

DEPARTMENTS OF LABOR, HEALTH AND HUMAN
SERVICES, EDUCATION, AND RELATED AGENCIES
APPROPRIATIONS FOR 2023

HEARINGS
BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SEVENTEENTH CONGRESS
SECOND SESSION

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**DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, EDUCATION, AND RE-
LATED AGENCIES APPROPRIATIONS FOR
2023**

WEDNESDAY, MAY 11, 2022.

NATIONAL INSTITUTES OF HEALTH

WITNESSES

**DIANA BIANCHI, M.D., DIRECTOR, EUNICE KENNEDY SHRIVER NA-
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**ANTHONY S. FAUCI, M.D., DIRECTOR, NATIONAL INSTITUTE OF AL-
LERGY AND INFECTIOUS DISEASES**

**GARY H. GIBBONS, M.D., DIRECTOR, NATIONAL HEART, LUNG, AND
BLOOD INSTITUTE**

**DOUGLAS R. LOWY, M.D., ACTING DIRECTOR, NATIONAL CANCER IN-
STITUTE**

**LAWRENCE A. TABAK, DDS, PH.D., ACTING DIRECTOR, NATIONAL IN-
STITUTES OF HEALTH**

**NORA D. VOLKOW, M.D., DIRECTOR, NATIONAL INSTITUTE ON DRUG
ABUSE**

The CHAIR. I now call to order the hearing on the fiscal year 2023 President's budget for the National Institutes of Health.

This is a hybrid hearing, so we need to address a few house-keeping matters.

I welcome my colleagues who are with us on the screen. For the members joining virtually, once you start speaking, there is a slight delay before you are displayed on the main screen. Speaking into the microphone activates the camera, displaying the speaker on the main screen. So do not stop your remarks if you do not immediately see the screen switch. If the screen does not change after several seconds, please make sure that you are not muted.

To minimize background noise and ensure the correct speaker is being displayed, we ask that you remain on mute unless you have sought recognition. The chair, or an individual designated by the chair, may mute participants' microphones when they are not under recognition to eliminate inadvertent background noise. Members who are virtual are responsible for muting and unmuting themselves.

Finally, the House rules require me to remind you that we have set up an email address to which members can send anything they wish to submit in writing at any of our hearings. That email address has been provided in advance to your staff.

And with that, what I would like to do is to acknowledge and thank Ranking Member Tom Cole and all of the members of the subcommittee joining today's hearing, both virtually and in person.

And a thank you to our witnesses testifying before us today. Dr. Tabak, welcome to the subcommittee. While you started in this role just a few short months ago, you have proven, in your over 12 years as a Principal Deputy Director of the National Institutes of Health and 10 years as the Director of the National Institute of Dental and Craniofacial Research, to be a thoughtful, efficient leader. Thank you for your commitment to making America a healthier place and our healthcare research more equitable. Our deep thanks.

Let me also welcome institute directors joining Dr. Tabak today and our subcommittee this morning—Dr. Diana Bianchi, Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development; Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases; Dr. Gary Gibbons, Director of the Heart, Lung, and Blood Institute; Dr. Douglas Lowy, Director of the National Cancer Institute; and Dr. Nora Volkow, Director of the National Institute on Drug Abuse.

I also want to note, and I think I have said this before—we were able to do it once before—that I do intend to invite an additional panel of institute and center directors to testify before this committee later this year. We have not been able to hold a second panel in the past 2 years, but I value the research of every institute, every center, and want to make sure that the subcommittee has the opportunity to hear from others directly.

I am also going to be reviewing the funding across all the institutes and centers, looking for patterns over time and to hear more about how the institutes and the centers set priorities. So, and I just say this with all sincerity. I mean, I also always think that this is one of the most exciting and exhilarating and meaningful hearings that we have before the Appropriations Committee.

The work that you do, all of the staff, the grantees that the NIH supports, and what you have done to continue prioritizing COVID-19 research over the past 2 years, we would be nowhere close to where we are in defeating this virus. Through the research of the NIH's own science, and everyone talks about how quickly we moved and how successful we were in terms of a vaccine, that just didn't happen overnight. It was the years of research, of investment in the research that allowed us to move as quickly as we were able to.

So through the research of our scientists, researchers, grant institutions, and partnerships with the private sector, our knowledge of the virus has dramatically improved, reliable detection and diagnostic technologies have been developed, treatment options have been implemented, and vaccines and other prevention methods were accelerated and distributed all in record time.

NIH's response to COVID proved what I have known for a long time, that our significant and longstanding support for biomedical research is absolutely critical to ensuring we are prepared to prevent and address healthcare crises whenever they may arise. The work you do saves lives and protects families the world over. And with the proper resources and leadership at NIH, our biomedical

research can move very quickly in very focused ways to achieve high-priority goals and continue to save lives.

None of these transformational advances would have been possible without the annual sustained investment in basic biomedical research made by this committee in a bipartisan way in recent years, which is why I am so proud that over the past 7 years, Congress has increased NIH funding by nearly \$15,000,000,000, or 49 percent. And I repeat that this has been done with a bipartisan effort.

And in the 2022 omnibus recently passed, Congress provided a \$2,250,000,000 increase over 2021. This includes an increase of \$353,000,000 to fund a greater number of research proposals at the National Cancer Institute and support for the Cancer Moonshot initiative that will save lives by speeding cancer research progress and improving prevention, detection, and treatment efforts.

We also provided an increase of \$289,000,000 for Alzheimer's disease and related dementia research to help better understand the cause of Alzheimer's and advance research for diagnosis, care, treatment, and prevention for those with and at risk of developing this disease.

I am especially proud of the \$30,000,000 increase for the IMPROVE maternal health research initiative. The maternal mortality rate in this Nation is far too high, the highest of any developed nation. And more must be done to address this crisis that kills hundreds of mothers every year.

These increased funds to support research on maternal morbidity and mortality will reduce preventable causes of maternal death, improve the health of pregnant people, especially those mothers, the victims of our Nation's health disparities who have been historically underserved.

And health disparities impacting underrepresented communities are an unacceptable issue in nearly every corner of our physical and mental healthcare systems, which is why we delivered an increase of \$50,000,000 for research to identify and reduce health disparities across our country.

I am also proud of the \$8,000,000 increase that Congress provided for the Office of Women's Health—Research on Women's Health, to further promote the interests and involvement of women in NIH-supported research. And I am personally grateful for the \$159,400,000 in fiscal year 2022, the NIH grants that have been delivered. Many have been delivered to my own district, Connecticut's Third, following \$572,800,000 in fiscal year 2021. That is NIH funding for the district.

This funding has already advanced critical research efforts, strengthened the future economy, and grown opportunities in my community. But my hope, my hope is that this is replicated in cities and in small towns and in rural areas across the country. We have to move it beyond our cities to areas across our country.

As we continue to build on these transformative investments, I am pleased that the President's budget request for 2023 proposes an increase of nearly \$4,300,000,000 for NIH. I am pleased that included in the budget request is a proposal to increase research to address health disparities and the opioid crisis, two major issues impacting the health of far too many across the Nation.

I am particularly glad to see the proposed \$15,000,000 increase for universal flu vaccine research and development, an issue that I have been fighting to address for years. And the request for double funding for gun violence prevention research at the NIH, building off the investments this subcommittee has made over the past 3 years.

Despite all the great investments in the bill, however, I am concerned about the lack of balance between the budget request for ARPA-H and the request for other, more “traditional” NIH activities. I know the President’s fiscal year 2023 budget request for NIH was developed before the 2022 omnibus was enacted and might have been different had it been enacted sooner.

However, the proposed increase, \$274,000,000 for core NIH activities, is insufficient and threatens the progress the committee has made in the past several years through significant, sustained investments in biomedical research. I have said it before, and I will repeat it. I am proud of the work we have done together to establish ARPA-H. It is clear that the \$1,000,000,000 investment in 2022 funding this committee made to establish ARPA-H has the incredible potential to develop informative technologies that save lives.

It is historic funding, and it will be used to research the causes and address debilitating impacts of major diseases like Alzheimer’s, diabetes, cancer, ALS, and others that impact the lives of millions of Americans and exacerbate already existing health disparities. However, it is critical that we strike a balance between the investments that we make in ARPA-H and those in basic research and discovery at the NIH.

Dr. Tabak, I know this was not your decision. But while I strongly support NIH and recognize its long record of success in supporting biomedical research, I believe that placing ARPA-H within NIH is a mistake. It will hamper the agency’s ability to achieve the breakthroughs I just outlined. I strongly believe that ARPA-H would be more successful in its unique mission if it were established as an independent agency within Health and Human Services.

With that, let me just say I thank you all for joining us today. Your work, again, is invaluable to the health infrastructure of our Nation, to really improving our medical discoveries, for making these medical discoveries, and ultimately saving lives.

I look forward to our discussion this morning and our work together in the months to come.

And let me recognize Congressman Cole for his opening remarks.

Mr. COLE. Thank you very much.

Before I begin my prepared remarks, I draw one great lesson as a proud Yale graduate, it is a great thing to represent Yale.

What a great magnet for research in good things.

Well, good morning. I am pleased that we can come together in person this morning for the first time in 2 years to hear directly from the National Institutes of Health about the administration’s budget proposal for fiscal year 2023. This is our first hearing in many years without our friend Francis Collins, and we all wish him well in his new endeavors.

As I say every year, a sustained commitment to increasing funding for the NIH is a vital step to preserving our status as the world's leader in biomedical research and to finding cures for many diseases burdening our healthcare system. And we know the funding also does far more. Several studies have shown funding at the NIH has a multiplier effect, contributing to overall U.S. economic growth.

