, teach, drive buses

and coach just to name a few. For reservation districts, Impact Aid represents their “tax base” and they have virtually no other sources of income to support their educational programs.

Districts that have a diminished tax base due to the federal presence of grasslands, national parks, Army Corp of Engineer projects, and property encompasses the military academies also depend on Impact Aid. These Federal Land districts have faced an uphill battle in the Administration’s budget proposal that has eliminated the program for the past 4 years. This program is known as Section 8002 and supports those districts where the Federal government is often the largest landowner, thus reducing the school district’s tax base.

Military connected districts and their military families face challenges as they work through multiple deployments and transitions. School districts must be prepared to help these families and students academically and emotionally. Impact Aid funding is vital to maintain exemplary educational and support services for these families whose lives are devoted to serving our Country.

In Oklahoma, Tinker Air Force Base is the single largest employer. The base is named in honor of Oklahoma native, Major General Clarence Tinker, the first Native American Major General. The 25 schools in Mid-DeI serve 14,600 students; 2,275 that are federally-connected. Local support for all students in our District, whether federally connected or not, is funded at 19% collections from local property taxes. All of TAFB is exempt from these local property taxes. The Impact Aid maximum payment level based on the current formula is \$2.9M, but the district only receives \$600,000 of what is “owed” to the District.

This story of appropriations “not keeping up” is evident for my school district. In FY 2010, the payment as a percentage of the maximum payment was 24.9%. In FY 2012, the final payment was 21% of the maximum payment. In FY 2015, (using a 93% final LOT payout), the final payment would be 18.7% of the maximum for a 6.2% drop.

Lawton Public Schools, home of Ft. Sill, the largest recipient of Impact Aid in the State, is facing the same losses. In FY 2010, the payment as a percentage of the maximum payment was 56.6%. In FY 2012, the final payment was 49.9% of the maximum payment. In FY 2015, the final payment would be 41.4% of the maximum for a 15.2% drop. Nationwide the average percentage drop between FY 10 and FY 15 is approximately 9%.

Appropriations continue to slip each year as the cost of education increases, thus further reducing the amount “owed” to federally connected districts. How can we explain to our communities that the federal government is not paying its part, and that, in turn, forces school districts to depend more heavily on the State or reduce programs and services when State resources fail as well?

In Mid-Del, we have worked to consolidate our expenses by closing three schools and combining into two remodeled schools and two new schools. We are doing our part to manage our resources as are many school districts in the Impact Aid program. Reductions in Impact Aid payments from 24.9% to 18.7% since 2010 (keeping the maximum payment constant at \$2.9M), represents a loss of \$182,700!

While we understand that budget constraints are now a way of life at the local, state, and federal levels, we must continue to urge Congress to continue funding the entire Impact Aid program. We accept our responsibility for due diligence with our resources, making tough

decisions that could mean losing teachers, closing buildings, and reducing programs to just maintain a basic education. Telling people who work in these programs that the programs are closing and that they will lose their jobs or telling teachers that we cannot provide an aid in a class of 30 or more students or add another teacher have become frequent these days. Expectations for education have increased. The public, according to most polls supports its schools, but funding continues to lag behind, leaving dashed hopes for adding programs that prepare our students for the workforce of the future.

The need, Mr. Chairman, is evident that Impact Aid payments must, at a minimum, be maintained when compared to the percentage of the maximum. Both NCIS and NAFIS estimate that a 4% increase in Basic Support payments would put payments on a path that would bring the percentage of payments to maximum, almost back to where it was in 2010. We would also request that you do not give any consideration to the Administration's proposed budget that eliminates payments for Federal Property, Section 8002. There are 31 districts in Oklahoma that receive payments under this section of the law and most of them are small districts. In FY14, these districts received just over \$1.3M for an average payment of just \$42,000. While this may not be a large amount, to a district in Oklahoma it means a minimum of one teacher, textbooks, or school supplies.

In closing, Congress must continue to meet its obligation to fund schools that have lost their tax base due to the federal presence and who have additional students as a result of the federal presence that have special educational needs. We see it as an obligation and respectfully urge you to take the lead to support your federally-connected schools. They deserve your support. Thank you.

Mr. COLE. Thank you very much.

And just in full disclosure for the committee, not only is Dr. Deering an old friend, but the other military installation she mentioned, Fort Sill, is also in my district. They are the two largest employers. And we have 11 Indian tribes that also hold property that is exempt from local taxation. So it is a big problem for us, and we deal with it regularly.

But, Pam, good to see you here, and please give my regards to General Deering.

Ms. DEERING. I will. Thank you for that.

Mr. COLE. Secretary Deering. We don't know what to call him anymore, he has got so many titles.

Ms. DEERING. I don't either sometimes.

Mr. COLE. Okay. Any questions or comments?

Okay.

Ms. DEERING. Thank you, sir.

Mr. COLE. You bet.

Ms. DEERING. I appreciate that.

Mr. COLE. Good to see you.

If we can, next we have Dr. Lewis Mendelson, a clinical professor of pediatrics at the University of Connecticut.

And welcome. It is good to have you here.

WEDNESDAY, APRIL 29, 2015.

UNIVERSITY OF CONNECTICUT

WITNESS

LOUIS MENDELSON, MD, CLINICAL PROFESSOR OF PEDIATRICS, UNIVERSITY OF CONNECTICUT, ALLERGIST

Dr. MENDELSON. Thank you.

Good morning, Chairman Cole, Vice Chairman Womack, Ranking Member DeLauro, and Representative Lee. Thank you for this opportunity to testify today and for your recognition that antibiotic resistance requires strategic actions and investments from Congress and Federal agencies.

My name Lewis Mendelson. I have worked as an allergist in private practice in Connecticut for over 40 years, have been a professor at the University of Connecticut School of Medicine for 35 years. I have spent my professional life working with parents and patients facing severe allergies and been involved with penicillin allergy research since the 1970s.

As Congress begins to address the critical public health concern of antibiotic resistance, I would strongly urge you to play close attention to a relatively simple solution that is economical, proven, and available: Penicillin skin testing. Please do not commit the grave error of overlooking this very effective weapon for addressing this serious problem, in addition to also investing in research for new antibiotics.

The CDC reports that antibiotic resistance infections account for at least \$20,000,000,000 in excess direct health costs and up to an additional \$35,000,000,000 in lost productivity due to hospitalizations and sick days. There are an estimated 2 million illnesses and

23,000 deaths in the United States each year due to antibiotic resistance.

In this period of budget caps, sequestration, efforts to contain healthcare costs, especially in Medicare and Medicaid, the potential cost saving of successfully addressing antibiotic resistance are enormous. I urge you to direct the Centers for Disease Control and Prevention and other Federal health agencies to promote antibiotic stewardship that promotes penicillin allergy testing, including developing and sharing guidelines for appropriate antibiotic use and promoting public awareness about penicillin allergies and testing.

Antibiotic misuse, the unnecessary use of antibiotics, or the use of more powerful antibiotics than are necessary has enabled the rise of antibiotic resistance. An enormous contributor to this problem is the mislabeling of patients as allergic to penicillin. Ten percent of the population or 30 million people in the United States are medically categorized as penicillin allergic. However, when skin tested for penicillin allergies, about 90 percent of these 30 million are negative and can safely take this antibiotic.

The penicillin classes of antibiotics, such as amoxicillin and Augmentin, are very effective drugs to treat infections, are far more cost effective and generally safer with fewer side effects than the expensive broad-spectrum antibiotics and reduces the likelihood of contributing to antibiotic resistance.

There is a lack of awareness among physicians, public health officials, and policymakers about the critical value of penicillin skin testing. Neither the draft version of the 21st Century Cures bill to combat antibiotic resistance, nor the President's initiative on antibiotic resistance mentions penicillin allergy or testing.

Penicillin skin tests to rule out penicillin allergy were developed in the early 1970s, have been underutilized because all the tests have not been widely available for clinical use. The major purpose of my testimony today is to bring this important issue to the Congress' attention so this policy public health void can be remedied.

Along with my testimony, I have also submitted a letter from the American Academy of Asthma, Allergy and Immunology to the FDA, and I think they also wrote the members of this committee, also.

Efforts to make these essential penicillin allergy tests available for general use have been difficult. After years of unsuccessfully attempting to persuade the industry to produce these tests, my colleagues and I formed AllerQuest in 2005 to fill this void. In 2009, we brought back to market one of the penicillin tests and have been working for the past 4 years with the FDA to bring additional tests to the market. With the complete panel, the test accuracy rises from 70 to 90 percent to 98 percent accuracy.

I appreciate this committee does not have oversight of the FDA, but its role in addressing antibiotic resistance are crucial and important, along with the NIH, the CDC, and the Federal agencies that help develop clinical guidelines.

In summary, your leadership can enable researchers to investigate and bring to market essential drug allergy diagnostics as part of a plan to control antibiotic resistance and let practitioners know the need to test for penicillin allergy so that we can eliminate

antibiotic resistance as a major crisis facing public health and our economy.

I thank you.

[The information follows:]

Testimony of Louis Mendelson, M.D.
for the
Public and Outside Witness Hearing
before the
Subcommittee on Labor, Health and Human
Services, Education, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
April 29, 2015

Chairman Cole, Vice-Chairman Womack and Ranking Member DeLauro- thank you for the opportunity to testify today and for your recognition that antibiotic resistance requires strategic action and investments from Congress and federal agencies.

My name is Louis Mendelson. I have worked as an allergist in private practice in Connecticut for over 40 years, have been a professor at the University of Connecticut School of Medicine for 35 years, and have directed an allergy clinic at Connecticut Children's Medical Center for nearly 20 years. I have served as the President of the Connecticut Allergy Society and the New England Society of Allergy and on the Board of Directors of the American Academy of Allergy, Asthma & Immunology (AAAAI) and received leadership and distinguished clinician awards from AAAAI. I have spent my professional life working with patients and families facing severe allergies.

I am here today to talk to you about antibiotic resistance (AR) and urge the Labor, Health, Human Services (LHHS) and Education Appropriations Subcommittee and Congress to encourage the National Institutes of Health (NIH) to fund research and development for products to accurately diagnose patients with penicillin allergies. I also urge you to direct the Centers for Disease Control and Prevention (CDC) and other federal health agencies to promote awareness about penicillin allergy and skin testing to the public and medical professionals and to develop and disseminate best practice guidelines for penicillin testing and appropriate antibiotic use. Penicillin allergy testing is an existing and economical means to combat AR and significantly improve patient outcomes.

Antibiotic resistance is one of the most serious public health threats facing the world today. The CDC estimates that AR is responsible for 2 million illnesses and 23,000 deaths in the United States each year. Further, at least 240,000 Americans develop *C. difficile* infections each year as a consequence of antibiotic misuse. AR limits the ability to quickly and reliably treat bacterial infections, and the rise of resistance could hamper the ability to treat even common infections, such as strep throat and ear infections. Performing complicated medical procedures like surgery and dialysis could become life-threatening due to AR.

In terms of costs, the CDC reports that AR infections account for at least \$20 billion in excess direct health care costs and up to an additional \$35 billion in lost productivity due to hospitalizations and sick days each year. In this period of budget caps, sequestration, and efforts to contain health care costs, especially in Medicare and Medicaid, the potential cost savings of successfully addressing AR are enormous.

Antibiotic misuse--the unnecessary use of an antibiotic, or the use of a more powerful antibiotic than necessary--has enabled the rise of AR. An enormous contributor to this problem is the mislabeling of patients as allergic to penicillin. Thirty million people or--10% of the United States population--are medically categorized as allergic to penicillin, based on prior reactions, confusion of routine medication side effects for allergy symptoms, or inaccurate memory. When tested for penicillin allergy, however, about 90%% of those 30 million people test negative and can safely take penicillin without the risk of an acute allergic

reaction. Penicillin is a very effective drug to treat infections, and it is far more cost-effective and generally safer with fewer side effects than expensive broad-spectrum antibiotics.

In a recent publication by Macy et al. (Journal of Allergy and Clinical Immunology, 2014), the clinical experience of over 50,000 hospitalized patients with a history of penicillin allergy was studied. Patients categorized as penicillin allergic were more likely to receive broad-spectrum antibiotics and up to 30% more cases of antibiotic-resistant infections developed in those patients. Further, the average hospital stay was 0.6 days longer with an aggregate cost of \$65 million for patients categorized as penicillin allergic. If penicillin allergy skin tests had been used, these effects could have been mitigated in more than 90% of these patients, and more than 90% of the extra health system costs avoided.

Basic knowledge of penicillin skin testing to rule out penicillin allergy has been available since the early 1970's, but skin testing has unfortunately been significantly under-utilized. There is a lack of awareness among physicians, public health officials, and policy makers about the critical value of penicillin skin testing. Neither the previous Congress's version of Chairman Upton's and Representative DeGette's 21st Century Cures bill nor the President's initiative on antibiotic resistance mentions penicillin allergy and testing. The major purpose of my testimony today is to bring this important issue to the Congress's attention so that this omission can be remedied.

Since the 1970's, multiple studies have shown that five skin-testing reagents are needed to fully evaluate patients suspected to be penicillin allergic.

One of these reagents is commercially available in the United States, and efforts are underway to make the remaining four reagents commercially available.

When all of these reagents are approved by the Food and Drug Administration (FDA) and commercially available, testing can be accomplished more efficiently and more accurately, resulting in fewer mis-labeled penicillin allergies, reduced risk of AR, less costly patient care, and improved patient outcomes, as noted in the March 2015 Journal of Allergy and Clinical Immunology. Along with my testimony, I am also submitting a letter from AAAI to the FDA with this exact message. I appreciate that this committee does not fund the FDA, but the activities of the NIH, FDA, and CDC are all inter-linked, and coordination is essential to combat AR.

In 2005, two fellow allergists joined me and a pharmacologist to form AllerQuest LLC, because no pharmaceutical company was interested in bringing penicillin reagents to market for widespread clinical use. We have all been involved with penicillin allergy research since the 1970's. In 2009 AllerQuest brought back to market one of the penicillin testing reagents and has been working for the past three years with the FDA to bring the additional testing reagents to market to allow for a much more comprehensive penicillin allergy test. With the complete panel of penicillin skin-testing reagents, the test's accuracy rises from about 70-90% to about 98%. We are a very small company, though, and these efforts need to be executed on a far larger scale to reach the universe of 30 million patients categorized as penicillin allergic and to ensure that antibiotic resistance can be controlled and contained.

In summary, improved penicillin allergy diagnostics will make a significant impact on the incidence of antibiotic resistance in the approximately 27 million patients incorrectly categorized as penicillin allergic in the United States and enable the broader use of a safe, effective antibiotic, penicillin. Again, I urge Labor HHS and Congress to invest in effective and efficient ways to approach this serious problem with a focus on funding research and development for antibiotic allergy diagnostics in order to accurately diagnose patients with penicillin allergy. I also urge you to direct the Centers for Disease Control and Prevention and other federal health agencies to promote antibiotic stewardship, including sharing guidelines for appropriate antibiotic use and promoting public awareness about penicillin allergy and testing. Your leadership can enable researchers and companies to investigate and bring to market essential penicillin allergy diagnostics as part of any plan to control antibiotic resistance.

Thank you.

Mr. COLE. Thank you very much. I appreciate your testimony. Are there any questions or comments?

Gentlelady is recognized.

Ms. DELAURO. I want to just welcome you, Dr. Mendelson. Thank you. It is wonderful to see you here. Thank you for your wonderful years of practice and of research in these critical areas and the work that you have done with the Children's Medical Center.

Dr. MENDELSON. Thank you.

Ms. DELAURO. Really very, very grateful.

I do have a quick question. The other subcommittee that I serve on with Appropriations is the Agriculture Subcommittee, which does have jurisdiction over the FDA. I would like to pursue—because I know we are short of time this morning—pursue with you why it is that we aren't looking into the penicillin allergy testing and what seems to be the reluctance to do that. So we should be in touch and let's go for it.

Dr. MENDELSON. I welcome your assistance.

Ms. DELAURO. Okay. Thank you.

Thank you, Mr. Chairman.

Mr. COLE. Okay. Thank you very much. You bet.

Dr. MENDELSON. Thank you.

Mr. COLE. If we could, we will next move to Mr. Ryley Williams from the American Heart Association. I am going to defer to my friend from Arkansas, who has an introduction that he would like to make. It is a young man he knows well.

So welcome.

WEDNESDAY, APRIL 29, 2015.

AMERICAN HEART ASSOCIATION

WITNESS

RYLEY WILLIAMS

Mr. WOMACK. Thank you. Thank you, Mr. Chairman.

It is a source of immense pride and joy that I have an opportunity to introduce this next witness. And maybe for a little bit of background, less than 2 years ago, on the 8th of July, 2013, it was a normal football practice for this young man as a promising young sophomore, was warming up, getting ready for the demands of a hot summer football exercise and collapsed. And not to go through his entire story, but suffered a series of strokes that was caused by a condition, I guess—and, Ryley, you will have to correct me if I get all this wrong—endocarditis, which is a bacterial infection in the bloodstream that sent a number of embolisms to the brain, caused this young man a great hardship in his life.

But he has, Mr. Chairman, has made a remarkable recovery and is involved in a lot of things, to include finding a way to help his football team win the state championship this year after starting 0–4.

Mr. WILLIAMS. Yes, sir.

Mr. WOMACK. And I am so proud of this young man. He is joined today by his mother, Terri Rose. And he is an outstanding spokesman for the American Heart Association.

And, Ryley, I want you to know how much I love you. You are one of my heroes. And I am so excited to have you before our committee here this morning.

Mr. WILLIAMS. Thank you, sir.