Like the chair, I am proud of what this committee has done year after year on a bipartisan basis since 2015. The NIH budget has increased every year beyond inflation during that period, regardless of who was President, regardless of which party was in control of the Congress. And it shows that there are certainly some important things that we can work together on and I think will have positive results for the country.

And I particularly want to praise my good friend—I make this point a lot—the chairwoman. When I was privileged to be the chair of this subcommittee for 4 years, she was kind enough to back my budgets—not the first one, but the last one, the one that passed—every single time. And I have been very proud to vote for her budgets for three terms since then.

So we may start at different places, but we have a way of ending up at the same place. And this agency, the NIH, is a big reason why, quite frankly. So you actually contribute to bipartisan comity and cooperation.

Given all that, I hate to kick off the hearing on a sour note, but I am probably where the chairwoman is. I am perplexed as to why the administration has chosen to pour billion of dollars in funding into the new ARPA-H program at the expense of ongoing basic research at the NIH.

ARPA-H was funded for the first time in March and, I might add, with my support. Like the chairwoman, I see much potential good here. But as she pointed out in her remarks, there is still a great deal of controversy around it and different opinions from both Republicans and Democrats and, quite frankly, within their ranks over how it should be organized, where it should be placed.

In the end, almost every decision was simply left to the Secretary of Health and Human Services, someone I hold in high record, but he is an executive official, and I think it is unprecedented for the creation of a new agency to lie largely in the hands of one individual.

We still don't know the structure this new agency will ultimately take. We don't have a Director, any possible names of a Director, or any idea when this individual will be named. We don't have a physical location for the new agency. We don't know how grants will be made and who will be responsible for deciding how billions of tax dollars are disbursed.

We don't know how ARPA-H will interface with existing NIH institutes and research or how we can ensure that will be value-added rather than an agency that competes with and siphons off talent. We don't know the rules for hiring staff or how they will be compensated.

So I think it makes no sense to propose an enormous increase of \$4,000,000,000 for this new agency while proposing what is essentially flat funding, and for some important agencies even a modest

cut, for the rest of NIH. And I will have some tough questions about that today, but it sounds to me like we probably have some of the same concerns, Madam Chair.

Next, I think everyone in this room needs to address the difficult topic of the loss of public confidence and credibility across our public health agencies, including the NIH, during the COVID pandemic. I fear that the mistrust in our Government public health system has eroded to a dangerous level.

From our own leaders placing too much trust in the Chinese government in the beginning of the pandemic to locking down our society, economy, and schools, and mixed messages on masking and vaccine mandates, to what many believe is a cover-up on the role, if any, that the Wuhan lab played in the origins of the COVID virus, our public health agencies have made mistakes that need to be acknowledged and corrected.

Now this has weakened confidence in our public health and Government systems for many of our constituents at a time when we desperately need to come together as a people and heal. I certainly pledge to work with my friends across the aisle to rebuild a bipartisan coalition of support for basic science and research and talk honestly about ways we can translate that information into evidence-based practices using data, not just talking points.

Most of our constituents want to do the right thing to stop the spread of COVID. Many just don't believe what they are being told by Government officials anymore, and I suspect we will hear some difficult questions about that this morning.

Much attention in the past year has gone to COVID, and rightly so. But I hope we can also continue our conversations and scientific advancement in such areas as cancer treatment and dealing with Alzheimer's, diabetes, other dread diseases and chronic illnesses.

These diseases are responsible for the loss of hundreds of thousands of American lives every year. And again, I fear this work may be short-changed by the hyperfocus on the new ARPA-H, and I sincerely hope that will not come to pass.

We have an excellent team representing some of the largest institutes and most promising frontiers of new discoveries before us today. As we know, NIH is composed of 27 institutes and centers, most of whose leaders are not able to be with us today. But even though we are not able to have each Director come before us, our offices continually learn about the ground-breaking work and collaborative partnerships at all of the NIH components, and we are all very proud of that work and know our role in making sure that it goes forward. We know that the work done at NIH and each institute or center is a contributor.

In closing, I want to stress that each dollar invested in the NIH is, in my view, a down payment on our future. This work has in the past and will change the course of disease detection, cures in the years and generations to come. I know Congress' commitment to advancing these shared objectives is unwavering and bipartisan.

I want to thank you, Madam Chair, for holding the hearing and thank our witnesses for being here.

I yield back.

The CHAIR. I thank the ranking member.

And Dr. Tabak, your full written testimony will be entered into the record. And now you are recognized for 5 minutes for your opening statement.

Thank you.

Dr. TABAK. Thank you, Chair DeLauro, Ranking Member Cole, and distinguished subcommittee members. I am honored to be here today with my colleagues representing the National Institutes of Health.

This is a time for NIH and the entire biomedical research community to reexamine all of our efforts. During the COVID pandemic, we were driven by the urgency of the moment. NIH must learn from this experience and seize the opportunity to define a new normal.

As Acting Director, I am committed to new strategies, new voices, and a renewed focus on the future. Now is the time to reflect on what worked and did not work to address COVID and to shape new strategies. Your sustained investment in NIH research set the stage for the new mRNA technology and immunogen design that were key to the development of safe and effective vaccines in an unprecedented timeline.

Since these vaccines became available, it is estimated that more than 2 million American lives were saved, and more than 17 million hospitalizations were averted. Now we need continued support for a wide range of biomedical fields, including behavioral and social sciences, to identify and successfully implement better ways of responding to the short- and long-term health effects of COVID-19; to prepare for future pandemics; and to ensure equitable protection of our diverse population.

And it is not just about vaccines. Our Rapid Acceleration of Diagnostics, or RADx, initiative, fueled the development of many new approaches for COVID-19 testing that are already being used in our communities. To help ensure that such benefit was shared with those disproportionately affected by the pandemic, we initiated efforts like RADx Underserved Populations and the NIH Community Engagement Alliance. These experiences, along with other NIH-led efforts focused on COVID treatment development, demonstrate the extraordinary value of public-private partnership.

The NIH can build upon the momentum of the COVID response and apply it to other challenges through the Advanced Research Projects Agency for Health, or ARPA-H. Thanks to your inclusion of key authorities and funding in the omnibus, NIH is beginning to frame the basic administrative infrastructure for ARPA-H. This is a first key step in creating a permanent home for the strategic partnerships that are so urgently needed to address cancer, diabetes, Alzheimer's, and many other diseases.

But we can't stop there. In addition to new strategies, biomedical research needs new voices. A growing body of evidence demonstrates that inclusion of diverse perspectives yields better outcomes. In the clinical setting, diverse medical teams provide more accurate diagnoses and improved health of patients while building trust. We do better science when we have a diversity of scientists from different backgrounds and communities, scientific fields, and various career stages.

NIH continues to prioritize, fund, and empower early stage investigators so that they can succeed as independent researchers. In 2021, we reached an all-time high of early stage investigators funded, 1,513.

The passion and commitment of our scientists is matched by the voices of people with a wide range of diseases and conditions. Conversations with patients and their advocates are sometimes difficult, but those are often the discussions that teach us the most. From the AIDS advocacy groups of the 1980s to today's groups for autism, ME/CFS, long COVID, and many others, these voices have refused to be ignored, and ultimately, all of us benefit.

This is a moment for renewed focus on the future. I spend a lot of time encouraging early stage scientists, but I also think about the importance of engaging elementary school age children like those my wife has taught for over 40 years. During the COVID pandemic, exposure to the importance of science has been a big part of many of their lives.

Past pandemics have inspired young people to become scientists, but the images they saw were usually of older men who looked pretty much like me. Hopefully, today's kids are seeing more scientists who look like them. So we need to do better. Our Nation needs all the bright minds we can find, and I hope you will continue to work with NIH to make this happen.

The CHAIR. Thank you very much, Dr. Tabak.

I am going to try to get in two questions in this first round, and I mentioned the subcommittee has increased the budget by roughly \$15,000,000,000 over the past 7 years. It is almost 50 percent. What I would like to do is to just have you talk about how the NIH determines research priorities.

In many years, NIH proposes to increase funding for a small number of initiatives—the BRAIN Initiative, Precision Medicine Initiative, this year significant increase for ARPA-H. In fact, the proposed increase is significantly larger than the increase for the entirety of NIH research combined.

My question is what are the determining factors in setting NIH research priorities? Is there such an emphasis on large-scale initiatives? If there is, what is being left behind? What happens to research in important areas of health that are not included in large-scale initiatives or ARPA-H? And how do we determine progress in these initiatives?

Dr. TABAK. Well, as you know, it is a balance that needs to be struck, and in recent years, there has been an emphasis on large-scale investment because the scientific opportunity presented itself, either due to new technologies or emerging areas of concern. But in each instance, institutes and centers try and prioritize their effort based upon whether the science is ready to move forward, what the public health need is, and then whether or not the portfolio that they currently sustain is sufficient to move the field forward.

Each institute and center has a strategic plan, and they work with closely their National Advisory Council to make sure that work that is supported aligns with those strategic plans.

The CHAIR. I want to get on to my next question, but the concern is, you know, what do we believe these days is being left behind and that are not included in the large-scale initiatives?

Dr. TABAK. Well, our success rate overall is roughly 20 percent. And I think, historically, we have observed that meritorious applications come at least through the top one-third. So the difference between the 20 percent and the 33 percent represents what is being left behind, as you put it. Those are studies that are certainly worthy of support, but obviously, with finite resources, prioritization has to occur.

The CHAIR. Let me just ask you this. You mentioned success rate. So the success rate for NIH research grants increased each year, from 17 percent in 2013 to 20.6 percent in 2020. However, despite a funding increase of \$1,300,000,000 in 2021, the success rate actually declined to about 19 percent.