Mr. COLE. I can assure you, I have never heard Mr. Womack so effusive about anybody. He is usually a pretty tough colonel, National Guard service. But, Mr. Williams, you are recognized. It is a pleasure to have you here.

Mr. WILLIAMS. Thank you.

Ms. ROSE. I am Terri Rose or better known as the mother of Ryley Williams, my son, a 16-year-old stroke survivor. Because Ryley is still now suffering from controlled seizures from his strokes and his speech is still improving from the aphasia from the strokes, in light of the committee's time limit, I am going to read most of his statement, but Ryley will share with you the last part of his remarks.

On July 8, 2013, his life was changed forever. Ryley collapsed during warm-up exercises at sophomore football practice. He was rushed to the ER at Northwest Medical in Bentonville, Arkansas, and then air flighted to Arkansas Children's Hospital in Little Rock. He had suffered multiple strokes, and we found out it was up to five strokes actually. He could not speak or move the right side of his body. At the time, he was 15 years old and in the best shape of his life.

In an emergency surgery, a portion of his skull was removed to relieve the terrible swelling from the multiple strokes, and this surgery saved his life. The transesophageal echocardiogram showed a bacterial infection, and he was diagnosed with a heart valve infection. For 6 weeks, Ryley took by IV a variety of strong antibiotics to fight the infection. He broke all expectations and predictions from the stroke damage.

In the rehab unit, he was still eating through a feeding tube in his nose and could not sit up or move on his own. Doctors speculated that he might only get part of his right side working again. But gradually and in leaps and bounds, he started fighting to get his life back, beginning with talking, swallowing, moving, use of his arm and leg, and eventually sitting up and standing. After 3 weeks in rehab, Ryley took his first steps with the help of a walking machine and several physical therapists.

Next, he was transferred to a residential rehab hospital closer to our home and started daily physical occupational and speech therapy. After another 3 weeks, he was able to come home. During his 7 weeks in the hospital the doctor broke the news of devastation to him that he would never play football ever again or any other contact sport.

In November 2013, we returned to the hospital for his final surgery to replace the missing piece of skull with a prosthetic piece. Again, he fought the odds and went home after only 2 days and never lost any of his progress.

In January 2014, Ryley went back to school with daily physical, occupational, and speech therapies, and trying out his new role as a student athletic trainer.

It has been almost 2 years since his stroke, and it has been a very tough journey, physically and emotionally, for him. It has

been very hard for him to accept his new limitations and lifestyle, but he tells the other stroke survivors not to give up. Ryley likes to say even tiny progress is progress and it is further than you were a week ago.

It has been especially tough for Ryley to see his friends moving on with their lives when he is just fighting to run, ride a bike, or play video games. This will all happen again, just not as quickly as he wishes and that is okay.

During his recovery, Ryley celebrated his 16th birthday, but he won't able to drive for another year or so because of the seizures that are normal, along with the strokes, should be controlled by his daily medications. We are just thankful that he is alive and still on earth to help others that have been through what he has been through.

The reason we are here is Ryley and I are very aware the NIH invests only 4 percent of its budget on heart research, and shockingly only a mere 1 percent on stroke research. Americans deserve better.

Mr. WILLIAMS. Please do not forget me or other young people like me who depend on funding vital NIH. Like you, we want to live long, productive lives. Thank you.

[The information follows:]

**STATEMENT BY AMERICAN HEART ASSOCIATION
RYLEY WILLIAMS, VOLUNTEER AND STROKE SURVIVOR**

FY 2016 LABOR-HHS-EDUCATION APPROPRIATIONS: NIH, CDC, HRSA

Remarkable strides have been made in the prevention and treatment of cardiovascular disease (CVD) and stroke. However, we must face the hard truth. There is still no cure for America's No. 1 and most costly killer. CVD costs nearly \$1 billion a day. Stroke is our No. 5 killer and second leading cause of dementia.

Today, nearly 86 million U.S. adults suffer from some form of CVD and those grim statistics will only get worse. It is projected that by the year 2030, nearly 44% of U.S. adults will live with CVD at a cost exceeding \$1 trillion annually. Yet inexplicably, CVD research, prevention, and treatment remain disproportionately underfunded with no sustained and stable funding from the National Institutes of Health. Therefore, we emphasize that robust NIH-funded research is vital for a continuing and effective campaign against these deadly and debilitating diseases.

The American Heart Association recognizes the challenges our nation and Congress face to reduce the budget deficit. However, sequestration is not, and never is the answer. These cuts put at grave risk the health of tens of millions of CVD sufferers, stifle economic growth, and jeopardize our global leadership in medical research. We therefore challenge Congress to appropriate stable and sustained funding for CVD research, prevention, and treatment. Moreover, during the upcoming debate on funding, Congress should recognize that NIH-funded research has a proven return on investment. It drives economic growth, including good, high-paying jobs,

stimulates innovation, and maintains America's time-honored leadership in medical research—something that is now under threat with the current budget constraints on the NIH.

FUNDING RECOMMENDATIONS: INVESTING IN THE HEALTH OF OUR NATION

It comes down to this. Research that could move us closer to a cure for cardiovascular disease and stroke goes unfunded. Congress must capitalize on 50 years of progress or our nation will pay more in lives lost and health care costs. Our recommendations tackle these issues in a fiscally responsible way.

Capitalize on Investment for the National Institutes of Health (NIH)

Robust NIH-funded research helps prevent and cure disease, transforms patient care, stimulates economic growth, fosters innovation, and maintains U.S. leadership in pharmaceuticals and biotechnology. NIH is the world's leader of basic research—the foundation for all medical advances—and an essential Federal government function that the private sector cannot ever replace. But, our country's competitive edge in scientific research has been eroded in recent years by scarce funding.

In addition to improving health, NIH generates a solid return on investment. In FY 2012, NIH supported 400,000 U.S. jobs and created about \$60 billion in new economic activity. Every \$1 in NIH funding created \$2 in economic activity in 2007. Yet, due to scarce resources over the past decade, NIH lost more than 20% of its purchasing power. Sadly, this decline occurred at a time of unprecedented scientific opportunity as other countries wisely increased investment in science—some by double digits. These cuts have disheartened early U.S. career investigators who may decide against pursuing a career in research unless Congress takes action.

American Heart Association Advocates: We urge Congress to appropriate \$33 billion for NIH to begin to restore its purchasing power, and advance cardiovascular disease research.

Enhance Funding for NIH Heart and Stroke Research: A Proven and Wise Investment

NIH research plays a pivotal role in reducing CVD death rates. Today, scientists are close to discoveries that could result in revolutionary treatments and even cures. In addition to saving lives, NIH studies are economical. For example, investments in the NIH Women's Health Initiative postmenopausal estrogen plus progestin trial generated a total economic return of \$140 for every \$1 invested in the trial and led to 76,000 fewer cases of cardiovascular disease. The first NIH tPA drug trial led to a 10-year net \$6.47 billion reduction in stroke care costs.

Cardiovascular Disease Research: National Heart, Lung, and Blood Institute (NHLBI)

Much of the decline in cardiovascular disease death rates is a result of NHLBI-funded research. However, this begs the question, "Why has NHLBI extramural heart research fallen 17% in constant dollars since 2002?" Stable and sustained NHLBI funding remains key to building on investments that have led to major advances. Look at losartan as an alternative treatment for Marfan syndrome; the identification of loss of-function apolipoprotein C3 gene changes as a potential therapy for cutting heart disease risk; the use of nanoparticles to cut atherosclerotic plaque inflammation; and cells from human induced pluripotent stem cells to fix damaged heart tissue. Sustained funding will allow the NHLBI to implement its bold strategic vision.

Stroke Research: National Institute of Neurological Disorders and Stroke (NINDS)

An estimated 795,000 Americans will suffer a stroke this year and nearly 129,000 will die from one. Many of the 7 million survivors deal with grave physical, mental, and emotional distress. In

addition, stroke costs an estimated \$34 billion in medical expenses and lost productivity each year and a recent study projects that direct costs of stroke will triple between 2010 and 2030.

Stable and sustained NINDS funding is vital to building on stroke advances, including research showing that a stent system removes clots in large blood vessels to stop stroke damage. More resources could also help improve stroke recovery; boost NIH Stroke Trials Network; hasten translation of preclinical animal models into clinical studies; prevent vascular cognitive damage; expedite comparative effectiveness research trials; develop imaging biomarkers; refine clot-busting treatments; achieve robust brain protection; and promote the use of neural interface devices. Additional funding is also needed to support the BRAIN Initiative.

American Heart Association Advocates: We recommend that NHLBI be funded at \$3.3 billion and NINDS at \$1.8 billion.

Increase Funding for the Centers for Disease Control and Prevention (CDC)

Prevention is the best way to protect us from the physical and fiscal ravages of heart disease and stroke. Yet, proven efforts are not fully executed due to scarce funds. We thank Congress for retaining in P.L. 113-203 the needed boost for the Division for Heart Disease and Stroke Prevention. In addition to funding research and evaluation and developing a surveillance system, the DHDSP directs Sodium Reduction in Communities and the Paul Coverdell National Acute Stroke Registry. DHDSP and the Centers for Medicare and Medicaid Services are promoting the Million Hearts™ initiative aimed at stopping 1 million heart attacks and strokes by 2017. DHDSP runs WISEWOMAN, serving uninsured and under-insured, low-income women ages 40 to 64. It helps

them from becoming heart disease and stroke statistics through preventive health services, referrals to local health care, and tailored lifestyle plans to foster lasting behavioral change.

American Heart Association Advocates: We join the CDC Coalition in asking for \$7.8 billion for CDC’s program level. AHA requests \$130.037 million for the DHDSP to intensify work on the State Public Health Actions and on the State and Local Public Health Actions To Prevent Obesity, Diabetes, Heart Disease, and Stroke; and \$37 million for WISEWOMAN. We ask for \$5 million for Million Hearts™ to better control blood pressure—a “silent killer” of Americans.

Restore Funding for Rural and Community Access to Emergency Devices (AED) Program

About 90% of cardiac arrest victims die outside of a hospital. Yet, early CPR and use of an AED can more than double survival. Communities with full AED programs have survival rates near 40%. HRSA’s Rural and Community AED Program awards competitive grants to states to buy AEDs, tactically place them, and train lay rescuers and first responders in their use. As a result of this program, nearly 800 patients were saved from August 1, 2009 to July 31, 2010. But scarce resources allow only 19% of approved applicants in 6 states to receive funds in FY 2014.

American Heart Association Advocates: We advocate for an \$8.927 million appropriation for PHS Act sections 413 and 313, returning the program to FY 2005 levels with 47 funded states.

CONCLUSION

Cardiovascular disease, including stroke, still inflict a staggering physical and economic toll on the American people. Our recommendations for NIH, CDC, and HRSA will save lives and reduce health care costs. We respectfully ask the Committee to endorse our recommendations that are a wise investment for our great nation and the well-being of this and future generations.

Mr. COLE. Thank you very much.

Not too proud, are you, Mom?

It is a pleasure to have both of you here, and it is an inspiring personal story. I can understand why my friend from Arkansas is so effusive. So congratulations on fighting so hard and coming so far.

Any other comments or questions?

Ms. DELAURO. Just give us a tremendous honor to have you here today. Thank you.

Mr. WILLIAMS. Thank you.

Ms. DELAURO. And you know we are rooting for you.

Mr. WILLIAMS. Thank you.

Ms. DELAURO. Thank you, Mom.

Mr. COLE. Gentleman care to say something in closing?

Mr. WOMACK. I just have an enormous amount of pride in counting Ryley as one of my great friends. And he is engaged in a lot of things, but his work, they were 0-4 when they started, and Ryley and I had a conversation up here about the struggles that the Bentonville football team was having. And, by the way, one of those teams was from Broken Arrow that beat them early.

But I know—but I know—that it was Ryley Williams' influence on his teammates that helped that team find itself early in that season and reel off eight straight victories and claim the state championship in Arkansas. I cannot tell you how proud I am of this young man, and I look forward to seeing him every chance I get.

Mr. COLE. If you can turn around an 0-4 football team, when it comes times for college, we want you to think seriously about the University of Oklahoma.

Ms. LEE. Mr. Chairman.

Mr. COLE. Because we were 8-5 last year, and we could use some help.

Ms. LEE. Yeah. Let me just say—

Mr. COLE. Recognize the gentlelady.

Ms. LEE. First of all, Ryley, you give us a lot of hope, a lot of inspiration, and you remind us why we are here and that the impact of our decisions here affect real lives. And so thank you for that reminder.

Mr. WILLIAMS. Thank you.

Ms. LEE. Good to meet you.

Mr. COLE. We appreciate both of you for being here and testifying.

If we can, now we will move to Dr. Robert Anderson, director of vision research at the University of Oklahoma Health Sciences Center.

Dr. Anderson, good to see you.

WEDNESDAY, APRIL 29, 2015.

**UNIVERSITY OF OKLAHOMA HEALTH SCIENCES
CENTER**

WITNESS

DR. ROBERT ANDERSON, DIRECTOR OF VISION RESEARCH, UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER

Dr. ANDERSON. Good to see you, sir.

Mr. COLE. That is a tough act to follow.

Dr. ANDERSON. It really is. I am usually in these situations.

Thank you, Mr. Chairman and members of the subcommittee, for the opportunity to appear today and testify on behalf of NIH's institutional development award or IDeA Program. My name is Robert Eugene Anderson. I am professor of cell biology, ophthalmology, and geriatric medicine at the University of Oklahoma Health Sciences Center in Oklahoma City and director of research at the Dean McGee Eye Institute. My comments represent the views of the University of Oklahoma Health Sciences Center, the Dean McGee Eye Institute, and the Coalition of EPSCoR/IDeA States.

IDeA, authorized by the 1993 NIH Revitalization Act, improves biomedical research in 23 States and Puerto Rico. The program has had a tremendous impact on the State of Oklahoma. Since 2000, Oklahoma has received more than \$278,000,000 in IDeA funds, which enabled our researchers to secure NIH grants and more than double the amount of NIH funding coming into the State. Even more impressive is the staggering \$1,100,000,000 economic impact of the IDeA Program in Oklahoma.

The three main components of IDeA are Centers of Biomedical Research Excellence, or COBRE awards, the IDeA Networks of Biomedical Research Excellence, or INBRE awards, and the IDeA Clinical and Translational Research, or IDeA-CTR awards.

COBRE's are multidisciplinary centers led by an established senior investigator that increase the pool of well-trained investigators in the IDeA States by providing multiyear direct research support for young investigators, core laboratories to support their research programs, and mentoring by senior faculty. Oklahoma has seven COBRE awards currently and has received 11 awards since 2000, totaling \$192,000,000.

The INBRE program introduces outstanding students at primarily undergraduate institutions to the wonders and beauty of science and prepares them for graduate school and careers in biomedical sciences. It also improves their science faculty through research-intensive networking with other institutions. This program is especially important to those schools where a majority of the students are underrepresented minorities. Oklahoma has one current \$66,200,000 INBRE award.

The IDeA-CTR program mentors and trains young clinician scientists in clinical and translational research, a key step in moving basic science discoveries into clinical treatments. Another of its goals is to reduce health disparities in underserved and understudied population and enhance best medical practices in rural areas. Oklahoma has one current \$20,300,000 IDeA-CTR award.

I would like to describe my own personal involvement with the IDeA Program as the lead principal investigator for a COBRE project entitled "Mentoring Vision Research in Oklahoma." This grant significantly improved the quality and quantity of eye disease-related basic research in Oklahoma and far exceeded the goal of developing a new generation of NIH-funded independent scientists.

In this program, seven young investigators, supported by \$8,200,000 of the Vision COBRE have so far—and they are still

young—successfully competed for over \$30,000,000 in research funding, mostly from the NIH. This is not unique for our COBRE program. COBRE programs across all of the IDeA States will have similar success stories.

In our program, all seven have received and maintained NIH RO1 funding, the gold standard by which research funding is measured. Of the seven, only two were on a tenure track career path. Now, all are tenure track, five are tenured, and four have endowed chairs professorships. NIH's investment in Vision Research COBRE led to the creation of new knowledge and the translation of that knowledge to better treat and prevent debilitating and blinding eye diseases, which benefits all of the people in Oklahoma, the Nation, and the world.

In conclusion, I want to thank this subcommittee for your efforts over the years to provide increased funding for IDeA, and especially for the successful inclusion of a \$50,000,000 increase for the program in fiscal year 2012. The Coalition of EPSCoR/IDeA States respectfully requests that IDeA be funded at \$310,000,000 in fiscal year 2016, which constitutes just 1 percent of the total fiscal year 2016 budget request for NIH. Please continue to invest in the IDeA Program. It pays huge dividends for all of the programs in the IDeA States.

Thank you very much.

[The information follows:]

Statement of

**Robert Eugene Anderson, MD, PhD
Professor of Ophthalmology and Cell Biology
University of Oklahoma Health Sciences Center**

April 29, 2015

Mr. Chairman and Members of the Subcommittee; thank you for the opportunity to submit this statement regarding FY 2016 funding for the National Institutes of Health's Institutional Development Award or "IDeA" Program. My name is Robert Eugene Anderson. I am Professor of Cell Biology, Ophthalmology, and Geriatric Medicine at the University of Oklahoma Health Sciences Center in Oklahoma City. The IDeA program is funded by NIH's National Institute of General Medical Sciences (NIGMS), and was authorized by the 1993 NIH Revitalization Act (P.L. 103-43). I submit this testimony on behalf of the University of Oklahoma Health Sciences Center (OUHSC) and the Coalition of EPSCoR/IDeA States¹. The Coalition of EPSCoR/IDeA States respectfully requests that the Subcommittee provide \$310 million for the IDeA program in FY 2016.

The IDeA program increases our nation's biomedical research capability by improving research in states that have historically been less successful in obtaining biomedical research funds. Twenty-three states and Puerto Rico are eligible. The program funds only merit-based, peer-reviewed research that meets NIH's biomedical research objectives. While IDeA was authorized by the 1993 NIH Revitalization Act (P.L. 103-43), sizable increases in funding only began in FY 2000. The IDeA program then grew rapidly, due in large part to the thoughtful actions of this Subcommittee. Funding increases permitted the launch of two key program

¹ Alabama, Alaska, Arkansas, Delaware, Guam, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Puerto Rico, Rhode Island, South Carolina, South Dakota, Vermont, Virgin Islands, West Virginia, and Wyoming

States in **bold** letters are eligible for the IDeA program. All of the states listed above are also eligible for the EPSCoR program.

elements: the COBRE and the BRIN/INBRE programs. The COBRE program or “Centers of Biomedical Research Excellence,” are research clusters targeting specific biomedical research problems. The COBRE program is designed to increase the pool of well-trained investigators in the IDeA states by expanding research facilities, equipping laboratories with the latest research equipment, providing mentoring for promising candidates, and developing research faculty through support of a targeted multi-disciplinary center, led by an established, senior investigator with expertise in the research focus area of the center.

The BRIN or “Biomedical Research Infrastructure Networks,” targeted key areas such as bioinformatics and genomics, and facilitated the development of cooperative networks between research-intensive universities and primarily undergraduate colleges. The BRIN grants underwent competitive renewals in 2004 and were funded under the new name of “IDeA Networks of Biomedical Research Excellence,” or INBRE. The INBRE programs are designed to increase the pipeline of outstanding students, enhance the quality of science faculty in the IDeA states by research-intensive networking with undergraduate institutions, support research infrastructure and mentoring of young investigators, and finally, prepare students for graduate and professional schools as well as careers in the biomedical sciences.

Finally, the IDeA program has established a third mechanism named the IDeA-Clinical and Translational Research (IDeA-CTR) program. This program encourages and supports IDeA states to develop infrastructure for mentoring and training young clinician scientists to do clinical and translational research, which is a key step in moving basic science discoveries forward into clinical treatments.

Impact of the IDeA Program on Oklahoma. Since the year 2000, Oklahoma has received more than \$278 million in awards from the IDeA program. Oklahoma has seven

COBRE awards currently and has received 11 awards since 2000 totaling \$192 million. Oklahoma also has a current INBRE award totaling \$66.2 million and a current IDeA-CTR award totaling \$20.3 million. These IDeA investments have greatly enabled our researchers to secure National Institutes of Health grants and more than double the amount of NIH funding coming into Oklahoma. Even more impressive is the economic impact of the IDeA program in Oklahoma as it has had a staggering \$1.11 billion economic impact in the State.²

The COBRE, INBRE and IDeA-CTR programs generate, complement, and enrich Oklahoma's research strengths by leveraging NIH investment in personnel, equipment, core facilities and student programs to solve health problems, build research capacity, and build a better student pipeline for the next generation of physicians, healthcare workers, and scientists. The IDeA program increases Science, Technology, Engineering and Mathematics (STEM) degrees in Oklahoma through literally thousands of teacher and student interactions every year through INBRE-funded activities and is essential to building the necessary infrastructure for junior clinical and research investigators to launch their careers. Clinical and translational research supported by the Oklahoma Shared Clinical and Translational Research (OSCTR) program seeks to reduce health disparities in underserved and understudied populations as well as enhance best practices in rural communities.

The IDeA program has contributed to building a skilled workforce in Oklahoma by producing scientists, educators, and healthcare workers for Oklahoma and the entire country by leading biotechnology program development in the State, and by working with tribal groups to train health care workers to improve healthcare for Oklahoma tribes. Furthermore, the contributions of the IDeA program to overall public health in Oklahoma have also been

² •Batelle Technology Partnership Practice study estimated \$2.24 economic impact per \$1 of NIH funding.

significant and include participation as a lead institution in the National Cancer Institute's (NCI) National Clinical Trials Network, a \$6 million award that our Cancer Center was recently awarded. A COBRE award led by one of our Cancer Center investigators also is helping us to be more competitive as we aim to achieve NCI Cancer Center Designation. Improving health and healthcare for underserved and underrepresented populations and for all citizens through clinical and translational research; and leveraging a \$14.9 M award from the Agency for Healthcare Research and Quality to disseminate best practices to reduce cardiovascular disease through a partnership with 300 physicians and clinics throughout Oklahoma.

I would like to describe for you my own personal involvement with the IDeA programs as the lead Principal Investigator for a COBRE grant at the University of Oklahoma Health Sciences Center, entitled "Mentoring Vision Research in Oklahoma". The Vision Research COBRE grant, which expired in 2013, significantly improved and enhanced both the quality and quantity of vision-related fundamental research in Oklahoma. The project more than exceeded the goal of developing a new generation of NIH-funded independent principal investigators. One of the goals of the IDeA program is for PIs supported by IDeA funding to compete successfully for mainstream NIH funding. Seven PIs supported under the Vision Research COBRE by \$8,397,345 in COBRE funding have successfully competed for another \$30,253,225 million in research funding, mostly from the NIH. All seven have received and maintained NIH R01 funding, the "gold standard" by which research funding is measured. Of the seven, only two were on a tenure track career path. Now all are tenure track, five are tenured, and four have endowed chairs/professorships. COBRE programs in all eligible states have similar stories of success in launching the research careers of outstanding young scientists. The NIH investment in the Vision Research COBRE has contributed to enhanced knowledge and the translation of that

knowledge to better treat and prevent debilitating and blinding eye diseases, which benefits all of the people in Oklahoma, the nation, and the world. Additionally, the nature of the problems investigated under the Vision Research COBRE and using the eye as a model of disease, made much of our research immediately applicable to more generalized areas such as neurodegeneration, cancer, gene therapy, and pathogenesis of bacterial infectious diseases, to name only a few. Thus, in addition to intrinsic benefits to vision science, the collateral impact of the Vision Research is substantial.

Conclusion

We request that this Subcommittee recommend the program be funded in FY 2016 at \$310 million, which constitutes just 1% of the total FY 2016 Budget Request for NIH. This level of funding would continue funding for COBRE, INBRE, and IDeA-CTR programs. I want to express my gratitude to this Subcommittee for the efforts it has made over the years to provide increased funding for IDeA, in particular this committee's recommendations under former Chairman Dennis Rehberg to increase IDeA program funding by \$100 million and for the successful inclusion of a \$50 million increase for the program in FY 2012. I hope that you will continue to invest in this biomedical research program, which is so important to almost half of the states in the Union. Every region of the country has talent, expertise, and unique patient populations that can contribute to our nation's biomedical research efforts – and every region of the country must participate if we are to increase our nation's biomedical research capacity substantially. On behalf of the EPSCoR/IDeA Coalition, the University of Oklahoma Health Sciences Center and our partner institutions across Oklahoma, I thank the Subcommittee for the opportunity to submit this testimony.

Mr. COLE. Dr. Anderson, thank you very much.

Do we have any questions or comments?

Okay. Thanks again. Appreciate it.

If we can, we will go to Mr. Shan Lewis, president, the Inter Tribal Association of Arizona.

Welcome.

WEDNESDAY, APRIL 29, 2015.

INTER TRIBAL ASSOCIATION OF ARIZONA

WITNESS

SHAN LEWIS, PRESIDENT, INTER TRIBAL ASSOCIATION OF ARIZONA

Mr. LEWIS. Thank you.

Good morning, Chairman Cole, Ranking Member DeLauro, and distinguished members of the committee. My name is Shan Lewis. I am the vice chairman of the Fort Mojave Indian Tribe. I serve as president of Inter Tribal Association of Arizona, which represents 21 federally recognized tribes located in the State of Arizona and whose lands extend to the States of California, Nevada, New Mexico, and Utah.

On behalf of the association, I speak on the urgent need to restore appropriations in the amount of \$7,500,000 to the Community Services Block Grant/Rural Community Development program, or RCD program, at the U.S. Department of Health and Human Services.

Since 1983, tribes throughout the country have relied on the public health workforce programs funded by the multiyear RCD grant program. Although there continues to be significant measurable benefits from and a strong need for the RCD program, funding for this program was zeroed out in the President's fiscal year 2016 budget.

The RCD program is a lifeline for tribal communities nationwide because it is a primary source of funding for tribally led certification training and technical assistance services for water and wastewater operators. These services are vitally needed to ensure that tribal personnel have the knowledge and skills to safely operate and maintain drinking water and wastewater systems on tribal lands.

While States have funding available under the EPA Drinking Water and Clean Water State Revolving Funds for their operator certification training program, the associated tribal set-aside is statutorily restricted. There is not a similar source of funding for tribal operators working in Indian country. Tribes have turned to RCD program to help fill this gap.

The rural poverty-stricken conditions in Indian country commonly manifest in the form of inadequate drinking water and sanitation facilities. Federal agencies annually spend hundreds of millions of dollars on construction of water and wastewater systems attempting to improve access to safe drinking water and sanitation on tribal lands. Yet, building infrastructure is only part of the solution. Once constructed, these systems require ongoing operations

and maintenance by trained and certified personnel and the return of our taxpayers' investments in these systems to be fully realized.

In addition, small public water systems in Indian country are disproportionately suffering from noncompliance with Safe Drinking Water Act standards when compared to nontribal counterparts. Certification designates that water and wastewater system operators is a public health professional. The industry has a saying: You go to the doctor when you are sick, but water and wastewater operators are working frontlines 24/7 to prevent you from getting sick.

In order to ensure continued health and safety of tribal communities, it is critical that tribes have trained and certified professionals from their own communities who are dedicated to operating and maintaining their own water and wastewater system. Tribes that employ or contract State-certified water operators often high turnover rates and a lack of operational continuity. State certification programs are generally not aligned with the jurisdictional framework that exists on tribal lands.

These important points were overlooked in the HHS fiscal year 2016 budget justification, which rationalized zeroing out the RCD program based upon the misconception that the services funded by RCD program are duplicative of other agencies, such as EPA. This is simply incorrect when it comes to tribal needs.

Safe drinking water and adequate sanitation are fundamental to the economic success and viability of all tribal communities, just as it is for neighboring nontribal communities. These needs cannot be met without having certified professional tribal operators dedicated to working on their own tribal communities.

The RCD program is a primary source of funding for these tribal certification and training services. The loss of the RCD funds would dangerously undermine the future of safe water and sanitation in Indian country.

On behalf of the Inter Tribal Association of Arizona and tribes across the United States, we urge that you restore appropriations of \$7,500,000 to the HHS Rural Community Development program.

Mr. Chairman, I request to submit for the record the National Congress of American Indians resolution which supports this testimony.

Thank you for this opportunity to present this testimony.

[The information follows:]

Testimony for the Record by

Shan Lewis

**President of the Inter Tribal Association of Arizona
and Vice Chairman of the Fort Mojave Indian Tribe**

**APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, EDUCATION, AND RELATED AGENCIES
U.S. HOUSE OF REPRESENTATIVES**

**CONTINUED APPROPRIATIONS FOR THE
HEALTH AND HUMAN SERVICES--RURAL COMMUNITY DEVELOPMENT
(RCD) FUNDING PROGRAM**

**Public Witnesses Hearing
Washington, D.C.**

April 29, 2015

On behalf of its 21 Member Tribes located within the state of Arizona and whose lands extend into the states of California, Nevada, New Mexico, and Utah,¹ the Inter Tribal Association of Arizona (ITAA) appreciates this opportunity to provide testimony to the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies on the urgent need to restore \$7.5 Million in appropriations to the Community Services Block Grant/Rural Community Development program at the U.S. Department of Health and Human Services (HHS). Since 1983, ITAA Member Tribes, and tribes throughout the country, have relied on the public health workforce capacity development programs funded by the multi-year Rural Community Development (RCD) grant program of the HHS—Administration for

¹ The Members of the ITAA are the Ak-Chin Indian Community, Cocopah Indian Tribe, Colorado River Indian Tribes, Fort McDowell Yavapai Nation, Fort Mojave Indian Tribe, Gila River Indian Community, Havasupai Tribe, Hopi Tribe, Hualapai Tribe, Kaibab Band of Paiute Indians, Pascua Yaqui Tribe, Pueblo of Zuni, Quechan Tribe, Salt River Pima-Maricopa Indian Community, San Carlos Apache Tribe, San Juan Southern Paiute Tribe, Tohono O'odham Nation, Tonto Apache Tribe, White Mountain Apache Tribe, Yavapai-Apache Nation, and the Yavapai-Prescott Indian Community.

Children and Families. Although there continues to be a strong need for the RCD program and, in particular, the vital tribal water operator certification programs it has supported for 30-years, funding for the program was zeroed out in the President's FY 2016 budget. ITAA urges that this funding be restored.

The human health, economic well-being and self-determination of tribal communities throughout the Nation are directly dependent on the services that are funded by the RCD program. The RCD program is a life-line for tribal communities nationwide because it is the primary source of funding for tribally-led certification programs and related activities that are desperately needed to ensure that tribal personnel have the knowledge, skills, and abilities to safely operate and maintain tribal drinking water and wastewater systems on tribal lands. While there is funding available under the EPA Drinking Water and Clean Water State Revolving Funds (SRF) for certification and training programs for State operators, there is not a similar source of funding for tribal operators working Indian Country. The RDC program has filled this gap.

Currently, there are 566 federally-recognized tribes in the United States. Tribal lands, if combined into one area, would be approximately the size of the fourth largest state in the Union. According to the U.S. Census Bureau, American Indians & Alaska Natives have the highest poverty rate of any race group in the U.S. The rural, poverty-stricken conditions in Indian Country commonly manifest themselves in the form of inadequate drinking water and wastewater facilities. Approximately 13% of the homes in Indian Country lack access to safe drinking water and adequate sanitation (0.6% is the national rate of homes lacking such access). The U.S. EPA reports there were 985 tribal public water systems in 2012 that supplied drinking water to 1.3 million customers in Indian Country. According to U.S. EPA National Public Water Systems Compliance Reports, over the 17-year time period of 1996 to 2012, an average of 48%

of tribal public water systems nationwide had significant violations of the Safe Drinking Water Act. In 2009, the U.S. EPA concluded in the annual report that customers of small public water systems in Indian Country are disproportionately affected by noncompliance challenges shared by small systems.

Federal agencies annually spend hundreds of millions of taxpayers' dollars on infrastructure construction (increasingly complex systems of piping, treatment, storage and distribution) as an attempt to improve access to safe drinking water and basic sanitation in Indian Country. Yet, building infrastructure is only part of the solution. There remains a crucial need to ensure that tribes have trained and certified professionals who are dedicated to operating and maintaining the water and wastewater infrastructure in Indian Country. The RCD program is the primary source of funding for these tribal certification programs. The loss of these funds would dangerously undermine the future of safe drinking water and sanitation in Indian Country.

Once water/wastewater infrastructure is constructed, such systems require ongoing operation and maintenance by trained and certified personnel in order to protect the return on tax-payers' investments in the construction. Certification designates the water/wastewater system operator as a public health professional and demonstrates the operator has the necessary credentials to deliver safe drinking water or to provide protective sanitation services. In many instances, water and wastewater systems in Indian Country are required to have an operator that is certified by a U.S. EPA-approved certification authority. This leaves tribes with little choice but to employ or contract state-certified water operators, many of whom are not from the tribal community where they are employed and lack commitment to the tribal community. This results in high turnover rates and a lack of operational continuity for water/wastewater systems in Indian Country. State certification programs are often incongruent with the jurisdictional framework that exists on federal trust tribal lands.

These important points were overlooked in the FY 2016 HHS-ACF Congressional Budget Justification, which rationalized zeroing out the RCD program based upon the misconception that the services funded by the RCD program are duplicative of other agencies, such as the EPA and USDA. This is simply incorrect when addressing tribal needs. Specifically, the Budget Justification refers to the U.S. EPA and the Department of Agriculture funding programs for local communities for wastewater and drinking water systems. However, this justification fails to take into consideration that these funding sources are generally not addressing the critical tribal needs for water and wastewater certification and training programs in Indian Country.

The EPA SDWA and CWA State Revolving Funds are used by States for infrastructure construction, as well as for workforce capacity development and program implementation (e.g., state operator certification programs). The Tribal Set-Aside Program, which currently receives a 2% allocation of the SRF, is statutorily restricted to funding only infrastructure construction. This lack of parity creates an unfunded mandate for tribal water operator certification. Other funding sources have also fallen far short.

While the U.S. Department of Agriculture—Rural Utilities Service has offered short-term (12-months) water/wastewater workforce capacity building funds, these funds have limited benefits for capacity building in Indian Country. They heavily favor large national organizations and implement scoring penalties for repeat grant applicants. This undermines a sustained program for capacity building in Indian Country. The Indian Health Services Sanitation Facilities Construction Program focuses on construction, not tribal training and certification. For these reasons, when compared to the federal government's investments in infrastructure construction, the skills that are needed by the tribal communities in order to operate and maintain

increasingly complex water and sanitation systems go largely unaddressed. This is why the RCD program remains a crucial source of funding for tribes.

The economic viability of tribal communities, as well as surrounding non-tribal communities (and hundreds of thousands of non-tribal employees, tourists, and visitors), cannot exist without reliable safe drinking water and adequate sanitation. This need cannot be met without having certified professional water/wastewater system tribal operators dedicated to and working in Indian Country. Self-governance and local control are American core-values that are particularly applicable to the unique conditions faced by water/wastewater utilities of small rural communities. The same is true in Indian Country.