I know there are several factors that are at play here, but why did the success rate decline despite the funding increase in 2021, and what is NIH doing in 2022 to avoid another year of decline in the success rate?

Dr. TABAK. Well, as you know, the success rate is simply the number of applications that are funded divided by the number of applications that we receive. And in fiscal year 2021, we received an unprecedented number of applications, and this increase is largely what drove the modest decrease in the success rate.

Obviously, we can't control the number of applications that we receive, and as you alluded to, there are other factors. But the main driver for this decrease was the unprecedented increase in new applications.

The CHAIR. Thank you.

I am going to—I have got a few seconds left here. I am going to yield back and also to mention that I have to step out as there are two other hearings that I have to just pop into, and then I will be back. And I will ask Congresswoman Roybal-Allard to take the chair.

And with that, Congressman Cole.

Mr. COLE. Thanks very much, Madam Chair.

We really don't coordinate our questions, but they are pretty close some days. I want to go back to this concern that I think the chair and I both have about the disparate—or the imbalance, as we would both see it or—I don't presume to speak for her—as I see it, between ARPA-H and NIH.

And I suppose my first—and again, I want to stress, Dr. Tabak, I recognize you don't get to make all these decisions either. And I suspect, honestly, we are speaking for more of you than any of you could admit. But I don't want to throw out the baby with the bath water, and to me, here the basic mission of NIH, which I think you all have done a remarkable job advancing over the years, is the most important element.

And ARPA-H, you know, I hope over time will develop into something like DARPA, but we just simply don't know that yet. So tell me what would happen with \$4,000,000,000 when we don't know the Director. We don't know the procedures. And you can't possibly have that set up to be fair to you because you didn't even know how much money or this thing was going to even exist until March.

So we just sort of threw this at you with \$1,000,000,000 and say come back and show us something. I don't think we can probably

afford to follow that with \$4,000,000,000 more, particularly if we pinch the budgets of the other institutes.

So, again, tell me what that \$4,000,000,000 would do.

Dr. TABAK. Well, our first step, of course, is going to be to build out the infrastructure, the administrative infrastructure of the organization. And from a practical standpoint with the new organization within NIH, we can draw upon some equities that are standard that are used across HHS and, indeed, from other departments, things like our electronic eRA system for grant following and tracking and so forth.

A search is under way for the inaugural Director for ARPA-H, and as you know, this is a presidential appointee. And our charge at the moment is to really focus on the administrative issues. We will certainly bring in a small group of senior operational people focused on the administrative side, but no program managers who will be driving the science will be recruited until the Director is in place.

Mr. COLE. Again, I want to switch to another area, but that would suggest to me that we should be very cautious here about this amount of money, again because I just think it is going to take a while to set this up, get it right. And frankly, I am not convinced the other committees in Congress—Energy and Commerce is going to want to have something to say about this. They are not going to just let the Approps Committee create this out of whole cloth.

So that, again, just makes me very uncomfortable on balance. Although let me make this very clear, too. I totally favor the amount of money we are talking about. I don't have any problem with that. I just have a problem with the distribution between NIH and ARPA-H, given how formed and successful one is and the other is in the process of being formed.

Dr. Lowy, it is good to have you back, and I want to go to this question quickly that the chair touched on because I think probably in cancer, we are seeing one of the most difficult jobs is just the sheer number of applications that are quality applications you are getting. So what is the funding rate at NCI for applications, as compared to NIH district wide, and how promising is the science in cancer going forward?

Dr. LOWY. Well, thank you, Mr. Cole.

The funding rate at the NCI currently is 11 percent payline for experienced investigators and 16 percent for early stage investigators. Last year, thanks to the generosity of Congress, we were able to give more awards than we have ever given before, actually gone up by about 25 percent for experienced investigators over the last 4 years and about 60 percent for early stage investigators.

But as you know, there has been a big increase in the number of applications to NCI, substantially larger than the rest of the NIH. This is very good news in the sense that it is a reflection of the optimism that people have of being able to make progress in cancer. But a direct consequence is that there is a decrease in the payline and success rate.

Mr. COLE. Well, my time is up. But to me, again, you have just made the point as to why we need to get more resources in the various agencies, yours in particular. But I would say this across the board. We have got a lot of promising research here, and I don't

want to tie up money as we create new agencies when you have got worthy recipients right now that could make immediate contributions to the mission that you have there.

So, anyway, I am sure we will be having pretty robust discussion on that. I yield back, Madam Chair.

Ms. ROYBAL-ALLARD [presiding]. Dr. Tabak, I would like to ask about the chimpanzee retirement to sanctuary. In 2000, Congress signed the Chimpanzee Health Improvement, Maintenance, and Protection Act into law, instituting a national sanctuary system to resettle the chimpanzees that are no longer needed in research by Federal agencies.

Since November 2015, when NIH announced it would no longer support any biomedical research on chimpanzees, it has been a priority of mine to see these primates retired swiftly and successfully to the Federal sanctuary, Chimp Haven. However, in 2019, despite congressional directives and strong humane organization recommendations, NIH made the unilateral decision to keep the remaining 44 chimpanzees at the Alamogordo Primate Facility, which is run by the Charles River Research Laboratories, a global corporation whose business model is to breed, import, sell, and experiment on nonhuman primates and other animals.

Since that time, 12 chimpanzees have died, and at least half were euthanized. Multiple animal welfare experts have expressed concerns that Charles River management strategies may expose chimpanzees to an environment which results in chimpanzees meeting some criteria which leads to a euthanasia decision.

Because invasive research on chimps was still legal when the CHIMP Act was passed, Congress recognized chimps being retired would likely be older or have serious health conditions because they would no longer be useful for research. In fact, NIH's own regulations recognized the possibility that chimps with infectious disease and other health conditions will survive at sanctuaries, and NIH has been moving chimps from chronic health conditions to Chimp Haven for years.

Do you believe a laboratory facility managed by Charles River Laboratories can meet the physical and psychological needs of chimpanzees previously used in biomedical experiments better than the sanctuary created and designed specifically to meet the needs of chimpanzees retired from research?

Dr. TABAK. It is a balance between the facility that the chimp is currently housed in versus their physical condition, their medical condition, if you will. And it is the opinion of a panel of veterinarians from NIH and from Chimp Haven and from the facility—in this case, Alamogordo—that a certain number of chimpanzees are just too frail to be moved safely.

There is also some consideration where several of the chimps who are part of a social network, that they should remain for that purpose as well. So when you balance those two things, that is why there are some chimps remaining at that facility.

Ms. ROYBAL-ALLARD. Well, Dr. Tabak, with all due respect, they appear to be dying or being euthanized at a much higher rate than would be expected if they were in sanctuary. And the Humane Society has filed a lawsuit to force the transfer of the remaining chimps. And both the Humane Society and Animal Protection New

Mexico chimp experts have reviewed the chimp health records and strongly believe that the chimps could survive transfer and would have a much better quality of remaining life at Chimp Haven.

So I guess there is disagreement on that, but I am very much concerned by the fact that the record of euthanasia and the fact that so many have already died I think does not uphold the recommendation of NIH. And I hope that you will look at that more carefully.

Because my concern is I don't know what directive Congress could give that will make the NIH actually stop the current violation of the CHIMP Act and move these Alamogordo chimpanzees to Chimp Haven. I don't know what it would take to do that. And I won't expect you to answer that question, but I certainly hope that you will take that into consideration.

I have one question, but I am running out of time. So I will yield to Mr. Harris.

Mr. HARRIS. Thank you very much. Good to see you all again here.

Dr. Fauci, I am going to ask you a question. Last week, the White House warned us that there may be 100 million cases, COVID cases this fall because of waning immunity and other things. We don't know what variant it is going to be. Depending on the variant, 1 in 20 could end up on a ventilator. Of those, it could be up to 40 percent actually die. And we all know people who have died from COVID. It is usually people who end up on a ventilator and have untreatable lung disease.

Now you briefed us last year about the ACTIV-3 trial, with aivaptadil and remdesivir, and because it doesn't appear that remdesivir does anything in those late-stage patients, aivaptadil may be the last remaining therapy that we may have. And I and other physician Members of Congress actually have experience with some constituents who have recovered under the drug, under right to try. That, of course, is anecdotal. We do need more evidence than that.

The NIH is to be commended to be taking on the risk of studying this medicine from a small drug company—it is a very small company that makes it—because nobody could have predicted that this was kind of a last drug standing for late-stage COVID.

But we are out of time now. I mean, the bottom line is if we are going to have a surge in the fall, and right now, we have no late-stage therapeutic for the person who has failed all other therapy, on a ventilator in the ICU, BARDA is going to need months to ramp up production of a therapeutic.

So the question is—the problem right now is because the enrollment has slowed down in ACTIV-3, and I am sure you are aware of that, because there just aren't that many people with Omicron who proceed to that level. The question is, are your statisticians going to take an early look at that data to see if aivaptadil works or works adequately enough to authorize it, scale it up, so that this fall, when we have this potential surge, we will have a late-stage therapeutic?

Because we desperately need one. I mean, we still don't have something for those patients, and it is terrible. You go to the ICU.

You fail remdesivir. You—there is nothing left. I mean, you call the family in for a meeting.

Can you do that? Can you look at some of the data?

Dr. FAUCI. Yes. As you well know, Dr. Harris, that the company who sponsors this has the opportunity to present the data to the FDA for an application for an emergency use authorization. The NIH in our clinical trials provide all of the resources necessary to do that. So it is, with all due respect, it is not an NIH issue of whether or not this gets submitted to the FDA for an emergency use authorization.

Mr. HARRIS. But your DSMB is going to meet I think this month on this.

Dr. FAUCI. Right, exactly.

Mr. HARRIS. It could choose to take an early peek at the results.