The maximization and protection of the return on tax-payers' investments in the construction of expensive water/wastewater infrastructure in Indian Country can only be achieved through proper operations and maintenance conducted by skilled tribal professionals. It therefore remains imperative that Congress continue to support and fund the RCD program.

On behalf of the ITAA and tribes across the United States, we urge you to restore appropriations of \$7.5 Million for the U.S. Department of Health and Human Services—Community Services Block Grant/Rural Community Development (RCD) program.

Mr. COLE. All right. I thank the gentleman for presenting the testimony. It is great to have you here.

Any comments or questions?

With that, thanks again.

Mr. LEWIS. Thank you.

Mr. COLE. If I can, Ms. Emily Sheketoff, executive director of the American Library Association. It is great to have you here.

WEDNESDAY, APRIL 29, 2015.

AMERICAN LIBRARY ASSOCIATION

WITNESS

EMILY SHEKETOFF, EXECUTIVE DIRECTOR, AMERICAN LIBRARY ASSOCIATION

Ms. SHEKETOFF. Well, thank you very much, Mr. Chairman and members of the subcommittee. On behalf of the American Library Association and the 4 million Americans who use libraries every day, I am here to urge the subcommittee to include \$186,600,000 for the Library Services and Technology Act and \$25,000,000 for the Innovative Approaches to Literacy program.

America's libraries play an indispensable role in our communities, providing tens of millions of Americans free access to all types of information, career and skills training, digital and print literacy instruction, and computing services. The demand for such services continues to grow. Indeed, even as the economy shows signs of improvement, patrons continue to turn to their local library more and more for assistance and access to essential information, guidance, and instruction on a wide range of topics.

Every day libraries across the country provide no-fee public access to computers and the Internet in some of our most distressed communities, both rural and urban. According to a recent ALA report, 65 percent of all libraries nationwide are the only provider of free Internet access in their communities. And in rural areas, public libraries are even more critical, with 73 percent serving as their community's only free Internet provider.

As I noted in my written comments, this subcommittee will accept public comments only by electronic submission. That means, as a practical matter, for millions of Americans this subcommittee will only accept comments sent from a library.

Libraries, however, provide more than just access to the Internet and computers. The public library serves as an effective local delivery vehicle for government services, performing many functions of the government, albeit without specific Federal support or compensation.

Public libraries also extend the school day by providing materials and homework help to students. LSTA also funds summer reading programs in every State to prevent the erosion of students' reading skills while school is out.

Librarians are helping patrons to become better and more productive citizens. The services many patrons have come to expect at their local library include improving English literacy skills, obtaining and filing citizenship papers, applying for employment, filing

for veterans' and unemployment benefits, assistance in earning a GED and obtaining tax forms, and assistance in filing their taxes.

Libraries also serve as critical resource hubs for entrepreneurs and small businesses and as meeting places for communities. Many have even hosted townhall meetings for Members of Congress and local officials.

My written comments highlight how LSTA grants in Oklahoma have supported digital literacy classes for students, health literacy activities, and the purchase of databases that were searched nearly 13 million times in a single year. I also reference LSTA grants in Connecticut that serve the needs of the blind and visually impaired patrons, and grants in California that supported an innovative program for veterans seeking to return to mainstream society.

The value of LSTA as the only source of Federal funding for our libraries is clear. It would be economically inefficient, as it would be devastating to communities across America, for Congress to turn its back on libraries and their tens of millions of patrons now.

In addition to critical support for LSTA, ALA also asks that you maintain the current modest, but critical Federal investment in the Innovative Approaches to Literacy program. That provides competitive grants to school libraries and national not-for-profit organizations to put books into the hands of children and their families in high-need communities.

Providing books and childhood literacy activities to such children is crucial to their learning to read. The growing demands for a highly literate 21st century workforce cannot be met unless we begin to support literacy education for our youngest students. ALA urges and appreciates the subcommittee's continued strong support for LSTA and IAL.

Finally and more broadly, ALA urges the committee and every Member of Congress to support dedicated funding for effective school library programs in the Elementary and Secondary Education Act reauthorization and in fiscal year 2016 appropriations.

Thank you for your commitment to sustaining and strengthening our communities and our Nation by sustaining and strengthening America's libraries. Thank you.

[The information follows:]

**Testimony Submitted by
Emily Sheketoff, Executive Director
American Library Association Washington Office
Before the
House Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
April 29, 2015**

Thank you, Mr. Chairman and Members of the Subcommittee, for the opportunity to testify today on the FY 2016 Labor, Health and Human Services, Education, and Related Agencies bill. On behalf of the American Library Association (ALA), I urge the committee to include in the bill **\$186.6 million for the Library Services and Technology Act (LSTA)** under the Institute of Museum and Library Services (IMLS) and **\$25 million for the Innovative Approaches to Literacy (IAL) program** under the Fund for the Improvement of Education (FIE) of the Elementary and Secondary Education Act.

Libraries serve a vital role for communities by annually providing millions of Americans from every walk of life with ready and free access to all types of information, career and skills training, digital and print literacy instruction, and computing services. The demand for such services has grown especially as Americans have been increasingly unable to afford broadband in their homes. Indeed, even as the economy shows signs of improvement, patrons continue to turn to their local library more and more for assistance and access to essential information, guidance, and instruction on a wide range of topics.

Every day, libraries across the country provide no-fee public access to computers and the internet in some of our most distressed communities, both rural and urban. According to a recent ALA report, 65 percent of all libraries nationwide are the only provider of free internet access in their communities. In rural areas, public libraries are even more critical, with 73 percent serving as their community's only free internet provider.

Increasingly, the internet is the only means by which an individual can research job opportunities, take their GED, apply for a job, or submit government forms, such as tax filings or benefit claims. I note, for example, that this Subcommittee will accept public comment *only* by electronic submission.

Libraries, however, provide much more than just internet access. According to another ALA report, more than 92 percent of public libraries offer services that help patrons complete job applications, create resumes, and access job databases and research. Libraries also provide resources and specialized collections for small businesses, which help them create business plans, develop new growth strategies, and research target markets.

Libraries, of course, also expose children to books and information to help them gain and enhance literacy skills. Surveys show that many of our nation's children living in poverty have no books at home. These children depend on their local libraries' story-time and summer reading programs to help them prepare to learn in school and to succeed.

Unfortunately, during this time of increased and increasing demand, many libraries are under severe budget pressure, often leading to their closures and reduced hours. Therefore, support for the Library Services and Technology Act (LSTA) is critical as this program is the primary source of annual funding for libraries in the federal budget. The bulk of LSTA funds are distributed to each state through IMLS according to a population-based grant formula. Each state must match the federal funds received and determines for itself how it will allocate its LSTA funds, often relying upon this money to provide job searching databases, resume workshops, summer reading projects, creative programming for children, best practices training for local librarians, and so much more. Libraries have used LSTA funding for diverse and innovative programs. For example:

- In Oklahoma's Fourth Congressional District, LSTA grant funds have supported computer lab classes for scores of students, health literacy activities, and data bases that had nearly 13 million searches in just a year. Also in Norman, Oklahoma, as a result of the STEM emphasis in the summer reading program, LSTA grants were given to purchase LEGO packages to combine computers with the building components. These were wildly popular. One child told the librarians that the Norman Public Schools had the LEGO packages, but that they were only available to the gifted and talented classes, so the library afforded his only opportunity to use them.
- In Connecticut, LSTA support was combined with state funding to serve more than 7,000 patrons of the Library for the Blind and Physically Handicapped. This program distributed over 190,000 talking books and almost 10,000 playback machines.
- A library in Alabama used its grant to create an Autism Resource Center for the community and provided teaching tools, targeted learning pathways, autism information, and expanded hours for families with autistic children.
- In California, pilot programs made possible with LSTA support underwrote development of a Veterans Resource Center to serve the special needs of veterans and their families.

Participants were connected with available federal, state, and local resources and benefits.

In addition, LSTA also funds: the Native American and Native Hawaiian Library Services program to support improved access to library services for those populations; National Leadership Grants to support activities of national significance that enhance the quality of library services nationwide, and provide pilots for coordination between libraries; and the Laura Bush 21st Century Librarians program, used to help develop and promote the next generation of librarians.

I'd also like to highlight, Mr. Chairman, that the President's FY 2016 budget request included a \$5.6 million increase for the IMLS to create a "national digital platform." This new

and much needed initiative will connect library users to federal library services and collections online. This NDP will foster new forms of inquiry and exploration, at any time of day or night.

Accordingly, ALA asks that you provide \$186.6 million for LSTA in order to ensure that Americans of all ages have access to libraries, internet, and information services; the resources they need to develop literacy skills and achieve academically; and the services and tools to search for, find, and create jobs. The examples discussed above amply show how libraries are uniquely capable of meeting these services well and with great fiscal efficiency.

In addition to fully supporting LSTA, ALA also asks that you maintain the current modest, but critical, federal investment in the Innovative Approaches to Literacy (IAL) program under the Fund for the Improvement of Education. IAL provides competitive awards to school libraries and national not-for-profit organizations (including partnerships that reach families outside of local educational agencies) to put books into the hands of children and their families in high-need communities. Providing books and childhood literacy activities to such children is crucial to their learning to read. The program also supports parental engagement, and focuses on promoting student literacy from birth through high school.

Congress recognized the importance of this program in FY2012 when \$28.6 million was first appropriated. In successive years, \$25 million has been dedicated to this essential childhood literacy initiative. In 2012, the U.S. Department of Education awarded two-year IAL grants to 46 nonprofit organizations and school districts in 21 states and the District of Columbia. In 2014, the Department made 32 new awards to national non-profits and school libraries. As with LSTA funds, community libraries and others are doing remarkable, valuable work with IAL support as just one example reveals.

The Todd County, Kentucky School District utilized its IAL grant to fund book distribution to help build home libraries for preschool, kindergarten, and first grade students.

During the two-year grant period, 10,303 books were distributed. Care was taken to select books to fit individual students' needs, interests, and reading levels. The books were distributed through each school's library media center. Todd County also was able to use its grant to develop technologically advanced media centers with high-quality, student-friendly digital tools and resources. The centers were designed to engage students to improve reading skills and produce multimedia projects. The program also allowed librarians to work more efficiently from school or at home. Providing current, up-to-date technologies in the media centers helped reduce gaps between Todd County's technology "haves and have-nots."

Ensuring a child's year-round access to books is a critical first-step towards literacy and life-long learning. For American families living in poverty, access to reading materials is severely limited. These children have fewer books in their homes than their peers, which hinders their ability to prepare for school and to stay on track.

Congress has taken an important step in supporting the needs of disadvantaged students by providing IAL funding for book distribution, early literacy services, and effective school library programs. We urge the Subcommittee and full Committee to continue this important work by maintaining a \$25 million investment in IAL in the FY 2016 Labor, Health and Human Services, Education, and Related Agencies bill.

ALA urges and appreciates the Subcommittee's continued strong support of LSTA and IAL, Mr. Chairman. Finally, and more broadly, ALA urges the Committee and every Member of Congress to support dedicated funding for effective school library programs in the ESEA reauthorization and FY2016 appropriations. Thank you for your commitment to sustaining and strengthening our communities and our nation by sustaining and strengthening America's libraries.

Mr. COLE. Thank you. I have no direct questions, but two comments. Just best practices to my colleagues, at least, I have found, whenever I do townhall meetings in libraries, your constituents behave a lot better. It is unbelievable. They just feel like they have to be nicer in that environment than if you get them at a gym or someplace like this. So it really, really works.

And second, I would be remiss not to mention, at least in our experience, I know this was true on the East Coast during Sandy, how critical libraries were actually in a disaster situation where we had people who had lost the ability to communicate through the Internet because their homes were destroyed, had a place to go and extra services provided to them where they could reestablish contact and, frankly, get their lives up and running again. So it is just an unbelievable service in every community.

So thank you for what you do.

Any comments or questions.

Ms. ROYBAL-ALLARD. Well, I just would like to point out that in communities such as the ones that I represent that are very underserved and a lot of students don't have access to the Internet, that as schools are requiring students to more and more do their homework online, libraries are becoming even more important than ever before.

Ms. SHEKETOFF. Well, ma'am, you will find that at 3 o'clock in libraries across this country the Internet usage skyrockets. And all libraries offer wireless, as well as workstations, and that is so that when kids come into the library after school—and many do—they can use their devices if they have them or they can use their workstations if they don't. And that is the place that children go after school because it is safe and it offers the resources and the expertise in librarians to help them with homework help and projects so that they do get a better education. And it enables children to have a seamless day going from school to the library so that they can continue learning.

And, also, Mr. Chairman, in all sorts of disasters, in Ferguson and in Baltimore yesterday, it was the library that was open to the community so that they could come in and meet together for whatever they needed, including solace and just the place to be able to talk to each other in a safe space. And we hope to continue to do that.

Mr. COLE. Well, thank you very much for your testimony. It is great to have you.

Ms. SHEKETOFF. Thank you, sir.

Mr. COLE. You bet.

And next, if we could call on Dr. Lynn Jorde, director of the Utah Genome Project, the University of Utah School of Medicine.

Welcome. Good to have you here, Doctor.

WEDNESDAY, APRIL 29, 2015.

**UTAH GENOME PROJECT, UNIVERSITY OF UTAH,
SCHOOL OF MEDICINE****WITNESS****DR. LYNN JORDE, DIRECTOR, UTAH GENOME PROJECT, UNIVERSITY
OF UTAH, SCHOOL OF MEDICINE**

Mr. JORDE. Thanks very much.

Well, good morning, Chairman Cole, Ranking Member DeLauro, and distinguished members of the subcommittee. Thank you for allowing me to testify. My name is Lynn Jorde. I chair the Department of Human Genetics at the University of Utah School of Medicine. I am also the former president of the American Society of Human Genetics.

I would like to talk with you today about genetic discovery, precision medicine, and big families.

As you know, new developments in DNA technology have literally revolutionized genetics in medicine. For about the cost of one MRI, we can now sequence an entire human genome, allowing us to analyze the 3 billion DNA bases that are the blueprint for life, the causes of disease, and the source of our genetic uniqueness.

Because of this uniqueness at the DNA level, we each respond differently to medical treatments, including many therapeutic drugs. So knowing a person's DNA sequence is a critical step in practicing precision medicine, ensuring that each individual gets the best and most effective possible treatment.

An example of this is the APC gene discovered at the University of Utah some 20 years ago. Those who have disease-causing variants of this gene are virtually certain to develop colorectal cancer by age 50 or so. Before this gene was identified, at-risk family members, usually someone with an affected parent, had to undergo annual colonoscopies starting at age 12.

Now, for less than the cost of one colonoscopy, we can do a genetic test to determine who inherited the variant and who didn't. Those who did inherit the variant could be closely monitored and treated when necessary to prevent colon cancer. Those who didn't inherit the variant don't have to undergo a \$3,000 colonoscopy each year, avoiding anxiety and a lot of needless medical expense.

So how do we find these genetic culprits? Well, one approach is to examine large cohorts of unrelated people who have a given disease, let's say Type 2 diabetes. But because there are many possible causes, both genetic and nongenetic, of diabetes, we are likely to find a large and often confusing array of potential causes.

Now, in Utah we are making this task a lot easier by looking for these genes in large families where we can trace a gene as it is passed from generation to generation. We can think of these families as a sort of genetic magnifying glass. They allow us to view a gene and its disease consequences over and over again, effectively amplifying the genetic signal.

Now, you probably know that Utah has a lot of big families. In fact, because these families keep very good genealogical records, we know that some individual Utah founders now have more than 10,000 living descendants. And these families are phenomenally co-

operative in our genetic studies. More than 90 percent agreed to participate. So we have in Utah some very powerful magnifying glasses.

These families are a part of the 7 million-member Utah Population Database. This is the world's largest repository of computerized family histories, linked with more than 22 million public health and medical records. Using this noncommercial resource, scientists at the University of Utah have identified dozens of diseases, dozens of genes responsible for diseases, including breast and ovarian cancer, melanoma, and sudden cardiac death.

Now the Utah Genome Project is harnessing the power of Utah's large families to discover new disease-causing genes that underlie conditions like diabetes, cancer, and heart disease. These families, because they magnify our ability to identify disease-causing genes, accelerate the pace of genetic discovery. They are an ideal complement to and should be part of the million-member cohort proposed under the NIH Precision Medicine Initiative. Large families and large cohorts are a potent combination with the potential to improve and even transform precision medicine.

Now, it has been estimated that the \$3,000,000,000 spent on the Human Genome Project has returned \$800,000,000,000 in economic return.

Now, that is more than a 250–1 return on investment.

Likewise, our own ongoing research on genetics and precision medicine is a sound investment in the future. By using genetics to target the right treatment for each patient, we can save billions of healthcare dollars and countless thousands of patient lives.

I urge you to support continued research on genetics and precision medicine, incorporating the power and potential of large families. It is an investment that will ultimately benefit all of humanity now and for generations to come. Thank you.

[The information follows:]

**Statement by Lynn Jorde, Ph.D., Chair of the Department of Human Genetics
University of Utah Health Sciences Center on FY 2016 Appropriations for the
Department of Health and Human Services submitted to the Subcommittee on
Labor, Health and Human Services, Education and Related Agencies
Committee on Appropriations – United States House of Representatives
April 29, 2015**

Good morning, Chairman Cole, Ranking Member DeLauro, and distinguished members of the Subcommittee. Thank you for allowing me to testify. Today, I would like to talk with you about genetic discovery, precision medicine, and the telescope.

A New View

Though many contributed to the technology, a Dutch eyeglass maker named Hans Leppershey is credited as the first to file a patent on the telescope. In 1608, when astronomers first began to use this groundbreaking invention, human understanding of our place in the universe was forever changed.