Dr. FAUCI. Yes, it will. And one of the things that is very clear is that we don't interfere with the DSMB's—the way they look at clinical trial data. I think that would be a conflict. So we would always welcome what they do. And if they look at the data and feel it should be an early look, then we welcome that. We have nothing against that, I promise you.

Mr. HARRIS. Okay, good. Because, I mean, they will never get to 650—I think that is the end number. I mean, we are just not enrolling patients anymore.

Dr. FAUCI. Right. It is a good news/bad news thing.

Mr. HARRIS. Right. That is right. You understand it. So—

Dr. FAUCI. Indeed.

Mr. HARRIS [continuing]. Thank you very much.

Now, Dr. Tabak, I am going to ask you something because for years, I have been holding up a graph of the young investigators age of discovery. You are aware of this, the 2010 Jones paper, which suggested the inventiveness kind of peaks that are in the late 30s or so. And yet I see the report from last November that looked at—from the NIH that looked at the—by Dr. Lauer that looked at the long-term trends in the age of principal investigators. You are aware of this, right?

Now you have created all kinds of committees. You have done everything. And the result is while age has been continuously increasing in R01s, the rate of increase has slowed over the last 10 years. Well, Dr. Tabak, it is not going to continue forever. It is not going to continue to age 100.

I mean, saying that, I mean, I don't get it. NIH has failed at reducing the mean age. I am looking at it. The mean age increased in 2015 to 2020. Whether you are male or female, the mean age increased. The NIH is failing to address this properly. What are you going to do?

I mean, it is nice to say, well, we need a diversity of people, and we need people who look like a college age graduate. But we are not funding those people. What is the concrete plan?

Dr. TABAK. Dr. Harris, you are correct in the data, and we are doing several things. First, unfortunately, institutions around the country increasingly want their new faculty hires to have bridge funding before they give them a permanent appointment on their faculty. And that was never an intended purpose of some of these

transitional awards, but they become a surrogate for deciding who gets a tenure track position or not.

So one of the things that we are doing is we have instituted what was known as the Katz award, which is an R01 application that does not require—in fact, no preliminary data is allowed for the submission of that award. The purpose there, of course, is it frees the young person from the work that they did as a postdoc or as a graduate student and allows them to go straight away to apply.

We have also done a series of mentoring networks, if you will, around the country to convince young people that that first award, that first R01 is something that they should really be striving for sooner rather than later, despite what the old sages at their institution may be telling them. “Oh, you will never get that award. It is too big. Apply for a small, little award.” I mean, you know this well.

Mr. HARRIS. I have been there.

Dr. TABAK. And so we are trying very hard to get the word out that, in fact, we are incentivizing, we are prioritizing early stage investigators.

Now the final piece of this, and I don’t have a good answer for it, is—and it doesn’t account for—it only accounts for a fraction of the time. Students enter graduate or professional schools later. They take so-called gap years—1, 2, or more years. That is something that I don’t have a good solution for.

But when you take all these things together, I think it has kept us sort of in stasis with regard to our ability to drive that number down. But we are going to keep working on it because it is important. I agree with you.

Mr. HARRIS. Thank you, Madam Chair.

Ms. ROYBAL-ALLARD. Mr. Pocan.

Mr. POCAN. Thank you very much to the committee.

And I really respect and appreciate all the work that everyone at the table does, as well as many of your peers.

Dr. Fauci, I just want to single you out for a second to say thank you. You have been the face of everyone at this table and many other researchers, and you have taken a lot of unfair abuse, thanks to fringe social media and crackpot theories out there.

On behalf of normal people, to you and your family, thank you. Because your family has also had to go through much of this. So, appreciate it.

I wanted to ask you a question. You talked at I believe it was whip meeting, and you mentioned something about the number of coronaviruses we have had over several decades. And I found that very interesting because I don’t think I have heard other people talk about that. What aren’t we doing to address what potentially is the next whether it be coronavirus or anything else? What do we still need to be doing and we are not doing?

Dr. FAUCI. Well, thank you for that question. That is very important, and it is really part of the strategy that we have already put into place not only to address better the current outbreak of coronavirus, in this case SARS-CoV-2, but also as part of our forward-looking Pandemic Preparedness Plan.

So, very briefly, what we are doing with regard to the current coronavirus is having already in place studies that have entered

into preclinical and early clinical studies of what some people refer to as a “pan-coronavirus vaccine,” which is really very aspirational because the coronavirus phylogenetic tree is pretty big. If you focus on SARS-CoV-2, we have already had in the world four or five variants. The United States has experienced three of them.

So the strategy is to develop a vaccine that would have not only effectiveness against all the current variants and any variant that might actually arise out of the SARS-CoV-2 group and then to extend that throughout the phylogenetic tree of coronavirus. So that just addresses coronavirus.

But the Pandemic Preparedness Plan is built on a concept that was developed in our group by Barney Graham, who is the person who actually developed the SARS-CoV-2 mRNA vaccine for Moderna, that to take a representative microbe from each of the multiple families that have potential pandemic capability and to do studies that would essentially position us that if we do get an outbreak from an arenavirus or an alphavirus or a flavivirus, to be able to get a vaccine into trial and ready to go within 100 days and in the second 100 days to be able to start distributing it.

So we are referring that to our prototype pandemic plan. That is what we are doing.

Mr. POCAN. Great. That is great to hear. And again, I found that very helpful when you talked to us about it in caucus.

Just a real quick, do you consider pandemics like COVID and other infectious disease like COVID a threat to national security?

Dr. FAUCI. Oh, there is no doubt about that. I mean, whenever you have something that threatens the economy and political stability of nations, it is part of global security. And that is the reason why we take very seriously outbreaks. And as you know, the SARS-CoV-2, COVID-19, is historic the likes of which we haven’t seen in 104 years.

Mr. POCAN. Thank you.

Dr. Tabak, same question. Do you consider pandemics like COVID as a threat to national security?

Dr. TABAK. Absolutely.

Mr. POCAN. Short and sweet on that one.

Dr. TABAK. Absolutely. Anything that destabilizes the economy and the Nation represents that threat.

Mr. POCAN. It is interesting. We were talking about the \$4,000,000,000 around ARPA-H and lots of conversation. And I look at the Department of Defense budget that comes in at, what, \$770,000,000,000. It is 12 times NIH’s. It is about 70 times the CDC budget. I think it is time maybe for a more modern definition of “defense.”

Because I agree that this has been a national security threat. And since that budget seems to have such an easier time moving forward, if we could use more of those resources to protect our country and, for that matter, the globe, I think that would be helpful.

I got 37 seconds. I think I can get this in. Dr. Tabak, with the global vaccine we just talked about having the chance of having this be a broader vaccine, will the NIH require its awardees to meet global access conditions on pricing, supply, and technology sharing for any future vaccine?

Dr. TABAK. Can I turn to Dr. Fauci for that question?

Mr. POCAN. Sure.

Dr. FAUCI. We don't have that capability of guaranteeing global access. That is part of the broader Government plan, which we are trying to do right now. And as you well know, \$5,000,000,000 of the \$15,000,000,000 was supposed to go to global, and that global was not necessarily to get vaccine doses. Because we do have enough vaccine doses for the developing world. It is to get vaccines into vaccinations, to develop the infrastructure to be able to do that.

So we are very committed to that, and we have always been. But that is not within the realm of what NIH can do.

Mr. POCAN. Thank you. My time is up. I yield back.

The CHAIR [presiding]. Thank you.

Before I yield to Mr. Fleischmann, I was just saying I was just in a hearing with Director Power at USAID, and that I would at some point to really hear from all of you about what the effect of not moving forward on a COVID supplemental will have on our ability to deal both domestically and internationally with this pandemic. I think we are at great risk.

But that is not my question because I want to yield to Mr. Fleischmann, but I think it is an important issue, and it is one where we need your voices loud and clear about what the consequences are.

Congressman Fleischmann.

Mr. FLEISCHMANN. Thank you, Madam Chair and Ranking Member Cole. I appreciate your having this hearing today.

And to each and every one of the witnesses, thank you very much. I have enjoyed my tenure on this subcommittee. I love being an appropriator, but this committee, this subcommittee is really incredible. And the depth and breadth of the NIH research is truly outstanding. So, appreciate your being here today.

I have two questions, if I may? As most of you know, I have substantial moral and ethical concerns surrounding fetal tissue research. Part of the debate right now is not necessarily about initial cell lines, but about the continued collection and use of aborted fetal tissue and the use of Federal dollars to support that research. Much of the available fetal tissue was obtained from children killed by abortion, and their bodies are then used for experimentation at taxpayer expense.

Dr. Tabak, what is the NIH's plan for moving towards more ethical alternatives for research and treatment, sir?

Dr. TABAK. We continue to support research for alternatives in this instance. But as you know, in order to validate the alternative, you have to compare it to something, and that, in fact, is in many instances fetal tissue.

But we have awarded a number of grants in this area, and we continue to make progress in that direction. But it is difficult work, and so we continue to fund that type of effort.

Mr. FLEISCHMANN. Yes, sir. And just for the record, I want to be clear that I can speak for myself that I would continue to wholeheartedly oppose the use of aborted fetal tissue for experimentation, and that is my personal position on that.

Moving on to another topic, sir. The Undiagnosed Diseases Network has been a very successful program building on the strength

of specialized knowledge at the clinical center in Bethesda and a network of 12 academic medical centers across the country, including the great Vanderbilt University Medical Center in my home State of Tennessee.

For the past decade, the UDN program has been helping patients with rare and undiagnosed conditions find answers and, for many, an informed path toward treatment. Often, these families and individuals have been on a diagnostic odyssey, having seen countless medical professionals unable to give them a full picture of their rare or unknown medical condition.

My question, Doctor, is how does the NIH plan on supporting the network of UDN sites once the Common Fund support expires? And as a follow-up to that, how could we help develop a plan to sustain the work of UDN going forward, sir?

Dr. TABAK. So, as you know, programs that are initially supported by the Common Fund do graduate, if you will, out of that program. It is meant to be an incubator space.

In this instance, this program has done very important and outstanding work, and you reach a point where the effort begins to blend into standard of care versus research. And so we need to define where that boundary is and are working with the various groups around the country, as you said, to see what options we may have going forward to sustain that portion of the UDN that remains in the research space but allow that portion which is standard of care to move into that arena.

Mr. FLEISCHMANN. Yes, sir. Thank you.

For Dr. Fauci, good morning, sir. There has been significant debate in the scientific community regarding the risk-benefit of gain-of-function research, including unintentional lab leaks and the intentional release of pathogens into the population. My question, Dr. Fauci, considering the impact the COVID-19 pandemic has had across the world, do you advocate for a continued pause of gain-of-function research, sir?

Dr. FAUCI. I think it is very important, Congressman, to make sure that we abide by the set guidelines of the conduct of research. One of the problems with the word "gain-of-function," it means so many different things to different people. So what we have done, and we are very, very flexible in relooking at those guardrails, that when you are doing work on different pathogens, there have been a multiyear process that have set the guardrails of doing that.

And those guardrails have worked really quite well. We, as everyone is, is obviously very sensitive to make sure that research that is conducted is conducted in a safe and effective manner and that is it peer reviewed before it is done by a group of people who are really qualified to make that determination.

Mr. FLEISCHMANN. Thank you, sir.

Madam Chair, I yield back.

The CHAIR. Thank you. Congresswoman Watson Coleman.

Mrs. WATSON COLEMAN. Thank you, Madam Chair, and thank you to the Acting Secretary.

I don't know if these questions have been pursued because I was actually in another appropriations hearing, but I am very concerned about NIH and the investment that is made in diversity and inclusion. In not only the application of resources, but in the re-

viewers of grant applications as well as the recipients of grant applications.

We were fortunate enough to have conversations with the former Director, who was committed to expanding the diversity of the workforce and the diversity of the raters and the diversity of the grants that were actually funded. And so I would like to know kind of specifically as you can, what kind of success you have had in moving in that area?

Dr. TABAK. I want to assure you and all members of the committee that I am equally committed to diversifying of the biomedical research workforce. We have been using a variety of approaches to try and diversify our grantees. For example, we have developed the FIRST award, which is designed to build communities of scientists, a recruitment of cohorts, if you will, in an effort to ensure that you have a sustainable and inclusive environment for new hires. We have also increased support for the NIH MD Loan Repayment Program, which currently supports over 100 talented scientists each year from racial and ethnic minority backgrounds or scientists interested in health disparities or clinical research.

Several of the institutes have specific programs. For example, the NIGMS MOSAIC Program is specifically designed to on-ramp individuals from diverse backgrounds into positions of tenure track faculty-level positions at universities.

Mrs. WATSON COLEMAN. Can I interrupt? Let me ask you this. Which of these initiatives are you talking about that have just been sort of implemented in the last year and a half?

Dr. TABAK. The FIRST initiative—

Mrs. WATSON COLEMAN. Or are you talking about programs that have been in existence longer than that?

Dr. TABAK. The FIRST program that I mentioned, it is in its second year, and we are currently looking at applications for Year 2. They are under review.

The MOSAIC Program from NIGMS is new. It is within the last year. The Loan Repayment Program has been used in prior years.

Mrs. WATSON COLEMAN. How about your recruitment efforts and interactions with and outreach to the HBCUs? Has anything been innovative there? Has anything been increased there?

Dr. TABAK. So the most recent innovation there has been a specific outreach with our contract organizations. Many HBCUs do not avail themselves of Government research and development contracts. And we had a specific outreach initially with four HBCUs, and I believe it is now up to 19, where we work together with their administrative offices to really guide them in how one goes about applying for successful R&D contract.

Mrs. WATSON COLEMAN. So I am really interested in what success has been built upon in terms of individuals who get to look at the grant applications and rate them and the number of grants that are actually funded that are directed to cultural competencies and the underserved communities, black and brown communities in particular.

And so you probably don't have time to answer that, but through my chairman, I would like to ask for kind of an update where your agency is, where your institute is with regard to those issues,

measuring from where you were to where you are now and just how you plan to move forward.

And I thank you for this time, and I thank you, Madam Chairwoman. I yield back.

Ms. ROYBAL-ALLARD [presiding]. Ms. Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Madam Chair.

You know, I wanted to ask you, Dr. Tabak, a couple of questions, and I do think in light of the ranking member's comments, just overall the NIH has—it has done some great things. I am a big supporter. I think most of us have been big supporters in terms of increasing your funding because we believe in what you are doing.

But it has been a little challenging in the last couple of years when there were times when I do think the image has been called into question not—I am not talking about crackpots. I am talking about average Americans who maybe don't get to see up close and personal what is happening, and they get conflicting information.

And one of the areas where I think it would possibly help, I found last year I followed some reports that genomic data, early genomic sequence from Wuhan, China, were deleted from the Sequence Read Archive. And we worked to get to the bottom of this, and I think partially just because there were concerns, rational concerns that the Chinese Communist Party had something to do with this, and where is the information?

I wanted to see what, with regard to the Sequence Read Archive, you are doing to secure it from those types of either truly harmful things, or maybe it is an image thing, but what are you doing in that space?

Dr. TABAK. There is no question that the communication that we had about the Sequence Archive, Sequence Read Archive could have been improved. I freely admit that. If I may, the archive never deleted the sequence. It just did not make it available for interrogation.

Ms. HERRERA BEUTLER. So, wait, you have the information still?

Dr. TABAK. We have the information.

Ms. HERRERA BEUTLER. So it wasn't—the way it was reported is it was pulled out. The early genomic sequencing was removed by a Chinese researcher.

Dr. TABAK. So anybody who submits to the Sequence Read Archive is allowed to ask for it to be removed, and that investigator did do that. But we never erase it.

Ms. HERRERA BEUTLER. Oh, so you don't have the information anymore?

Dr. TABAK. We do. We never erase the information. We keep it—

Ms. HERRERA BEUTLER. So they were able to withdraw public viewing of it?

Dr. TABAK. Public viewing. That is correct.

Ms. HERRERA BEUTLER. Okay. So researchers can apply to the NIH and get the information from you?

Dr. TABAK. And so in the way that it was originally eliminated from public view, it was withdrawn, and that is the most difficult for people to access.

The error that was made—and we found this out after a review of all of our processes—was it should have been suppressed. The

distinction being that if it is withdrawn, it is kept archivally on a tape drive. Old technology, but that is how it is done. But when it is withdrawn, it can still be accessed by accession number, and so researchers are able to access that information.

Ms. HERRERA BEUTLER. So the information is still there?

Dr. TABAK. That is correct.

Ms. HERRERA BEUTLER. That is helpful. Thank you.

Dr. TABAK. The information was never lost.

Ms. HERRERA BEUTLER. I wanted to switch gears really quickly. I mean, I could spend a lot of time on that one, but on to overuse and opioids and overdose deaths. In Washington State, just in 2021, there was a 66 percent increase in drug-related overdose deaths, and more than half of these are due to fentanyl.

Your testimony talked about working on research to decrease overdose deaths. I wanted to see if you could explain how the 2023 budget request is going to help you reduce that.

Dr. TABAK. If I may, I would like to turn to Dr. Volkow here.

Ms. HERRERA BEUTLER. Sure.

Dr. VOLKOW. Thanks very much for that question, and the budget is going to help us accelerate research in this area that is becoming very, very challenging. And it becomes challenging because the complexity of overdose deaths actually has increased and been made worse during the COVID pandemic.

Initially, we started with research investments to improve the treatment of patients that suffer from pain so that they would not be given opioids when they didn't need it. Then it shifted to heroin, and then it shifted to synthetic opioids like fentanyl. And now fentanyl is being used to mix with cocaine, methamphetamine, and illicitly manufactured pills.

So we need to diversify our scientific projects to go beyond interventions for prevention that just focus on pain. Very important, crucial, but not sufficient. We need to expand into addressing the needs and vulnerabilities of individuals that may be exposed by accident to these substances.

So it goes a range of interventions from very much implementation sciences to services research and, at the same time, doing the research that can give us better medications to reverse those overdoses because naloxone is not so effective in this new era of very powerful drugs.

Ms. HERRERA BEUTLER. That is helpful, and I will yield back. I have more questions for Dr. Bianchi if we end up doing a second round. I don't know, Madam Chair. Yield to you.

Thank you.

Ms. ROYBAL-ALLARD. Ms. Frankel.

Ms. FRANKEL. Thank you. And thank you to our panel today.

I got a question. I think it is for Dr. Lowy, but whoever can answer it, I would be happy to hear from you. My question really has to do with patient navigator programs, which help low-income patients and those in underserved communities access early screening, diagnosis, and treatment. And specifically in terms of cancer, can you tell me how the Cancer Moonshot program will invest in patient navigator services to ensure access to any of the new treatments?

Dr. LOWY. Congresswoman, thanks for this question.

Patient navigation is one of several aspects of trying to provide optimal treatment for patients with cancer, which has become much more complicated in recent years, in part because of its success. In terms of approval of patient navigation, this is beyond the NIH, but we conduct implementation research to try to optimize patient navigation, along with many other aspects of trying to help people have appropriate and full access to cancer care.