Today, we genetic scientists find ourselves at a similar threshold as we begin to map the genetic universe in a search for the seeds of inherited disease. Thanks to modern DNA sequencing technology, what once took 10 years and 1 billion dollars can now be achieved with a few days' time and a few thousand dollars. For about the cost of an MRI, we can now sequence an entire human genome, enabling a view into the 3-billion base pairs of DNA that makes each of us unique. Our genomes dictate the color of our eyes, the curl of our hair and, in many cases, the diseases that we will confront in our lifetimes.

These diseases, both rare and common, are the very reason we are on this journey of genetic discovery—because when we know the genetic causes of disease, we can develop precision medications and diagnostics to treat and, in some cases, prevent them from ever occurring.

The Promise of Precision Medicine

From this genomic observatory we see gains in both the short and long terms. In the short term, we can describe illnesses more accurately; and we can better utilize existing therapies and basic tools like family history and diagnostics to identify at-risk patients. In the long term, when we identify disease-causing genes we can tailor our treatments to the unique genetic constitution of each patient—improving outcomes and avoiding the enormous financial costs of trial-and-error drug administration.

Take, for example, the recently discovered *PCSK9* gene. *PCSK9* is expressed in the liver, where it is involved in the processing of cholesterol. In a small number of families, a variant of the *PCSK9* gene causes abnormally high cholesterol levels that are inherited from generation to generation and often lead to fatal heart disease. Genetic studies of these families revealed the cause of their high cholesterol levels. This discovery in turn gave scientists the clue they needed to develop a new class of drugs that lower cholesterol levels by more than 50%. Importantly, these drugs, called PCSK9 inhibitors, lower cholesterol not just in these rare families, but also in the great majority of people who have high cholesterol levels—including those who are already taking statin drugs. The PCSK9 story illustrates how collaborative genetic studies can benefit millions of people worldwide.

Another story is that of the *APC* gene, which was discovered at the University of Utah more than 20 years ago. Those who have disease-causing variants in *APC* are virtually certain to develop colorectal cancer by age 50 or so. Once identified, at-risk family members can be genetically tested to determine whether or not they have inherited a disease-causing *APC* variant. Those who inherit the variant can be closely monitored by colonoscopy and treated when necessary, a life-saving procedure that can prevent

colon cancer in these patients. Those who do not inherit the variant do not need costly annual colonoscopies, avoiding anxiety and needless medical expense.

Genetic research at our institution also contributed to the discovery of the major genes that cause familial breast and ovarian cancer (*BRCA1* and *BRCA2*) and dozens of others. Genetic tests for disease-causing versions of these genes have helped to save thousands of lives and millions of dollars.

The Value of Genetic Science

With the costs of health care continuing to skyrocket, we are driven to improve the outcomes we deliver for every precious dollar spent. As we increase our ability to identify the genetic and environmental origins of disease, we advance our capacity to practice precision medicine by delivering the right intervention to the right patient at the right time and at the right cost.

At the University of Utah, we have a long history of genetic discovery and translational science. In our health care system—an ecosystem dedicated to operationalizing medicine in a high-quality, patient-centered and value-based manner—we view advances in genetic science and precision medicine to be in direct alignment with our ability to improve patient care.

So how do we find these genetic culprits?

Genetic Science, Powered by Families

Finding an unknown disease-causing gene in an individual's 3 billion base pairs of DNA is like scouring all the books in the Library of Congress for one misspelled word. Despite the needle-in-a-haystack challenge, scientists at the University of Utah have identified dozens of genes responsible for diseases—in addition to the aforementioned

breast cancer, ovarian cancer and colon cancer genes—including cardiac arrhythmia and high blood pressure. Much of this success is due to Utah’s large and well-documented families, who serve as a singular resource for genetic discovery. Indeed, some Utah founders have more than 10,000 living descendants. These families are part of the 7.3-million-member Utah Population Database (UPDB), the world’s largest repository of family histories linked with more than 22 million public health and clinical records. The second largest, by comparison, is the deCode database that contains records from about 500,000 persons from Iceland, which is genetically distinct from the Utah population and therefore is likely to contain a distinct set of disease-causing genetic variants.

The families recorded in UPDB allow us to trace a gene as it is passed from generation to generation. These families are thus a genetic “magnifying glass,” which enables us to identify the causes of disease with a precision and efficiency that has never before been achievable. The Utah Genome Project (UGP), which was launched in 2012 at the University of Utah, capitalizes on this unique resource and harnesses the power of Utah’s large families to discover new disease-causing genes that underlie conditions such as diabetes, psoriasis, Crohn disease, obesity, and heart disease. UGP discoveries are enabling the development of genetic diagnostics and precision therapies that can transform health care.

Most of the large-scale genetic discovery projects currently under way involve large cohorts of unrelated patients and controls. These resources are extremely valuable, but the UGP is unique in that it provides large-volume family data, where genetic signals are most easily discovered because they occur in multiple family members. Imagine a faint star in a distant galaxy. With only one fleeting view in a telescope, we can’t be sure

of its existence. But with multiple, repeated views, our confidence grows. In the same way, families offer repeated signals of the same genetic variant, greatly increasing our ability to discover and validate a disease-causing gene. Because of the added power of family analysis, fewer individuals need be analyzed in order to make genetic discoveries. The UGP thus complements existing cohorts and provides a wealth of added potential for discovery.

Another major challenge in modern genome analysis is the sheer volume of data (3 billion DNA bases) generated for each of thousands of patients. To meet this challenge, Utah Genome Project investigators have built a software platform for efficient, accurate analysis of family genetic data. In just hours, each person's disease-predisposing genetic variants can be identified. This genetic search engine, now used globally in more than 300 research institutions, will lead to genetic discoveries, new genetic tests and precision treatments to end diagnostic odysseys and advance precision medicine.

The Utah Genome Project is already enabling gene and drug discovery, identification of at-risk families, and development of some of the best genomic analysis platforms in the field. With continued support for UGP, and synergistic programs like it, the analytic tools and informative data generated by the UGP will become international resources for genetic research. In fact, the UGP has already catalyzed active collaborations with scientists and physicians at Washington University in St. Louis, Vanderbilt University, and Phoenix Children's Hospital.

It is estimated that the \$3 billion spent on the Human Genome Project has yielded nearly \$800 billion in economic return. Likewise, our ongoing research on genetics and

precision medicine is a sound investment in the future. By using genetics to target the right treatment for each individual patient, continued investment will save billions of health-care dollars and millions of patient lives.

Outlive Your Family History

Each of us has a history of diseases that run in our families. As a nation, we have the opportunity to unlock the genome and apply these discoveries to precision diagnostics, treatments, and drug developments. With this knowledge, we have the opportunity to outlive our own family histories.

Mr. COLE. Thank you very much. I don't have a question, but I do want to make a quick comment. Not surprisingly, as a Republican, I have occasional disagreements with the President, but he deserves a lot of credit here for having in his State of the Union address, as well as his budget proposal, highlighted the importance of precision medicine and called on a major investment in this area.

So hopefully that is an area that we can work, and I suspect it is, across party lines. It is just stunning some of the things that have already been developed and what is in the works out there if we can make a sufficient commitment in terms of research. Your testimony is timely and very effective.

Either of the gentleladies have a comment or question?

Thank you very much.

Mr. JORDE. Thank you, sir.

Mr. COLE. If we can, we will move next to Dr. Wanda Lipscomb, chairwoman of the National Council for Diversity in the Health Professions.

Doctor, good to have you here.

WEDNESDAY, APRIL 29, 2015.

NATIONAL COUNCIL FOR DIVERSITY IN THE HEALTH PROFESSIONS

WITNESS

DR. WANDA LIPSCOMB, CHAIRWOMAN, NATIONAL COUNCIL FOR DIVERSITY IN THE HEALTH PROFESSIONS

Ms. LIPSCOMB. Thank you.

Chairman Cole and members of the subcommittee, thank you for the opportunity to speak with you this morning. My name is Dr. Wanda Lipscomb, and I am here as the president of the National Council for Diversity in the Health Professions, NCDHP. I am also the project director of the Center of Excellence for Diversity in Medical Education at Michigan State University.

NCDHP is a consortium of our Nation's current and former institutions with Minority Centers of Excellence, COE, and Health Careers Opportunity Program funded grants supported by Title VII to address diversity in the health professions.

Our mission is to increase and strengthen health professions workforce diversity to address the unmet healthcare needs and underserved populations and communities through training in health professions for those from disadvantaged and underrepresented minority backgrounds.

The COE and HCOP programs address a critical national need. Persistent staffing shortages exist in all health professions in our Nation's most medically underserved communities. Our Nation's health professions workforce does not mirror our population. African Americans, Hispanic Americans and Native Americans constitute more than 30 percent of our population, yet only account for approximately 8.7 percent of physicians, 6.9 percent of dentists, and 9.9 percent of pharmacists.

There have been numerous studies published that state the minority health professionals serve minority and medically under-

served populations at higher rates than other professionals. There is a clear, well-established link between health disparities and a lack of access to culturally competent health care in many of our medically underserved areas. Health professionals also who spent part of their time training providing care for the underserved are up to 10 times more likely to practice in underserved areas.

There is also a significant need to diversify faculty in health profession schools. Underrepresented minority faculty only account for 7.4 percent of the U.S. medical school faculty and 8.6 percent of dental school faculty.

So the NCDHP is very, very pleased to see efforts to revitalize both the COE and HCOP in recent fiscal year appropriations, and we urge you to continue to fund these important programs.

The Minority Centers of Excellence focus on improving student recruitment and performance, increasing faculty diversity, improving curricula and cultural competence, facilitating research on minority health issues, and training students to provide health services in underserved communities. Initially established at four historically Black health professions institutions, the COEs were later expanded by Congress to authorize the establishment of Hispanic COEs, Native American COEs, and other COEs in institutions with significant enrollment and graduation of underrepresented students. For fiscal year 2016, the NCDHP supports the recommended funding level of \$25,000,000.

The Health Careers Opportunity Program, HCOP, provides support to provide pipeline recruitment and educational enrichment activities that encourage disadvantaged students to pursue careers in the health professions while partnering with school districts, community colleges, community organizations, and colleges and universities in an attempt to identify, nurture, and prepare promising students for entry into the health professions.

Over the past three decades, HCOPs have trained approximately over 20,000 health professionals. In the recent fiscal year 2009, 2011, approximately 5,000 HCOP participants entered the health professions workforce, including over 2,500 physicians, 900 dentists, 300 veterinarians, and many other health professionals.

For fiscal year 2016, the NCDHP recommends the funding level of \$14 million for HCOP with the continued focus on disadvantaged populations at multiple levels of education, including high school, college, postbaccalaureate, and the health professions school level.

NCDHP recognizes that the administration has recommended a rebranding of the current HCOP program to address objectives outlined in the original language. We have shared our recommendation regarding this with the committee in our written testimony.

Thank you to the committee and to Mr. Chairman for this opportunity to speak.

[The information follows:]

WRITTEN TESTIMONY OF WANDA D. LIPSCOMB, Ph.D.
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PRESENTED TO THE
HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, EDUCATION AND RELATED AGENCIES

SUMMARY OF FISCAL YEAR 2016 RECOMMENDATIONS:

- 1) \$300 MILLION FOR THE TITLE VII HEALTH PROFESSIONS TRAINING PROGRAMS, INCLUDING:**
 - **\$25 MILLION FOR THE MINORITY CENTERS OF EXCELLENCE.**
 - **\$14 MILLION FOR THE HEALTH CAREERS OPPORTUNITY PROGRAM**

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present my views before you today. My name is Dr. Wanda Lipscomb and I am here as the President of the National Council for Diversity in the Health Professions (NCDHP). I am also the Project Director of the Center of Excellence for Diversity in Medical Education at Michigan State University. NCDHP, established in 2006, is a consortium of our nation's current and former institutions with Minority Centers of Excellence (COE) and Health Careers Opportunity Program (HCOP) funded programs supported by the Health Resources and Services Administration (HRSA) under Title VII. The mission of the NCDHP is to increase and strengthen health professions workforce diversity. These institutions are committed to providing training in the health professions for those from disadvantaged and minority backgrounds.

Mr. Chairman, you have encouraged your colleagues and the citizens of this country to take a look at our nation and evaluate our needs over the next ten years. The Title VII Health Profession Training programs address a critical national need. Persistent and severe staffing shortages exist in a number of the health professions, and chronic shortages exist for all of the health professions in our nation's most medically underserved communities. The Association of American Medical Colleges (AAMC) called for a 30% increase in medical school enrollment to address the critical workforce shortage expected by 2020 when the demands of health services will increase with the upcoming retirement of the baby boomers (AAMC, 2009). Furthermore, our nation's health professions workforce does not mirror the racial composition of our population. While African Americans, Hispanic Americans, and Native Americans constituted more than 30% of the U.S. population in 2008 (Nivet, et al, 2008), these groups accounted for only 8.7% of physicians, 6.9% of dentists, and 9.9% of pharmacists (Sullivan & Mittman, 2010). Coupled with the rising representation of minorities among school-aged children, increasing diversity in the health professions is a very important goal.

An October 2006 study by the Health Resources and Services Administration (HRSA), entitled “The Rationale for Diversity in the Health Professions: A Review of the Evidence” found that minority health professionals serve minority and other medically underserved populations at higher rates than non-minority professionals. The report also showed that minority populations tend to receive better care from practitioners who represent their own race or ethnicity, and non-English speaking patients experience better care, greater comprehension, and greater likelihood of keeping follow-up appointments when they see a practitioner who speaks their language. There is considerable data that shows that African American, Hispanic American, and Native American physicians are far more likely to practice in underserved communities and provide service irrespective of patients’ incomes (Komaromy, et al, 1996). Studies have also demonstrated that when minorities are trained in minority health profession institutions, they are significantly more likely to: 1) serve in rural and urban medically underserved areas, 2) provide care for minorities and 3) treat low-income patients.

There is a well-established link between health disparities and a lack of access to competent healthcare in medically underserved areas. As a result, it is imperative that the federal government continue its commitment to minority health profession institutions and minority health professional training programs to continue to produce healthcare professionals committed to addressing this unmet need.

As you are aware, Title VII Health Professions Training programs are focused on improving the quality, geographic distribution and diversity of the healthcare workforce in order to continue eliminating disparities in our nation’s healthcare system. These programs provide training for students to practice in underserved areas, cultivate interactions with faculty role models who serve in underserved areas, and provide placement and recruitment services to encourage students to work in these areas. Health professionals who spend part of their training providing care for the underserved are up to 10 times more likely to practice in underserved areas after graduation or program completion.

Institutions that cultivate minority health professionals, like the NCDHP members, have been impacted by the cuts to the Title VII Health Profession Training programs in fiscal year 2006 (FY06), FY07, and FY08. This is particularly true for the minority health professions institutions. Given their historic mission to provide academic opportunities for minority and financially disadvantaged students and healthcare to minority and financially disadvantaged patients, minority health professions institutions operate on narrow margins. The cuts to the Title VII Health Professions Training programs amount to a loss of core funding at these institutions and have been financially devastating.

The current shortage of minority faculty to serve as mentors for minority health profession students is another institutional challenge that impacts the health professions workforce.

Underrepresented minority faculty only accounted for 7.4% of the U.S. medical school faculty and 8.6% of dental school faculty in 2007-2008. There is a significant need to diversify faculty in health professions schools in order to ultimately increase the representation of minorities in the health professions, to improve the climate in the learning environment, to increase cultural competence education, to expand health disparity research, and ultimately to improve health care services for the disadvantaged.

The NCDHP has been pleased to see efforts to revitalize both COE and HCOP in recent fiscal years, but it is important to fully fund the programs at least at the FY 2004 level so that more diversity is achieved in our health professions. With the passage of health care reform, the Congress showed the importance of the many of the Title VII programs, including the Minority Centers of Excellence (COE) and Health Careers Opportunity Program (HCOP), by reauthorizing these two important programs.

Minority Centers of Excellence: COEs focus on improving student recruitment and performance, increasing faculty diversity, improving curricula in cultural competence, facilitating research on minority health issues and training students to provide health services to minority individuals. COEs were first established in recognition of the contributions made by four historically black health professions institutions to the training of minorities in the health professions (School of Medicine at Meharry Medical College; School of Dentistry at Meharry Medical College, College of Pharmacy at Xavier University; and School of Veterinary Medicine at Tuskegee University). Congress later went on to authorize the establishment of “Hispanic”, “Native American” and “Other” COEs. *For FY16, the NCDHP supports the recommended funding level of \$25 million for COEs.*

Health Careers Opportunity Program (HCOP): HCOPs provide grants for minority and non-minority health profession institutions to support pipeline, preparatory and recruiting activities that encourage minority and economically disadvantaged students to pursue careers in the health professions. Many HCOPs partner with high schools, school districts, community colleges, and colleges to identify and nurture promising students who demonstrate that they have the talent and potential to become a health professional.

Collectively, the absence of HCOPs will substantially erode the number of disadvantaged and minority students who enter the health professions. Over the last three decades, HCOPs and HCOP institutions have trained approximately over 20,000 health professionals including physicians, dentists and public health workers. In a study conducted by the NCDHP in 2013, nineteen (19) HCOPs reported for the FY09-FY11 period that their respective HCOP programs have served a total of 67,771 disadvantaged students in the pathway to health professions including 12,581 primary school level students, 35,495 secondary level students, 14,157 undergraduate students, 1828 post-baccalaureate students and 3710 health professions students.