This includes doing patient care at home, changing radiotherapy, for example; shortening the duration of radiotherapy; and trying to look at patient navigation in the context of this overall issue of how to provide optimal care to virtually everyone in the United States who is unfortunate enough to develop cancer.

Ms. FRANKEL. Well, thank you, and I hope you will work closely with whatever agency it is that directs the navigators because, obviously, you can have all kinds of new developments, but if we are not able to get it to our full population, I think we will be missing a lot.

Dr. LOWY. Thank you.

Ms. FRANKEL. I want to ask a question. Yes, so let me ask this question in terms of research on something sort of basic. I think everybody I have ever met in my life, and you hear about this on TV, all kinds of diets. And there is fad diets, and then you read about especially in underserved communities where people are not even getting access to the nutrition that they need.

What kind of research is being done in that regard in terms of dieting and access to food for everyone?

Dr. TABAK. So we have recently launched a new set of initiatives in nutrition. Among them is a study of so-called food deserts, where inadequate nutritional foods are available within a given neighborhood, and part of this research will be focused on how one can address that in the best way possible.

Other areas of research have been powered by advances in analytical technology. Just as you have the human genome and the human proteome, you also have the human metabolome. And the metabolome is really a reflection of your nutritional state.

And so we now can study things at the molecular level that give great insight into the value or not of various nutritional agents. So we are doing this from both the community-based level all the way through the molecular level.

Ms. FRANKEL. At some point, I would love to just get some information on that. And then I know tomorrow we are going to be talking about, or this week, elderly, issues that affect our elderly. One is falls. But I do have a research question.

The healthcare system is costing us over \$50,000,000,000 annually on falls for older people, 36 million older adults who report falls every year. I am sure it is much more than that.

We heard about technology to monitor falls in older adults and habits that could change to reduce them. Is there a timeline for these products? Can you explain what they are, these products, to monitor falls? Is anyone on this panel aware of that?

Dr. TABAK. Yes. So through the National Institute on Aging, their SBIR, small business program, has made several awards. For example, they have supported a small company, BioSensics, that has developed something known as ActivePERS, which is a medical

alert pendant that does do automatic fall detection. And this has now been licensed and integrated into medical devices broadly, and it is available through a variety of mass market retailers.

But they are supporting additional research to develop sensors, for example, that detect floor vibrations, which could be very valuable, obviously, for those who are hospitalized or otherwise infirm.

Ms. FRANKEL. Okay. Thank you, and I yield back, Madam Chair.

The CHAIR [presiding]. Mr. Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair.

Good to see all of you today. Thank you for being with us.

Dr. Tabak, I would like to start by asking you, I know you are new in this role, but you are familiar with policies, and I noticed you have a background as an ethics—advising on ethics. And it has recently come to my attention that there is a policy at the NIH where scientists and people can receive royalties.

One of the concerns I have, and I would like you to speak to this issue, is the NIH is in the midst, as you know, of awarding grants for research, is also in the position of sort of evaluating or giving opinions on drugs that work or don't work. And the idea that scientists may be benefiting financially from work that they have done at NIH, that creates to me the appearance of a conflict of interest.

And just building on what Mr. Cole said about public confidence in NIH, to me, one of the biggest concerns people had during this last couple of years is, were they getting truthful information from their Government? Could they trust what people were saying about the medicines?

And to me, that creates a very disturbing appearance, and I would like you to comment on that policy and whether you are going to take a fresh look at that policy.

Dr. TABAK. The award of royalties is based on the Bayh-Dole Act, which makes no distinction as to whether or not the inventor is paid by the Government, the private sector, academia, and so forth. So we are following the Bayh-Dole Act when it comes to that.

Mr. MOOLENAAR. So if I understand what you are saying, so you are saying it is Federal law that allows the NIH to do that?

Dr. TABAK. That is correct.

Mr. MOOLENAAR. Okay.

Dr. TABAK. But in terms of the potential for conflict, no individual who is in a decision-making role on a particular product would have benefited from being the inventor of that product because we separate out those functions. The individuals who make recommendations to leadership of institutes and centers are in the extramural space. The individuals who are making the discoveries that you speak to are in the intramural space. They are active scientists. And we do not allow those two things to interdigitate.

Mr. MOOLENAAR. Well, but my understanding is leaders of the organization receive royalty payments. Some, I think, Dr. Fauci, you have said that you have donated your royalties to charities is my understanding.

But what strikes me is you are in a position where you are saying certain drugs don't work, but then you can, at the same time, be getting royalties from other—and I understand you are saying there is a firewall. But that information has not been made public,

and I think sooner rather than later you should make that information public because right now, I think the NIH has a credibility problem, and this only feeds into this.

And I am just learning about this. People have always in my district been saying, well, so-and-so has a financial interest in a certain—they don't like ivermectin because they are benefiting from that royalty. Or they don't like hydroxychloroquine.

Now you may have very sound scientific reasons for either recommending a medicine or not, but the idea that people have a financial benefit from certain research that has been done and grants that were awarded, that to me is the height of the appearance of a conflict of interest.

Dr. TABAK. Again, NIH does not—we support the science that validates whether an intervention is or is not efficacious. We don't say this is good and this is bad.

Mr. MOOLENAAR. Truthfully, I would say you had leaders of NIH saying certain medicines are not good.

Dr. TABAK. Based upon the clinical trials that were supposed by the agency.

Mr. MOOLENAAR. But if the agency is awarding who the beneficiary of the grant who is doing the trial, and there are somehow finances involved, that there is a financial benefit that could be accrued if someone's patent or invention is considered valid, do you not see that as a conflict or an appearance of a conflict of information?

Dr. TABAK. I certainly can understand that it might seem as an appearance, but—and it is the sort of thing that maybe we could work together on so that we can explain to you the firewalls that we do have in place because they are significant and substantial.

Mr. MOOLENAAR. Okay. Well, I would appreciate that, and I think in terms of restoring public trust, I think that would be a good next step.

Thank you. I yield back, Madam Chair.

The CHAIR. Congresswoman Bustos.

Mrs. BUSTOS. Thank you, Madam Chair.

Good morning to all of our doctors here today. Appreciate you being here. Thanks for your service.

I am going to address my first question to you, Dr. Tabak. And I want to thank you for your work on biomedical workforce and appreciate what you are doing there.

I want to start by looking at the administration's work to address inequities. So the NIH plays a leading role in advancing biomedical research, developing diagnostics, improving cures, treatments, ailments, diseases. And really, the impact the NIH makes is tremendous.

And if I want to—you know all the stats, but I drill down to the State of Illinois where I am from. You have got 732 awards that were given, totaling \$311,000,000, and these are in these competitive grants. So we are very pleased with that.

This opportunity to use the funding to advance biomedical research is tremendous, but it also plays a meaningful role in addressing health disparities. So that is what I would like to ask you about.

I know that the NIH budget requests \$350,000,000 in increase to support research on health disparities. Can you talk, Dr. Tabak, about what broader impact that the President's budget request would have on addressing inequities that lead to disparities in access to care and patient outcomes?

Dr. TABAK. It will do so in several ways. Our work in health disparities increasingly is being done at the community level. We have learned that you can't just parachute into a community, study it, and then disappear—

Mrs. BUSTOS. Amen.

Dr. TABAK [continuing]. And you have to establish meaningful trust. That takes time, but it is obviously quite, quite worth it.

And indeed, Dr. Gibbons has set up the so-called CEAL program. If I may, I would like him to comment on that.

Mrs. BUSTOS. Please.

Dr. GIBBONS. Thank you for that question.

This is critically important. Addressing health inequities often involves what we call the social determinants of health, the fact that the context matters, the place matters. And so, often, because these are such vexing problems, you need a multiprong, multilevel strategy that, as Dr. Tabak indicated, often begins in the community that, indeed, knows its assets, knows its challenges, and even can co-develop with us strategies to address them.

Certainly, we, the NHLBI, have a program where it is cardiovascular health, which is clearly problematic in certain communities—low income, rural, communities of color—in which community-engaged research strategies are being shown to be effective in, for example, maintaining blood pressure control, preventing strokes.

Indeed—you mentioned Illinois—we have teams in South Side of Chicago literally working on this, involving members of the community. Actually, we have mental health issues that are intersecting with their challenges in terms of their cardiovascular risk.

That holistic approach that we can take in this context, this has been borne out to be very successful in addressing the pandemic and, indeed, has a broad array of capabilities for a variety of those conditions. Whether it is cardiovascular disease, HIV research, maternal morbidity and mortality, these strategies we are finding to be particularly effective.

Mrs. BUSTOS. And could we drill down a little bit more, too, and can you talk about the President—and whoever is best to address this—the President's budget request for NIH supporting the recently announced Equity Action Plan? Would that be best for you to address, Dr. Gibbons or Dr. Tabak?

Dr. TABAK. I can start. Actually, any one of my colleagues can speak to this because each institute and center is developing such a plan for their own individual organization, understanding that there is some variation among the groups. And in it, they will point out what gaps exist within their own organization both in terms of what they do externally, but also internally.

And these plans are going to be shared among all the institute and center directors so we can learn best practices. And this will be an annual event, and so they will be updated going forward.

Mrs. BUSTOS. Great. And just to play off of Dr. Gibbons a little bit about what you said, Chairwoman DeLauro and Ranking Member Cole have been great on this issue, but we actually have a Social Determinants of Health Caucus. I am co-chair of that. And then we have a bill called the Social Determinants Accelerator Act, where we initially asked for \$25,000,000 that would, to your point, Dr. Gibbons, that would start at the local level to come up with plans, and then we would have this interagency council that would then help decide where these grants go.

And so we got \$3,000,000 last fiscal year, \$8,000,000 this fiscal year. The President put in his budget \$153,000,000 for it. So we want—that number needs to grow. Obviously, that is the job of the appropriators to be able to get that through, but something that I think is really the answer to having these, looking at this at a very local level, the social determinants, and helping really get healthcare in a better place for so many people who need us to pay attention to this.

So thank you very much again to all of you. Thank you for your service to America and for trying to make people healthier.

With that, Madam Chair, I yield back.

The CHAIR. Congressman Cline.

Mr. CLINE. Thank you, Madam Chair.

My questions are for Dr. Fauci. Dr. Fauci, in October of 2020, Dr. Jay Bhattacharya, a professor of epidemiology at Stanford; Dr. Martin Kulldorff of Harvard Medical School; and Dr. Sunetra Gupta of Oxford University issued the Great Barrington Declaration. The declaration of these medical scientists argued that the appropriate strategy for coping with COVID-19 was a strong targeted response designed to safeguard the most vulnerable populations—older persons with comorbidities—while avoiding mass lockdowns with damaging social and economic costs like the ones that we have seen and the forced isolation of younger and healthier persons with vastly less risk of severe illness, hospitalization, and death.

In response, Dr. Collins described these medical scientists as fringe scientists, and you likened their responses akin to AIDS denialism. Dr. Collins, in an October 2020 email, called for a “quick and devastating published takedown of the authors and the declaration.”

The claim that the medical scientists opposing a strategy of comprehensive lockdowns were somehow fringe was proven to be baseless. Dr. Ioannidis, professor of the Department of Medicine at Stanford University, published a quantitative analysis of the professional publications as well as the social media visibility of the 47 original signers of the Great Barrington Declaration in the *British Medical Journal* this year.

He found that among the 47 original signatories of the GBD, 20, 19, and 21 respectively were among the top cited authors for career impact in the recent single year of 2019 for either. Likewise, Professors Galea and Stein of the Boston University School of Public Health cited the lack of reasoned debate over the Great Barrington Declaration as a sign of the growing intolerance of disagreement in the field of public health.

So I will ask you on what basis did you and Dr. Collins identify these doctors, the authors of the Great Barrington Declaration, as fringe scientists out of the mainstream epidemiological science?

Dr. FAUCI. I never characterized them as fringe scientists, if you look at the record. That is incorrect. Okay?

Mr. CLINE. Dr. Collins did. You referred to their—

Dr. FAUCI. Well, you are asking me the question. I never called them fringe scientists.

Mr. CLINE. And your comment regarding AIDS denialism?

Dr. FAUCI. Well, the issue with the Barrington Declaration is that what they were stating is that if you let the virus run free in society and only so-called protect the vulnerable, and the question is who are the vulnerable in society that you are going to protect? And most public health officials totally disagree with the Barrington Declaration.

And in fact, if you did that, let it just run free and not try to protect the population in general, we almost certainly would have had many more infections, many more hospitalizations, and many more deaths. So with all due respect to the scientists who signed the declaration, I completely disagree with them.

Mr. CLINE. Okay. Would you agree that during the times of the lockdowns, the data that we have seen following these lockdowns has shown that we have had increases in depression among young people?

Dr. FAUCI. There is no doubt that when you put—

Mr. CLINE. Yes or no, if you could just—

Dr. FAUCI. Well, I will answer the question. There is no doubt when you put restraints on society that it causes emotional and mental stress. There is no doubt about that. But you have to have a balance of saving people's lives from getting infected and hospitalizations.

Mr. CLINE. Would you agree that suicide rates have increased among young people?

Dr. FAUCI. Indeed, they have.

Mr. CLINE. Would you agree that domestic violence rates have increased?

Dr. FAUCI. Yes. The answer is yes, but I am wondering what that has to do with the question you are asking me.

Mr. CLINE. Would you agree that drug and alcohol use increased during these lockdowns?

Dr. FAUCI. Well, I am not sure the lockdowns itself did it, and I am wondering why you are asking me about lockdowns because there were not complete lockdowns in this country. There were restrictions, obviously, but there were not lockdowns.

China is now going into a real lockdown. So I would disagree with characterizing whatever went on in this country as a full lockdown.

Mr. CLINE. All right. Moving on, when the prospect of a lab leak from Wuhan gained traction in April of 2020, Dr. Collins told you that you should find some way to “put down this very destructive conspiracy.” We also understand that Dr. Collins emphasized that the lab leak theory could damage science and international harmony.

Did you direct letters to two professional journals be written, to Lancet and Nature Medicine?

Dr. FAUCI. No.

Mr. CLINE. You did not ask Daszak to write the letter to the Lancet?

Dr. FAUCI. No.

Mr. CLINE. Did you review it before it was sent?

Dr. FAUCI. No.

Mr. CLINE. I yield back.

The CHAIR. Congressman Harder.

Mr. HARDER. Thank you so much, Chair DeLauro, for hosting this hearing.

And thank you all, for our witnesses, for being here in front of the subcommittee.

Since we last met, the American Lung Association released their 2022 State of the Air report. That report gave my district in California both Stanislaus and San Joaquin Counties an F grade. This means that they received an F grade for both ozone and particulate pollution in a 24-hour period, and a failing grade for particulate pollution annually.

And this has huge health impacts for my constituents. One in five kids in our community has childhood asthma. I had it. My brother had it. I know what it is like to worry whether or not your inhaler is in your backpack every day. And these F grades illustrate what everybody in our community already knows, which is our air is bad. It is only getting worse. And frankly, I refuse to let my daughter grow up breathing worse air than I did.

My question is for Dr. Tabak. With this continuing trend in my community and I believe in many parts of our country regarding poor air quality and the staggering cases of childhood asthma, what can the NIH commit to doing with this year's budget to ensure that Federal dollars are directed to programming and research to tackle the issues of air quality and asthma?

Dr. TABAK. The budget does request resources to study the effect of climate on health, and certainly, this is part and parcel. If I may, I will turn to Dr. Gibbons, who is very deeply involved in this initiative.

Dr. GIBBONS. And thank you, Representative Harder, for pointing out that very challenging situation.

We have known for many years, obviously, that air pollution has an impact actually on the lung development of children such that it stunts the development of lungs and predisposes to conditions like asthma, as you described. And we have actually seen trends over time that when the air quality improves, there is an improvement in that childhood lung function. So we know that if we can mitigate that exposure, it can have benefits.

Certainly, we recognize that there are many communities—often lower-income communities, communities of color—that are particularly besieged by the challenges of the particulate matter that you described. And clearly, that is an exacerbant that promotes not only lung disease, but cardiovascular disease and a lot of other complications.

Now we are making progress in terms of the family history you have described with asthma. Certainly, we are getting greater un-

derstanding of the inflammation. In fact, the inflammation induced by those particles on the lung. And so our treatment strategies I think have improved substantially as a result of this basic research in which we are understanding now the pathways and now new therapeutic targets to reduce that inflammation and enhance lung health.

And so, indeed, there is greater precision medicine now in how we treat asthma. But certainly, we still need to do a lot more at the root causes that relate to climate, climate change, and the effect of wildfires and everything that is exacerbating that whole spectrum of etiology of asthma.

I will stop there.

Mr. HARDER. Thank you, Dr. Gibbons.

How impactful do you think those wildfires are? Obviously, this is something we are seeing all across California. How influential do you think that is in some of the asthma and air quality concerns we are seeing?

Dr. GIBBONS. Yeah. No, it is an important observation. It clearly is contributory. We are seeing that pattern as measured in changes in those particulate matter. The air quality is deteriorating.

Moreover, as you can appreciate there on the west coast, with the prevailing winds, even those changes in wildfire—declines in air quality sweep across the country as well, and so we recognize that this is going to be a national problem. And with the trends of climate change, wildfires, and declining air quality, an ongoing problem that we hope we can potentially address the health effects through this trans-NIH program of climate change and health.

Mr. HARDER. Thank you. That is very helpful.

I could just draw this attention to some of the efforts in this budget for a new community air quality monitoring and notification program, which is trying to, I believe, in essence, take some of the NIH research to make it as practical as possible. I think that is a no-brainer that we would really benefit from.

So, so thank you so much, Dr. Gibbons. And with that, I yield back my remaining time.

The CHAIR. Congresswoman Clark.

Ms. CLARK. Thank you, Madam Chairwoman.

Again, it is an absolutely honor and delight to be here with so many representatives of NIH, and our deep gratitude for your science, your research, your leadership in this time of great challenge globally and certainly here in our country.

I want to start with one of the increasing crises that we are seeing, and that is worsening mental and behavioral health. We are especially seeing this in our young people. And while much of the concern is focused on the limits of caring for this population, I am concerned that we need to be redoubling our commitment to better understand the issues that span neuroscience, traumatic brain injury, addiction, genetics, and more.

So my question for Dr. Tabak and Dr. Volkow is how is the NIH ensuring this multifaceted topic is appropriately addressed, including coordination among multiple relevant institutes and centers? And do you have the resources necessary to meet this moment?

Dr. TABAK. We do have opportunities across NIH for the different institutes and centers in this space to collaborate with one another.

Through, for example, the BRAIN Initiative, which is now seeking to understand the circuits of—how the circuits in the brain work. But there is also emphasis on the community-based level of making sure that the appropriate mental health services are provided to those who need as well as efforts to avoid the stigmatization that accompanies mental health conditions.

But let me turn to Dr. Volkow for her input.

Dr. VOLKOW. Yes, thanks very much for that question, and I think that as we are addressing all of the challenges with the COVID pandemic, we realize that when we solve the public pandemic, the problems that have arisen from mental health issues are going to be remaining. And particularly vulnerable are children and adolescents, and we are already seeing that, with 30 percent increases in depression, anxiety, loneliness.