Of the disadvantaged students served by the Respondents, 5486 have become health professionals, most notably 2580 physicians, 963 dentists, 313 veterinarians, 234 physical therapists, 196 physician assistants and 613 other health professionals. ***For FY16, the NCDHP supports the recommended funding level of \$14 million for HCOPs.***

Mr. Chairman, please allow me to express my appreciation to you and the members of this subcommittee. With your continued help and support, NCDHP member institutions and the Title VII Health Professions Training programs can help this country to overcome health and healthcare disparities. Congress must be careful not to eliminate, paralyze or stifle the institutions and programs that have been **proven to work**. NCDHP seeks to close the ever widening health disparity gap. If this subcommittee will give us the tools, we will continue to work towards the goal of eliminating that disparity everyday.

Thank you, Mr. Chairman.

Mr. COLE. Doctor, thank you very much for coming and offering testimony.

Are there any questions?

Ms. LEE. Thank you very much, Dr. Lipscomb. Really happy to meet you and hear your testimony. Let me just ask you one very hopefully focused question as relates to cultural competence and death and dying. And I have had personal experience with this, so I would like to kind of get your sense of the data and the research that is there.

Different cultures deal with death and dying differently, and there is, from what I learned, very little sensitivity around the different ways that different cultures and ethnic minorities deal with that process as it leads to, quote, the decision to go on comfort care or palliative care. And I experienced this with my mother.

The disparities research that was cut, that has been proposed to be cut, we talked about this in this committee, is minus \$32,000,000 this year. And I am wondering, one, those cuts, how that is going to affect the healthcare personnel and the type of diversity in care that we see based on the knowledge and what the research data would show.

And secondly, have there been any studies or is there any data on cultural competence as it relates to different ethnic minorities as it relates to death and dying? Because this is a serious issue. And I have talked to a lot of minority health professionals, and it seems like the research and the data is not there and the sensitivity is not there, and we need a whole lot of work done in this area.

Ms. LIPSCOMB. So I think when you talk about cultural competence, you look across the entire spectrum of health care, and many of us who are seated in the room who represent those from underrepresented groups, our lifestyles, our way of growing up, our belief systems are often very, very discarded in the healthcare system. With the baby boomers retiring, many of us, there are going to be many more of us in the healthcare system, so I think that the question that you raise is really important.

For the COEs and HCOPs, we try to address cultural competence from the standpoint of training the healthcare professionals of the future, and it is really, really important that they have exposure to patients who come from diverse backgrounds during their training. It is very important that we have the researchers who understand those sensitivities actually conducting the research.

I think you have probably heard from Dr. Sullivan in some past presentations, and much of the work that has been done by Dr. Sullivan and his colleagues, by Dr. Satcher at the primary care institute down in Morehouse, really does look at some of the sort of delivery things that happen.

I think you raise a very good issue. If we cut budgets and we don't take a critical look from a research standpoint at how those populations are impacted, it will be very, very difficult for us 10, 15 years from now to be able to provide the services that we need, especially to the aging population. And I would be happy to send you some additional information.

Ms. LEE. Thank you very much.

Thank you, Mr. Chairman.

Mr. COLE. Thank you very much for your testimony. It is great to have you here.

Ms. LIPSCOMB. Thank you.

Mr. COLE. Next if we could call on Mary Reese. She is a board member for VOR.

Thank you. It is good to have you here.

WEDNESDAY, APRIL 29, 2015.

VOR

WITNESS

MARY REESE, BOARD MEMBER, VOR

Ms. REESE. Good morning, Chairman Cole and members of the subcommittee. Thank you so much for this opportunity to be with you today on behalf of VOR. My name is Mary Reese.

VOR is a national nonprofit, nonprovider organization advocating for high quality care and human rights for people with intellectual and developmental disabilities. I am a VOR board member, and I have over 50 years of experience working with and advocating for people with developmental disabilities.

Today, VOR is not asking for any money, but instead we ask that the future appropriated funding be used as intended, according to law, and in support of family values and choice. VOR respectfully requests the subcommittee's support for language in the Health and Human Services appropriations bill to prohibit the use of such appropriations in support of forced deinstitutionalization activities which evict vulnerable individuals with profound disabilities from HHS-licensed Medicare facilities. HHS-funded deinstitutionalization which targets HHS-funded and licensed homes is an absurd and cruel use of Federal funding.

In the past several decades, deinstitutionalization has led to human tragedy, and it violates Federal law. Like the vast majority of VOR members, my family member, Ginger—here she is, my sweetie—is my motivation. Ginger is profoundly intellectually disabled and is a medically fragile 70-year-old. Two years ago she moved to Holly Center, a State Medicaid intermediate care facility in Maryland. It took 8 long, hard years to secure the services she requires for her health and her happiness.

While we fought for admission, Ginger endured many health emergencies, inconsistent nursing care, and often neglect and injuries at the hands of poorly trained and unsupervised caregivers in her community setting.

Ginger is not alone in her past sufferings. Headlines across the Nation tell people of widespread tragedies in small settings serving people with profound disabilities. In Georgia, 500 people with developmental disabilities died in community settings in 2013, 62 of whom had recently been transferred from Medicaid facilities. Also, in 2013, U.S. Senator Chris Murphy requested an inspector general investigation due to what he called an alarming rate of deaths and cases of abuse of developmentally disabled individuals in group homes.

There are many more such examples of increased mortality, abuse, and neglect in small homes serving people with profound disabilities across the country, including Tennessee, Maryland, Pennsylvania, Virginia, Connecticut, and California. Unconscionable is the fact that the very HHS-funded agencies that Congress entrusted to protect people with developmental disabilities rarely concerns themselves with these community-based tragedies and routinely dismantles the HHS-licensed and funded facility homes that provide highly specialized care.

Top-level HHS administrators either encourage or are unaware of the resulting human harm by certain HHS-funded agencies. This was made clear in questioning by Congressman Womack of Kathy Greenlee, the Administrator of the Administration on Community Living within HHS. At the February 26, 2015, hearing of this subcommittee, Representative Womack asked Ms. Greenlee a series of questions about Protection and Advocacy's deinstitutionalization tactics, including lawsuits, lobbying without regard to the choice of the families and the legal guardians. Ms. Greenlee's response to the vice chairman's questions were incomplete and worrisome.

There are many other examples of HHS programs arrogantly disregarding families and guardians, as well as the individuals that I am speaking of today. We emphasize we want to make sure that the subcommittee is aware that the Supreme Court's Olmstead decision, which has been the basis for moving people out of facility care, has been incorrectly cited as a justification for serving people only in community settings.

The Supreme Court in Olmstead says about deinstitutionalization, and I quote: "We emphasize that nothing in ADA or its implementing regulations condones the termination of institutional settings for persons unable to handle or benefit from community settings. Nor is there any Federal requirement that community-based treatment be imposed on patients who do not desire it."

VOR implores this subcommittee to take action. I see my time is over. You have our full statement. Thank you so much for your attention, and we are counting on you to help us with this matter. Thank you so much.

[The information follows:]



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Submitted by Mary Reese, VOR Board Member

April 22, 2015

VOR, Speaking out for people with intellectual and developmental disabilities

Written Testimony for the House Appropriations

Subcommittee on Labor, HHS, & Education and Related Agencies

I. Agency, Program and Amount of Funding Involved in the Request

VOR has serious concerns about the activities of certain U.S. Department of Health and Human Services (HHS) agencies, including the Administration on Intellectual and Developmental Disabilities (AIDD), the National Council on Disability (NCD), and the Centers for Medicare & Medicaid Services (CMS). **We do not seek any funding, but instead seek language in the Labor, HHS, Education and Related Agencies appropriations bill that expressly prohibits the use of HHS appropriations in support of activities which attempt to downsize or close a Medicaid-licensed Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or any other Medicaid-licensed settings serving people with intellectual disabilities, unless the purpose of the action is to remedy systemic abuse.**

VOR is a national 501(c)(3) nonprofit, non-provider organization advocating for high quality care and human rights for all people with intellectual and developmental disabilities (I/DD).

II. Concerns and Rationale for Bill Language Prohibiting HHS Agencies from Using Federal Appropriations in Support of Forced Deinstitutionalization

Forced deinstitutionalization is the elimination of specialized services for people with I/DD and is contrary to federal law and cause human harm. HHS-funded AAID, NCD and CMS pursue deinstitutionalization activities including advocacy, lobbying, class action lawsuits, and other tactics that result in the downsizing and closure of HHS-licensed and funded ICF/IID

For more information, please contact Tamie Hopp at thopp@vor.net or 605-399-1625

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homes, some specialized group homes, sheltered workshops and day programs. **These HHS v. HHS deinstitutionalization activities are a cruel and absurd use of federal funding.**

The legally-protected rights of families and legal guardians to serve as primary decision-makers are routinely ignored and predictable tragedies are widespread when fragile citizens are removed from life-sustaining, specialized care [see e.g., Hundreds of deaths (*Augusta Chronicle*, March 2015); 1,200 “unnatural and unknown” deaths in New York (*New York Times*, 2011-March 2015); a risk of mortality in community settings of up to 88% in California (peer reviewed studies, 1996-2005); more than 100 deaths in Connecticut (*Hartford Courant*, March 2013); 53 deaths in Illinois (*Belleville News-Democrat*, June 27, 2012); hundreds of deaths in the District of Columbia (*Washington Post*, reports since 1999); plus **many more reports of abuse, neglect and death** across the majority of all states (Widespread Abuse, Neglect and Death in Small Settings Serving People with Intellectual Disabilities (VOR, 2015)).

Bill language is desperately needed to prohibit these HHS-funded actions that lead to human harm and are contrary to federal law.

III. Examples of HHS Agencies Using HHS Funds to Eliminate HHS-Supported Homes, Resulting in Human Harm

A. Administration on Intellectual and Developmental Disabilities (AIDD): AIDD, within HHS, administers the DD Act programs: Protection & Advocacy (P&A), DD Councils, and University Programs. AIDD persists in its support for DD Act programs’ deinstitutionalization activities and even proposed a recommendation to “[d]evelop and implement plans to close public and private institutions,” and “[k]eep people with disabilities out of congregate institutions,” in collaboration with Department of Justice and The Arc (2011). The national organizations for the three DD Act programs have referred to families who select HHS-

licensed homes (ICFs/IID) as “clueless” and “unaware.” [June 14, 2010 and July 30, 2007 letters to Congress referring to families as “unaware” and “clueless,” respectively].

With AIDD directive, state-level DD Act program deinstitutionalization activities continue, exacting great harm on the very people Congress entrusted these HHS-entities to protect. For example, Disability Rights Ohio (DRO), the P&A, cited *Olmstead* and threatened a class action lawsuit purportedly on behalf of thousands of Ohioans with I/DD who receive care and support in licensed state and private ICFs/IID, sheltered workshop, or day program settings (July 1, 2014 letter to state officials). In response to DRO allegations and threats, more than 19,000 families (and growing) signed a petition objecting to the budget proposals and many have testified prompting legislators to ask “who does DRO [P&A] speak for?”

In addition, since 1996, more than fifteen (15) P&A class action lawsuits for closure – *not* relating to conditions of care and over the known objection of residents and their families – and other deinstitutionalization tactics have been pursued. The P&A class action lawsuits are a particularly egregious use of federal funds; **they equate HHS suing itself** because the targets of these HHS-funded lawsuits are HHS/Medicaid-licensed ICFs/IID.

B. The National Council on Disability (NCD): NCD is an HHS-funded, independent federal agency that advises the President, Congress, and other federal agencies on issues affecting people with disabilities. On October 23, 2012, NCD released a 230-page policy paper and related toolkit calling for the closure of residential homes for people with I/DD, arbitrarily targeting residential homes for four or more people. NCD spent nearly \$150,000 in federal funds to prepare and publish “Deinstitutionalization: Unfinished Business,” calling on the broader advocacy community to engage in advocacy efforts and lawsuits to evict people with I/DD from their homes. NCD did not consult with the individuals who could be evicted from their homes,

nor their families and legal guardians.

C. Centers for Medicare & Medicaid Services (CMS): Last year, CMS finalized a new regulation (“rule”) that very narrowly defined settings which qualify as “home and community-based” for the purpose of receiving Medicaid Home and Community-Based Services (HCBS) funding. Individuals living in settings deemed too “congregate” or too close to ICFs/IID may not be able to continue to receive necessary HCBS supports. According to CMS, “we seek to ensure that Medicaid is supporting needed strategies for states in their efforts to meet their obligations under the ADA and the Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).” [79 FR 11 (Jan. 16, 2014)]. The ADA, however, forbids public entities from excluding or denying individuals with disabilities equal opportunity to receive program benefits and services, and must provide services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. [*Olmstead* at 592, *citing* the ADA, 28 CFR §35.130(d) (1998)]. The new CMS rule defines “community” so narrowly that it will disqualify certain community homes, essentially redefining them as “institutions” for the purpose of HCBS funding eligibility. In so doing, CMS has effectively denied individuals with disabilities access to the very services they want and need by disqualifying some community settings that are in fact “the most integrated setting appropriate to the needs of qualified individuals with disabilities,” in direct violation of ADA.

IV. The Law: The *Olmstead* Decision, Medicaid Law, and the DD Act Protect Individual Choice Based on Need

HHS-funded organizations pursuing forced deinstitutionalization cite the landmark Supreme Court decision of *Olmstead v L.C.* (1999) as justification for its position to close HHS homes. However, the Supreme Court is clear in its holding that the ADA requires individual choice

before community placement can be imposed and recognizes the need for specialized care: “We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings...Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it.” *Olmstead*, 527 U.S. 581, 601-02 (1999) (1999) (majority).

Medicaid law and regulation also require that ICF/IID residents be “[g]iven the choice of either institutional or home and community-based services.” [42 C.F.R. §441.302(d)(2)].

The **DD Act**, which authorizes funding for AIDD programs, and related Congressional history, support residential choice and recognizes that individuals and their families are the “primary decisionmakers” with regard to services, supports and policies (DD Act, 42 U.S.C. 15001(c)(3)(2000); *see also*, H. Rep. 103-442 (March 21, 1994) (“[T]he goals expressed in this Act to promote the greatest possible integration and independence for some individuals with developmental disabilities may not be read as a Federal policy supporting the closure of residential institutions”)].

V. Solution and Conclusion

HHS-funded agencies must be *prohibited* from advancing a federally-financed ideological agenda in support of evicting eligible people from HHS-licensed homes, contrary to the ADA/*Olmstead*, the DD Act, and Medicaid law. Such actions are a cruel and absurd use of federal funding that is exacting great harm on our nation’s most vulnerable citizens with I/DD, and contrary to societal values and laws which respect individual and family decision-making. Please support language to ***prohibit* HHS-funded deinstitutionalization activities.** Federal agencies must not define “choice” so narrowly and illegally as to disenfranchise the most vulnerable segment of our society.

Mr. COLE. Thank you so much for your testimony. It is a genuine problem. Sometimes the effort to deinstitutionalize goes too far in some cases. So thank you for bringing it to our attention.

Ms. REESE. It is literally throwing the baby out with the bathwater. And for people like Virginia, for 16 years living in the community was a disaster, and I am only grateful to God that she lived through it and we were able to get her the right care. So thank you so much.

Mr. COLE. We thank you for your testimony.

If we could, next we will call on Whitney O'Neill Englander, government relations manager of the Harm Reduction Coalition.

Good to have you here.

WEDNESDAY, APRIL 29, 2015.

HARM REDUCTION COALITION

WITNESS

**WHITNEY O'NEILL ENGLANDER, GOVERNMENT RELATIONS MANAGER,
THE HARM REDUCTION COALITION**

Ms. ENGLANDER. Hi. Thank you so much, Chairman Cole, and thank you, Representative Roybal-Allard. I really appreciate the opportunity to testify today.

My testimony with focus on the opioid epidemic. The fiscal year 2016 HHS budget request includes \$99,000,000 in new funding for the Secretary's opioid initiative. The Harm Reduction Coalition supports this request, and at a minimum, asks the subcommittee to prioritize the SAMHSA requests for \$12,000,000 to prevent opioid overdose-related deaths, and \$25,000,000 for medication assisted treatment.

Additionally, we support the division of viral hepatitis request for \$62,000,000 to address rising opioid-related cases of hepatitis C, and we strongly recommend removing the policy rider currently restricting States from using existing Federal funds to support syringe exchange programs critical to preventing infectious disease. The opioid epidemic, which had previously been confined to a few epicenters has now spread and is devastating every corner of the Nation. Oklahoma has the fifth highest overdose rate in the Nation.

According to CDC data, opioids were responsible for 24,000 fatal overdoses in 2013. We lose an average 67 Americans a day. The majority of these deaths are preventable. Tragically, however, unintentional opioid overdose is continuing to rise, substance use disorders continue to go untreated despite availability of evidence-based interventions, and viral hepatitis cases are exploding with new co-occurring outbreaks of HIV.

To date, our Nation's response has largely centered on policies focused on controlling the supply of prescription opioids through interdiction efforts and the closing of pill mills, efforts to stem over-prescribing. These are all important efforts and are helping to make a difference. Recent CDC mortality data demonstrate that prescription-related deaths are leveling off, but these gains are being more than offset by a sobering 39 percent increase in heroin-

related deaths. We are facing an unprecedented availability of cheap, abundant, and potent heroin.

Our opioid response framework must be broadened to address both prescription and heroin dependency comprehensively tackling both supply and demand with sustained investment in proven health public strategies. One strategy is the expansion and utilization of a life saving rescue medication, naloxone that safely and effectively reverses an overdose with no potential for abuse. I have cried with parents who have lost children because they did not have access to naloxone. One parent received an naloxone kit weeks before her daughter's overdose. Her daughter lived because she had access to naloxone. Emergency services arrived a full 25 minutes after she found her daughter blue and not breathing.

First responders should be armed with this lifesaving tool, but it is not enough. Every American household who has a loved one whose life may depend on a dose of naloxone deserves to have it in the medicine cabinet. We support the SAMHSA request for \$12,000,000 to provide grants to States to support overdose prevention education and the purchase of naloxone and strongly recommend this investment be focused on community-based programs that provide family members and other lay persons with this lifesaving tool.

We must also strengthen the capacity of our Nation's substance use treatment system. The NIH Office of National Drug Control Policy and World Health Organization all recognize that buprenorphine and methadone are the standard of care for the treatment of opioid dependency. NIDA studies have found that maintaining a patient on buprenorphine lowers overdose risk by two-thirds, prevents hepatitis C infection, and significantly increases recovery rates from substance use. Yet only 1 in 10 individuals will make it into the treatment system, and of those, only 8 percent of eligible patients will receive evidence-based medication therapy.

We support SAMHSA's request for \$25,000,000 for medication assisted treatment, for prescription drug and opioid addiction to ensure families have access to lifesaving medical interventions they need and deserve.

Lastly, the attendant health and downstream impacts of the opioid epidemic are becoming evident in infectious disease outbreaks. The CDC released data last Friday demonstrating new hepatitis C infections increased nationally by a shocking 150 percent. And Scott County, Indiana has identified as of now 143 cases of HIV linked to prescription drug use. We should be utilizing every evidence-based tool and strategy we have available and recommend removing the Federal funding ban on syringe exchange services.

Some people may say that the policies we recommend send the wrong message. I disagree. I believe they send exactly the right message that your life matters. You have an opportunity to change your future. This is often the message that propels people to a life of long-term recovery. Thank you for the opportunity to testify today.

[The information follows:]



Testimony on the Opioid Epidemic and Concomitant Health Consequences

Whitney O'Neill Englander, Government Relations Manager, Harm Reduction Coalition

Thank you Chairman Cole, Ranking Member DeLauro, and the Members of the Subcommittee for the opportunity to testify. My testimony will focus on the impact of the opioid epidemic on communities, families, and millions of individuals across the nation. The FY 2016 HHS Budget Request includes \$99 million in new funding for various activities to support the Secretary's Opioid Initiative. The Harm Reduction Coalition supports this request, and at a minimum, asks the Subcommittee to prioritize the SAMHSA requests for \$12 million for Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths, and \$13 million (\$25 million total) for Medication Assisted Treatment (MAT) for Prescription Drug and Opioid Addiction. Additionally, Harm Reduction Coalition supports the Division of Viral Hepatitis request for \$62 million to address rising opioid related cases of hepatitis C and we strongly recommend removing the policy rider currently restricting states from using existing federal funds to support syringe exchange programs that are critical in preventing infectious disease.

The opioid epidemic is complex, pervasive, deadly, and tragic. According to CDC data, opioids – both prescription painkillers and heroin – were responsible for 24,000 fatal overdoses in 2013. We lose an average 67 Americans a day to opioid overdose. The majority of these deaths are preventable through primary prevention, access to quality, evidence-based treatment, overdose prevention education and – in the event of an overdose – the timely administration of the live-saving rescue medication naloxone. Tragically, however, unintentional opioid overdoses continue to rise, substance use disorders continue to go untreated despite availability of evidence-based interventions, and viral hepatitis cases are exploding with new co-occurring outbreaks of HIV. The opioid epidemic, which had previously been confined to a few epicenters,





has now spread and is devastating every corner of the nation. Rural and suburban communities that lack prevention and treatment infrastructure have been disproportionately impacted.

To date, our nation's response has largely centered on policies and programs focused on controlling the supply of prescription opioids through interdiction efforts and the closing of pill mills; prescription drug monitoring programs (PDMP's) designed to identify aberrant doctor and patient behavior; disposal programs to safely discard unwanted medications; and efforts to stem overprescribing. These are all important efforts and are helping to make a difference. Recent CDC mortality data demonstrate that prescription opioid related deaths are leveling off, but those gains are being more than offset by a sobering 39% increase in heroin related deaths. We are facing an unprecedented availability of cheap, abundant, and potent heroin that is increasingly mixed with lethal drugs such as fentanyl. Currently, Pennsylvania is experiencing a rash of fentanyl related overdoses, and in Kentucky, a national leader in addressing the prescription drug epidemic, heroin related overdoses have increased by 550%. Our opioid response framework must be broadened to address both prescription and heroin dependency comprehensively, tackling both supply and demand with sustained investment in proven public health strategies.

One strategy is the expansion and utilization of the lifesaving, rescue medication naloxone, an opioid antidote that safely and effectively reverses an overdose by displacing opioids from opioid receptors, allowing the resumption of breathing that has stopped or slowed. There is no potential for abuse of naloxone and it is benign in individuals without opioids in their system. Naloxone has been used in hospital and emergency settings for nearly 50 years and over the past few years, 32 states and the District of Columbia have passed laws to expand its use in the home and community. Idaho, in response to a 250% rise in opioid overdose related deaths, recently took legislative action to expand naloxone access. Similarly, in my home state of

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California, policymakers recently passed statute and promulgated regulations to allow naloxone to be accessed in all pharmacies without a prescription. I've cried with parents as they've told me harrowing stories of holding their children when they've stopped breathing while waiting for an ambulance. No parent, no family should have to experience this tragedy. One parent received a naloxone kit and training on its use by a community-based program less than two months before her daughter's overdose. She described to me the chilling scene of finding her daughter blue and not breathing while screaming for her younger daughter to call 911. She put her daughter in the recovery position and administered the naloxone; she said the few minutes felt like hours. It took two doses and her daughter lived because she had naloxone on hand; emergency services arrived a full 25 minutes later. If this mother had not been armed with naloxone to rescue her daughter, her daughter likely would have died or experienced severe brain damage.

Community naloxone access empowers families to care for their own. First responders, police, fire, and rescue personnel should be armed with this life saving tool, but it is not enough. Every American household who has a loved one whose life may depend on a dose of naloxone should be able to have it in the medicine cabinet. To expand family and friend access to naloxone, we support the SAMHSA request for \$12 million to provide grants to states to support opioid overdose fatality prevention efforts and the purchase and distribution of naloxone. We strongly recommend this investment be focused on community-based programs and initiatives that provide family members and other laypersons with overdose recognition and intervention training and education coupled with access to rescue medications. Such programs can also facilitate linkage to treatment and recovery services for individuals with opioid dependency. We must also strengthen the capacity of our nation's substance use treatment system. The NIH, Office of National Drug Control Policy, and World Health Organization all recognize that





buprenorphine and methadone are the standard of care for the treatment of opioid dependency. NIDA studies have found that maintaining a patient on buprenorphine treatment lowers overdose risk by two-thirds, prevents hepatitis C infection, and significantly increases recovery rates from substance use disorder. Sadly, these life saving medications are too often out of reach for people who need them. As NIDA director Nora D. Volkow, M.D., explains: "These medications can improve lives and reduce the risk of overdose, yet medication-assisted therapies are markedly underutilized." Only one in ten individuals will make it into the treatment system, and of those only 8% of eligible patients will receive evidence-based medication therapy. I recently spoke with a mother who was losing hope as her daughter had been through eight detox programs and five in-patient treatment centers. Shamefully, they had never been told about buprenorphine as an option; thirteen gut wrenching episodes and not once were they offered the one medical intervention proven effective to treat this young woman's potentially fatal disease. Tragically, this story tends to be the rule and not the exception. The Harm Reduction Coalition supports SAMHSA's request for \$13 million (\$25 million total) for Medication Assisted Treatment (MAT) for Prescription Drug and Opioid Addiction, to ensure individuals with opioid dependency have access to lifesaving medical interventions they need and deserve.

An explosion of hepatitis C infections linked to prescription opioid and heroin injection is having a particularly devastating impact on young adults already struggling with opioid use disorders. The CDC reports that new hepatitis C infections increased nationally by a shocking 75% in only two years, with the majority of states reporting rising new infections. CDC has requested an additional \$31.5 million for the Division of Viral Hepatitis, for a total of \$61.2 million, with part of the new funding aimed at preventing hepatitis C among people who inject drugs. We support this request, and ask that at a minimum the Subcommittee prioritize at least





\$10 million in additional funding to address the urgent hepatitis C prevention needs of states and communities struggling with the opioid epidemic.

Public health officials are concerned that rising hepatitis C rates could be a harbinger of a new wave of HIV infections. In Southeastern Indiana, Scott County has been rocked by an HIV outbreak linked to prescription opioid injection. One hundred and thirty HIV cases have been identified with many more people at risk. Each HIV infection could cost the public \$600,000 to treat and manage because most of the payment for care will be borne by the public health system. This outbreak was preventable: twenty-five years of experience and data have proven that syringe exchange programs prevent infectious disease, do not increase or encourage drug use, and provide an essential bridge to substance use disorder treatment and recovery. We should be utilizing every evidence-based tool and strategy we have available; as such, Harm Reduction Coalition recommends removing the federal funding ban on syringe exchange programs.

Like one in three American households, my life has been personally touched by substance use disorder. I have seen firsthand the devastation of overdose, hepatitis C, and failed treatment. But I have also seen what works and I've witnessed firsthand the redemption of reaching a hand out to those who have been pushed down, pushed aside and forsaken. Some people may say the policies we recommend send the wrong message. I disagree. I believe it sends exactly the right message; your life matters and you have an opportunity to change your future. This is often the empowering message that propels people toward a life of long-term recovery. Thank you for the opportunity to provide testimony. Harm Reduction Coalition stands ready to be a resource to you and the Subcommittee on these issues of national importance.



Mr. COLE. Thank you very much for your testimony, and without committing to any of the requests, as I am sure you are aware, this is a problem that the chairman of the full committee has a great deal of interest and concern about. You are exactly right in terms of the epidemic of both overdose and misuse and prescription, so it is a timely presentation. Thank you very much. The gentlelady have any comment or question.

Thank you. Okay. Next, if we could, Karen West, who is a director of out of school programs, the Afterschool Alliance. Good to have you here. You have been very patient.

Ms. WEST. Good morning.

Mr. COLE. Good morning.

WEDNESDAY, APRIL 29, 2015.

AFTERSCHOOL ALLIANCE

WITNESS

**KAREN WEST, SPECIAL PROJECTS CURRICULUM SUPERVISOR,
CORBIN INDEPENDENT SCHOOLS OF CORBIN, KENTUCKY AFTER-
SCHOOL ALLIANCE**

Ms. WEST. Chairman Cole and other members of the committee, I would like to thank you for providing me an opportunity on behalf of the Afterschool Alliance to share with you the benefits of the 21st Century Community Learning Centers to our schools across the Nation. 21st Century plays a vital role in communities by providing services to students most at risk for academic failure and especially those in gap populations. These programs represent unique collaborations between schools and community members to provide a balance of academic and nonacademic interventions to students who lack family support, individual drive, or connection to the schools they attend. These programs operate before school, during summer months, and in peak afterschool hours when students are most likely to engage in illicit behaviors.

My home district knows the impact of successful implementation of the 21st Century model. In the most recent academic school year, Corbin Independent had an enrollment of just under 3,000 students. Poverty rates are as high as 43 percent. This is not the result of unemployment or in a bleak economy, but it is representative of generational poverty perpetuated by cycles of undereducation.

Nearly one in three students hails from a home in which a parent does not have a high school diploma. 88 percent of our students are latchkey children. There are no available summer, afterschool, or educational programs outside 21 Century.

Despite these circumstances, the Corbin school district has found a path to success in leading our students to achieve postsecondary transition. In fact, we have consistently ranked in the top five district in our State's accountability measures. More importantly, Corbin has had zero students drop out since the implementation of 21st Century programs more than 10 years ago.

The success of our district is not accidental. It is parallel to the implementation of 21st Century programs for all of our students in grades K through 12. Outcomes for our participants from the most

recent academic year reveal 1,329, or one-third of our students attended the 21st Century program. 82 percent who attended regularly improved reading grades from fall to spring. 81 percent improved math grades.

Students participating in Afterschool ACT prep achieved as much as a 7-point gain. The use of harmful substances among our students has declined dramatically. Prescription drug abuse dropped 73 percent. Marijuana usage rates decreased 50 percent.

My story is not unique to the Corbin district. This level of success is seen in countless schools and communities across Kentucky, nationwide who implement 21st Century programs. Statewide, Kentucky has seen tremendous impact. A total of 189 program sites are funded across the State, and in 2013, 47,315 children and youths were served in these programs. These numbers are replicated in other States as well.

What makes 21st Century programs work? These centers are individualized to each State and community who examines the needs of the population and designs a program to close achievement gaps and to prepare students to become college and career ready in their transition to postsecondary life. Our programs orchestrate opportunities that anchor students to peers and adults in the schools so that they value coming to school and see education as a pathway to the future that otherwise seemed only vaguely possible.

If anything, the greatest weakness of the program is that there is not enough funding to offer 21st Century more schools and communities. In fact, only one of three requests is funded nationwide. I am grateful for the opportunity today to share the wonderful work that 21st Century Afterschool and summer learning programs are doing for our children. The impact of these centers on our students is immeasurable. Many come to the program because we have policies that require makeup work or testing. When they walk in the door, they quickly find a place where they are home, where they are welcome, where they connect to a new friend, a teacher, or a volunteer in a way that did not seem possible. Suddenly school isn't a punishment, isn't a place that they have to be. It is a place where they can develop interests and talents and see the connection between what they are learning in the school day courses and the real world around them.

Instead of dropping out of school or misbehaving, these students become focused on their future, a brighter future, and clearly see the pathway to the possibilities before them. 21st Century programs change millions of lives. As a representative of the community that has directly benefited from these programs, I encourage the committee to ensure that funding remains dedicated to Afterschool, before school, and summer programs through 21st Century Community Learning Centers.

[The information follows:]

U.S. House Committee On Appropriations

Subcommittee on Labor, Health, and Human Services, Education and Related Agencies

April 29, 2015

Testimony of Karen West

Special Projects Curriculum Supervisor, Corbin Independent Schools of Corbin, KY

Afterschool Alliance

Good morning. I would like to begin by personally extending my sincere appreciation to Chairman Cole and Ranking Member DeLauro for the invitation to share the success and need for the 21st Century Community Learning Center initiatives for our students across the nation, within the state of Kentucky, and in my community of Corbin, Kentucky.

21st Century Community Learning Centers play a vital role in communities across the nation in providing services to students most at-risk for academic failure and especially those in gap populations who typically achieve at rates lower than their highest-achieving peers. These programs represent unique collaborations between schools and community members to provide a balance of academic and non-academic interventions to students who lack family support, individual drive, or a connection to the schools they attend. These programs operate before school, during summer months, and in peak afterschool hours when students are most likely to engage in illicit behaviors such as substance abuse.

My home district knows the impact of successful implementation of the 21st Century Community Learning Center Model. In the most recent academic school year (2014), Corbin Independent had an enrollment of just under 3,000 students. We are situated in one of the Five Promise Zones across the nation in a rural area in which economic despair is rampant. Poverty

rates are as high as 43%. This is not the result of unemployment or a bleak economy but is representative of generational poverty perpetuated by cycles of under-education. Nearly one in three students hails from a home in which a parent does not have a high school diploma. 88% of our students are latchkey children. There are no available summer, afterschool, or educational programs outside the 21st Century programs in our rural area.

Despite these circumstances, the Corbin school district has found a path to success in leading our students to achieve postsecondary transition – in fact, we have consistently ranked in the Top 5 districts in our state’s accountability rankings. More importantly than this tidbit, Corbin has had ZERO students drop out of school since the implementation of 21st Century programs for our youth.

The success of our district is not accidental – it is parallel to the implementation of 21st Century Community Learning Center programs for all our students in grades K-12. Outcomes for our participants for the most recent academic year reveal:

- *1,329 (one-third) of our students attended our 21st Century program;

- *82% who attended regularly improved reading grades from fall to spring;

- *81% who attended regularly improved math grades from fall to spring;

- *Students participating in our three-week afterschool ACT prep program saw an average gain of two points in their composite score, while some achieved as much as a 7 point gain from the December to March test dates; and

- *The use of harmful substances among our students has declined dramatically during the past five years of program implementation. Prescription drug abuse dropped 73%; Marijuana usage rates decreased 50%; cigarette smoking receded by 30%; alcohol use declined by 15%.

My story is not unique to the Corbin District. This level of success is seen in countless schools and communities across Kentucky and the nation who implement 21st Century programs. Statewide, Kentucky has seen tremendous impact.

*A total of 189 program sites are funded across the state with 21st Century dollars (*Kentucky Department of Education 21st Century APR program data*);

*21stCCLC brings in approximately \$17 million into Kentucky (which also funds a significant number of jobs) to provide quality after school and summer learning programs;

*In 2013, 47,315 children and youth were served in these programs (*Kentucky Department of Education 21st Century APR program data*); and

*Participation rates in Kentucky have grown from 7% in 2004 to 15% in 2014, largely due in part to the increase in appropriation levels (*America After 3PM report*).

What makes 21st Century programs work? 21st Century Community Learning Centers are individualized to each state and community who examines the needs of the population and designs a program to close achievement gaps and to prepare students to become college- and career-ready in their transition to post-secondary life. For students who attend the program, the opportunities provided in 21st Century are a lifeline that save them from being lost in a sea of ambivalence and disconnect from their future and the educational experience. 21st Century Community Learning Centers orchestrate opportunities that anchor students to peers and adults in their schools and communities so that they value coming to school and see education as a pathway to a future that otherwise seems only vaguely possible. This is accomplished through providing academic supports paired with personal connections, community partnerships, and structured opportunities that allow students to explore and develop talents and interests that are not addressed as part of the regular school day.

If anything, the greatest weakness of the program is that there is not enough funding to offer 21st CCLC in more schools and communities. In fact, only 1 out of 3 requests for 21st CCLC funding is awarded nationally. Over the last 10 years, \$4 billion in local grant requests were denied because of the lack of adequate federal funding and intense competition (*Learning Point Associates, 2012*).

Demand for afterschool programs continues to grow. Today, 10.2 million children participate in afterschool programs. Another 19.4 million children would participate if a program were available – up from 15.3 million in 2004. For the first time, a majority of school-age children either are, or want to be, in an afterschool program. In 2014, 11.3 million school-age children were unsupervised between the hours of 3 and 6 when juvenile crime and other inappropriate activities peak.

Nationally the outcomes of 21st CCLC are clear as well:

- Research in 2011 and 2012 from several state education agencies found that teachers report that students regularly participating in 21st Century Community Learning Centers show improvements in homework completion, class participation, attendance, behavior in class, and reading and math achievement scores and grades (American Institutes for Research, 2011 & 2013; Evers, 2012).
- A separate 2013 study out of the University of California, Irvine’s School of Education found that regular participation in afterschool programs helped to narrow the achievement gap between high-income and low-income students in math, improved academic and behavioral outcomes, and reduced school absences (Pierce, Auger & Vandell, 2013).

We also know the federal government is getting its money’s worth with 21st CCLC. A recent return on investment analysis in Vermont found that **for every \$1 invested in quality**

afterschool and summer learning programs, Vermont sees a return of \$2.18 in long-term benefits and savings.

I'm grateful for the opportunity today to share the wonderful work that 21st CCLC afterschool and summer learning programs are doing for our children and to ask that you do all you can to ensure that funding for afterschool programs continues and grows. The impact of these programs on our students is immeasurable. Many come to the program because we have school policies instituted that require make-up work or tutoring when they do not make adequate academic progress. When they walk in the door, they quickly find a place where they are home, where they are welcome, where they connect to a new friend, a teacher, or another caring adult in a way that did not seem possible. Suddenly, school isn't a punishment; it isn't the place they "have" to report each day – it's a place they can develop interests and talents and see the connection between what they are learning in school day courses and the real-world around them. Instead of dropping out of school or misbehaving, these students become focused on their future, a brighter future, and clearly see the pathway to the possibilities before them. **21st Century programs change lives!** As a representative of a community that has directly benefitted from 21st CCLC, I encourage the committee to ensure that 21st CCLC funding remains dedicated to afterschool, before school, and summer programs. In this difficult economy, it is especially critical that funds for afterschool not be diverted to other purposes, which would result in even more kids left without afterschool programs.

Mr. COLE. Thank you very much for your testimony. Any comments or questions? Thanks again. Great to have you here.

And now the most patient man in the room. Paul Fockler, executive director of NorthWest Domestic Crisis Services, Woodward, Oklahoma. Paul, good to see you and good to have you here and thank you for being so patient.

WEDNESDAY, APRIL 29, 2015.

NORTHWEST DOMESTIC CRISIS SERVICES

WITNESS

PAUL FOCKLER, EXECUTIVE DIRECTOR, NORTHWEST DOMESTIC CRISIS SERVICES, INC.

Mr. FOCKLER. Not a problem. Thank you.

Chairman Cole, Representative Roybal-Allard, it is a pleasure to testify in support of fully authorized funding for the Family Violence Prevention and Family Services Act. Domestic violence is in the national spotlight this year because of a high profile assault captured on video. Advocates know deeply the disturbing images from that elevator reflect real life experiences of victims every day.

Everyone agrees that all survivors should be able to feel free to flee violence and abuse. I testify today to ask for the resources that will lead us closer to that goal. As the executive director for the NorthWest Domestic Crisis Services in Oklahoma for the last 24 years, I have developed an in-depth understanding of the issues facing domestic violence victims. My organization provides services among the most rural parts of the Nation. It is over 129 miles from one end of our area to the other.

I want to take a minute and talk about Jane, a client's story who sticks with me. She called on our hotline because her husband threatened to kill her and her children. Jane and her three children came to our shelter and an advocate helped them obtain a protective order. We assisted Jane with job skills and resume development and she quickly obtained employment. She moved into our transitional housing apartment, and then she continued to utilize our counseling and advocacy services. Her abuser is now in jail. He was finally arrested after harassing and threatening to kill them. Jane is still safe, productive, and happy.

Jane is just over—is just one of over 12,000,000 people who are victims of domestic violence each year. Victims of intimate partner violence experience fear, concern for their safety, injury, need for medical care and housing, they miss work and school. The terrifying conclusion of domestic violence is often murder. Every day in our country an average of three women are killed by a current or former intimate partner. In fact, Oklahoma is ranked third in the Nation—highest in the Nation in the rate of women murdered by men. The cost of intimate partner violence exceeds \$5,800,000,000 every year. FVPSA was the first national legislation to address domestic violence and has remained the only Federal funding directly for shelter programs.

There are approximately 2,000 local programs offering services, which is emergency shelter, counseling, legal assistance, prevention education to millions of people annually. If these programs did not

exist, the consequences for victims would be dire, including homelessness, loss of children, and/or continued abuse or death.

Programs use the FVPSA funds to keep the lights on and the doors open. I cannot overstate how important this funding is. Victims must have a place to flee when they are escaping life-threatening violence. All roads lead to FVPSA. All increased attention to this issue such as training for law enforcement, prosecution, court personnel, and efforts to improve referrals from healthcare professionals of social service professionals have led to an increase in demand for our shelter and our services.

Each year, the National Network to End Domestic Violence releases a report, "Domestic Violence Counts." It is 24-hour national census of domestic violence services. The 2014 report revealed that in just one day, while more than 67,000 victims received services, almost 10,000 services were unmet due to a lack of funding and resources.

That day in Oklahoma, our program served over 800 victims, but over 60 requests for services went unmet. In 2014 domestic violence programs across the country laid off nearly 1,400 staff members and reduced over 1,800 services. In fiscal year 2013, FVPSA funded program sheltered and served over 1,300,000 million victims. Due to a lack of capacity, 186,552 requests for shelter went unmet.

In Oklahoma, requests for services rose 10 percent between 2013 and 2014, and these programs served over 10,000 survivors while turning away another 1,000 survivors.

In fiscal 2013, was the first time in our history, in my agency's history who could not meet the request for services. Imagine a victim like Jane who has the potential to live a safe, violence-free life but who can't because she cannot get the help she needed. Programs like ours are desperate to continue to serve victims and we want to do more. We never want to have to turn away victims away from services when they have finally built the courage to come forward.

Fully-funded FVPSA will help us move closer to that goal and will result in up to 390,000 additional victims served each year. In order to help us meet the immediate needs of victims in danger, continue our progress towards preventing and ending domestic violence and reducing societal costs, FVPSA funding must be increased to its authorized level of \$175,000,000. Thank you.

[The information follows:]

**Testimony for the Labor, Health and Human Services Appropriations Subcommittee
U.S. House of Representatives
Paul D. Fockler, Executive Director, NorthWest Domestic Crisis Services, Inc.
April 29, 2015**

Chairman Cole, Ranking Member DeLauro and distinguished Members of the Committee: It is an honor to testify in support of a targeted \$253 million investment in funding for the Family Violence Prevention and Services Act (FVPSA) shelter and supportive services, and related Violence Against Women Act (VAWA) programs administered by the U.S. Department of Health and Human Services in the FY 2016 Budget.

Domestic violence is in the national spotlight this year because of a high profile assault captured on video and the spotlight has encouraged our nation to reassess its efforts to prevent and end these degrading and life-threatening injustices. It has also meant that more victims are coming forward for help, at the same time that victim service providers are facing budget cuts. Advocates know that the deeply disturbing images from that elevator reflect the real, lived experiences of millions of survivors across this nation. We all know that ALL survivors should be able to flee such violence and abuse. I testify today to ask for the resources that will move us closer to that goal.

As the Executive Director of NorthWest Domestic Crisis Services for the last 24 years, I have developed an in-depth understanding of the issues facing victims of domestic violence and the advocates who serve them. I know that our experience is mirrored in shelters and programs across the country. My organization is in one of the most rural parts of the nation. NWDCS provides services to all victims in a ten county area of Oklahoma. It is 259 miles from one end of this service area to the other. We have a second shelter located 125 miles to the west, but it is still a significant distance for survivors across our vast region. While many generations of "Okies" have thrived there for a hundred years, the isolated communities keep many victims silent. One client's story has stayed with me for years. "Susan" called our hotline requesting assistance with a protective order. Her husband was threatening to kill her and their children. Our advocate

assisted Susan with obtaining a protective order for herself and three children. Susan was justifiably terrified to return home and decided to stay in our shelter. Her perpetrator was arrested but soon bonded out of jail. We assisted Susan with job skills and resume development, and she quickly obtained employment. Susan thrived in our support groups and we worked with her teenage children to better cope with the aftermath of abuse. Susan moved from shelter to our transitional living apartments where she continued to utilize our counseling and advocacy services for herself and her children to rebuild their lives after the abuse. The perpetrator continued to harass Susan and her children through text messages and he was finally caught and arrested in another state. He is still in jail for the violence, for numerous violations of the protective order, and for threats to their lives. Once he was incarcerated, Susan felt comfortable moving back to a location where she had family support and is very successful in her life. Susan increased her income while receiving services, her children are starting to graduate from high school, and occasionally she still contacts us to thank us and let us know that her life is good now.

Susan is just one of the 12 million people who are victims of domestic violence each year. Female victims of rape, physical violence, or stalking by an intimate partner experienced severe impacts such as fear, concern for their safety, injury, need for medical care, need for housing services, and missing work or school.ⁱ The terrifying conclusion of domestic violence is often murder, and every day in the United States, an average of three women are killed by a current or former intimate partner.ⁱⁱ In fact, Oklahoma is ranked the 3rd highest in the country in its rate of murders of women by men, and 55% of those homicides are related to domestic violence. In addition to the terrible cost domestic and sexual violence have on the lives of individual victims and their families, these crimes cost taxpayers and communities. The cost of intimate partner violence exceeds \$5.8 billion each year, \$4.1 billion of which is for direct health care services.ⁱⁱⁱ Domestic violence costs U.S. employers an estimated \$3 to \$13 billion annually.^{iv} Despite this grim reality, we know that when a coordinated response is developed and immediate, essential services are available, victims can escape from life-threatening violence and begin to rebuild their lives.

Here are the specific requests I would make on behalf of survivors and advocates across the nation.

Family Violence Prevention and Services Act (FVPSA) (Administration for Children and Families) –

a \$175 million request. Since its passage in 1984 as the first national legislation to address domestic violence, FVPSA has remained the only federal funding directly for shelter programs. Now in its 30th year, FVPSA has made substantial progress toward addressing domestic violence. Despite the progress and success brought by FVPSA, a staggering and unacceptable need remains for FVPSA-funded victim services. There are more than 2,000 community-based domestic violence programs for victims and their children (approximately 1,500 of which are FVPSA-funded through state formula grants), like NorthWest Domestic Crisis Services. These programs offer services such as emergency shelter, counseling, legal assistance, and preventative education to millions of adults and children annually and are at the heart of our nation's response to domestic violence. A recent multi-state study conclusively shows that the nation's domestic violence shelters are addressing victims' urgent and long-term needs and are helping victims protect themselves and their children. This same study found that, if shelters did not exist, the consequences for victims would be dire, including homelessness, serious losses (including loss of children) and/or continued abuse or death.”^v

There is an increased need for funding to maintain programs and bridge the gap. Many programs across the country use their FVPSA funding to keep the lights on and their doors open. We cannot overstate how important this funding is: victims must have a place to flee when they are escaping life-threatening violence. All roads lead to FVPSA. Meaning that increased attention to the issue, such as (1) increased training for law enforcement, prosecutors and court officials, (2) investments in homicide reduction programs and (3) efforts to increase screening and referral by healthcare and social service professionals, has led to a corresponding increase in demand for emergency shelter, hotlines, and supportive services.

Each year the National Network to End Domestic Violence (NNEDV) releases a report entitled *Domestic Violence Counts: A 24-hr **National Census of Domestic Violence Services (Census)***^{vi}. The most recent report revealed that in just one day in 2014, while more than 67,000 victims of domestic violence received services, almost 10,000 requests for services went unmet, due to lack of funding and resources. On that one day in Oklahoma, our programs served over 800 victims but over 60 requests for services went unmet. While Susan was able to get the services she needed to escape the violence, many survivors are left without adequate support. In 2014, domestic violence programs across the country laid off nearly 1,400 staff positions including counselors, advocates and children's advocates and also had to reduce or completely eliminate over 1,800 services including emergency shelter, legal advocacy, and counseling. To learn more, you can read NNEDV's DV Counts Census (www.nnedv.org/census).

In FY '13, domestic violence programs funded by FVPSA provided shelter and non-residential services to over 1.3 million victims. Due to lack of capacity, however, victims of domestic violence made an additional 186,552 requests for shelter which went unmet. In Oklahoma, the requests for services from victims of domestic and sexual violence rose 10% between 2013 and 2014, and programs served over 10,000 survivors while turning away over 1,000 survivors. Our staff, which is already overworked and operating at maximum capacity, provided shelter and services for an additional 64 women and their children and provided an additional 817 residential days in our shelters. Fiscal year 2013 was also the first time in the history of this agency that we could not meet the requests for shelter services, and had to refer women and children to other programs to help them find safety. Numerous times we have to ask families to share their rooms with another victim in need, simply to keep her safe.

NWDCS and programs like us across the nation are desperate to do more for victims. First, we never want to have to turn a victim away from services when she or he has built the courage to come forward. Imagine a victim like Susan who has the potential to live a safe, violence-free life, but who cannot

do so because she could not get the help she needed. Fully funding FVPSA will help us move closer to that goal. Increasing FVPSA from \$135 million (current level) to \$175 million is a 30% increase which could result in an additional 390,000 victims served each year nationally. According to the DV Counts Census, the most frequently requested non-residential services that could not be provided in Oklahoma were housing, advocacy, and financial assistance, followed by legal representation and transportation. With additional funds, NWDCS could hire a legal services attorney to reduce the number of victims who have to face their abusers with no representation. We would also provide more housing advocacy, financial assistance and financial stability services, transportation and childcare. Additional FVPSA funds will also help bolster targeted, specific services to children to help break the cycle of violence.

In order to help meet the immediate needs of victims in danger, continue our progress toward preventing and ending domestic violence, and reducing societal costs, FVPSA funding must be increased to its authorized level of \$175 million.

ADDITIONAL REQUESTS: Related programs at HHS work together to address domestic and sexual violence. These programs include the National Domestic Violence Hotline (ACF) (\$5 million) and CDC programs – DELTA Prevention Program (\$6 million), Rape Prevention and Education (RPE) (\$50 million) and the Preventative Health and Health Services Block Grant, Rape Set-Aside (\$7 million).

¹ Breiding, M.J., Chen J., & Black, M.C. (2014). Intimate Partner Violence in the United States — 2010. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

² Bureau of Justice Statistics. Intimate Partner Violence: Attributes of Victimization, 1993-2011 (Special Report NCJ243300)

³ National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States*. Atlanta (GA): Centers for Disease Control and Prevention; 2003.

⁴ Bureau of National Affairs Special Rep. No. 32, Violence and Stress: The Work/Family Connection 2 (1990); Joan Zorza, *Women Battering: High Costs and the State of the Law*, Clearinghouse Rev., Vol. 28, No. 4, 383, 385.

⁵ Lyon, E. & Lane, S. (2009). Meeting survivors' needs: A multi-state study of domestic violence shelter experiences. Harrisburg, PA: National Resources Center on Domestic Violence.

⁶ A 24-hr National Census of Domestic Violence Services, National Network to End Domestic Violence (forthcoming Spring 2015).

Mr. COLE. Thank you very much, and given the fact we had a chance to visit personally, I don't have any questions, but I appreciate you coming all this way, and much more importantly, I appreciate the work you do, the difference it makes in lives. You know, the only upside of some of the terrible incidents we have seen is I think it is getting a lot more attention now as we talked about, and frankly, hopefully, victims are more willing to come forward—

Mr. FOCKLER. We hope so.

Mr. COLE [continuing]. And communities more willing to be helpful and supportive, so thank you again.

Gentlelady, have any comments or questions?

Ms. ROYBAL-ALLARD. Other than to say the work that you do is absolutely critical. As we know, it doesn't just impact individuals, but the children, families, and then ultimately society as a whole is negatively impacted, so thank you for what you do.

Mr. FOCKLER. You got it. Thank you.

Mr. COLE. As always, the gentlelady makes a great point.

With that, I am going to gavel the hearing to a close. I think the Japanese Prime Minister is probably close into his speech, but much more importantly, I want to thank all of you that came from such a long way, in many cases, to testify. It is testimony that is extraordinarily helpful to us. We have a lot of government witnesses and government programs, but people that are actually dealing with real live problems in the field, the range of them you heard today is pretty extraordinary, and as the gentlelady from Connecticut mentioned earlier, it is not about programs. It is about genuine need, and when you come and offer the testimony, you educate all of us on this committee about the depth and the severity of those needs, and frankly, you give us a lot of tough decisions to make in terms of the resources that we have on how to allocate them, but I have no doubt we will do a better job because each and every one of you took the time to come here and educate us.

And frankly, dozens of other people have submitted testimony that weren't able to testify, but again, that, too, is always helpful. So again, we appreciate you coming all this way, and thank you again. The hearing is adjourned.

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