We are seeing an increase in suicides among teenagers, even though it is not happening in adults. And we are also seeing an increase in intentional overdoses among adolescents. And for the first time, we are seeing overdose deaths in adolescents from fentanyl.

So the situation is clearly urgent, and so what we are doing is, as Dr. Tabak was saying, we are joining our efforts across the different institutes to try to understand what are the effects and how they affect ultimately the behavior of a child. What are the trajectories, and what are the interventions that we can do to support them?

It is clear that is going to have to be personalized, and it is clear, something that we have been discussing here, that the social determinants of health are crucial, and we have learned to recognize that those that are in adverse economic situations or social stressors are the most vulnerable. So understanding those factors so that we can develop interventions that can be targeted.

And importantly, putting the resources that are necessary to provide those evidence-based interventions to protect our children and adolescents.

Ms. CLARK. Thank you so much.

I want to go back to ARPA-H, and my colleague Mr. Cole raised the question around the National Cancer Institute, and I share those concerns. But ARPA-H also has potential to transform frontiers of biomedical research.

I obviously think that if the decision has been made that ARPA-H should be located outside of NIH and outside of Washington, that Massachusetts, as the home of the most vibrant and promising biotech life science companies, leading-edge research, academic institutions, and hospitals, is a place where ARPA-H should go. But as far as I know, there is no proposed selection process for siting this agency and even less clarity on who will run it.

Can you tell me, is there a plan on how to solicit and evaluate proposals to site ARPA-H, and when do you expect a Director to be appointed?

Dr. TABAK. The search process is under way for the inaugural Director of ARPA-H. This is a presidential appointment, and so, obviously, this is being driven by the White House. There has been no commitment made to the physical location of where ARPA-H will be located.

We obviously are continuing to frame this out for the consideration of the Secretary and for whoever the inaugural Director may be. But until that appointment is made, no decision will be made on a physical location.

Ms. CLARK. And there is no timeline for an approval process, selection process?

Dr. TABAK. I can tell you that the search is definitely ongoing, and I know that the intention is to move that as rapidly as possible.

Ms. CLARK. Thank you. I see my time has expired.

Thank you, Madam Chair.

The CHAIR. Congresswoman Lawrence.

Mrs. LAWRENCE. Thank you, Madam Chair.

Doctor, I recognize that last September, the NIH announced 10 grants focused on firearm violence prevention, including one focused on firearm violence prevention tactics in K through 12. As you know, we had the last mass shooting that happened was right outside my district at a high school. And so I hope that this research is happening in Detroit, which I hope are just the first of many to address the gun violence epidemic that we have.

While I recognize that these awards were just made, can you speak to the importance of resuming Federal research into firearm violence reduction?

Dr. TABAK. Well, as you point out, 10 awards were recently made. Future research directions will likely include work to better understand the interplay of the neurological, biological, psychological, and social and structural processes that may enter into this. Also emphasis on violence and trauma screenings and interventions need to be developed and then made available both in healthcare settings as well as school settings.

And we have come to understand that the violence prevention efforts have to be multilevel and focused on mechanisms of action. So just to give you an example, one of the awards was made to evaluate the effectiveness of child and family traumatic stress intervention to reduce PTSS in youth after they were assaulted. It is things like this that will hopefully help us reduce and eventually eliminate these tragic events.

Mrs. LAWRENCE. Well, I just want to tell you I am very excited about the grants, but this must become a priority for us in America. Too many moments of silence and best wishes for your family. We have to do something in America to address gun violence.

In that vein, I want to commend the inclusion of more than \$100,000,000 for targeted research on mental health. We know that mental health plays a major role in gun violence and incarceration in America. And COVID-19 just added another whole level to mental health awareness. And drug addiction, a lot of that is tied to mental illness.

So my question is, can you highlight the impact of last year's investment on mental health research, and how does this year's increase build on the NIH work from last year?

Dr. TABAK. So the work that has been recently supported is really to strengthen mental health response during the time of the pandemic. It really—it seeks to really increase uptake of those practices that we know that are effective. So, for example, it turns

out that digital healthcare platforms are really good approaches, and we have to be able to figure out how to adapt those formats and platforms to where it is most needed.

If I may, NIMH and NICHD issued a joint Notice of Interest that Dr. Bianchi may wish to speak to.

Mrs. LAWRENCE. And Dr. Bianchi, before you speak, I just want you to know that the mental health piece and the virtual part of that was tremendous, and I hope we continue. You can go ahead.

Dr. BIANCHI. Thank you very much for your comments.

One of the things that we are very excited about is the destigmatization of youth mental health issues, and we are co-funding, along with a number of other institutes, but NIMH is the lead on this, we are funding a high school essay challenge to bring high school students in to write about their experiences and again with the goal of destigmatizing some of these issues. We need to bring this out in the open. There is no question that children and adolescents have been significantly affected by all kinds of issues related to the pandemic.

Mrs. LAWRENCE. And also we must look at the workforce in mental health. We know and I hear all the time that schools and other places say we don't have enough social worker or mental health professionals to address the growing demand in this crisis of mental health.

Thank you. My time has expired.

The CHAIR. Thank you. We are going to move to a second round, and we will try to get in as many questions as we can and are going to allot 5 minutes per member for the second round of questioning.

So, with that, let me—and I am going to try to get in two or three questions, if I can.

Dr. Fauci, first of all, my congratulations on being named Chief Medical Adviser to the President. I also want to ask about universal flu vaccine. Can you provide us with an update on the development of the universal flu vaccine?

It is 15—you are looking at \$15,000,000 in an increase. What will we accomplish with those funds and with what we have there, with what is in 2022 and the additional funds that were requested in 2023?

Dr. FAUCI. Yes, well, thank you very much for that question, Madam Chair.

Yes, the money that was given to us in the last appropriation has been very helpful, and I will summarize briefly what has happened since we spoke last. And the additional plus-up in the current 2023 budget will be very helpful.

So what we have been doing over the last couple of years now is bringing a number of new concepts into the universal flu vaccine. As I mentioned to you I think when I briefed you in a previous time, one of the approaches is to use new platforms, one of which is referred to as nanoparticle, which is a component of a vaccine that allows you to tack on to these microparticles any of a number of immunogens, as we call them.

One of them is one that is very common to virtually all of the flu within a particular group of influenzas. And in preliminary studies look really very good, both in the animal model and in

Phase I studies in which you are inducing a response that goes well beyond just the particular flu that you are vaccinating against.

In addition, a number of studies, both intramurally at the NIH campus in Bethesda as well as in our grantees, have now put into both preclinical and Phase I study a number of candidates using these various platforms. The results look actually really very good in the sense of a vaccination now that goes well beyond the particular isolate that you are dealing with and covers.

As you know, flu is divided into two main groups, Group 1 and Group 2, and the ones that we get exposed to, which are predominantly H1N1, H3N2 influenza B. In the influenza A's, we now look like we can get good responses that have both depth and breadth against multiple ones within either Group 1 or Group 2.

So each month and years that go by, we are getting closer and closer to what I think would be a much more effective and universal vaccine. But thank you for the support. It meant everything to get us there.

The CHAIR. All right. Well, thank you, and you know we will look to the \$15,000,000 to see if we can continue that.

Dr. Bianchi, just if I can, the \$30,000,000 increase to ramp up the IMPROVE initiative. And Dr. Tabak's testimony talked about establishing Maternal Health Research Center of Excellence. Can you tell us a little bit about your research to reduce rates of maternal mortality and morbidity? Are you seeing progress? How are the Centers for Excellence going to help achieve long-term success?

If you can tack onto that the \$8,000,000 that we did in 2022 for women's health research and research—for the Office of Research and where that is going?

Dr. BIANCHI. Thank you for your question and, importantly, thank you for the support for the IMPROVE initiative, which is an NIH-wide initiative, and it is addressing many of the themes that we heard about today in this session, particularly social determinants of health.

The goals of the IMPROVE initiative are to prevent maternal mortality, which shows major health disparities, also to decrease severe maternal morbidity and, importantly, to promote health equity. Because of the timing of the budget this year, what we have decided to do this year is to have three very strong pillars that will roll into the Centers of Excellence. The Centers of Excellence Funding Opportunity Announcement will come out this summer.

In the meantime, we have a major goal of increasing community partnerships, and in particular, we want to bring in communities that have knowledge of the local culture and have a trusted relationship. Trust has come up today as well. And so we need people who have a trusted relationship in the community to begin to implement changes that will result in improved maternal care.

The other thing that we are doing is we are developing technologies that will particularly improve care for women who are in underserved areas, the so-called maternity deserts, as well as women in rural environments who don't have access to obstetric care. So we are looking at wearables. We are looking at apps on your cell phone as ways that we can monitor women who are in trouble and who need to get appropriate care.

As far as the Office of Research on Women's Health, I think Dr. Tabak will answer that.

Dr. TABAK. So the additional resources to ORWH, which we are very thankful for, they will invest that in their so-called BIRCWH program, which I think you are familiar with. This is an interdisciplinary program which provides mentorship to participants and connects the junior faculty—they are known as BIRCWH scholars—to senior faculty who have a shared interest in women's health. And this is really a program that is key to supporting multiple goals of the NIH-wide strategic plan for women's health research.

The CHAIR. I am well over my time. I have another question, which I am going to try to squeeze in—not now, but later—on cancer immunotherapy.

Congressman Cole.

Mr. COLE. Thank you, Madam Chair. I couldn't help but reflect, my good friend from Massachusetts, when she made her pitch for ARPA-H, I thought, well, I could help her.

The CHAIR. New Haven.

Mr. COLE. The Patriots can come to Oklahoma City. I mean, we can work something out here. That is probably a private conversation.

I do have two serious questions, and I will try and ask them both. One will be for you, Dr. Tabak. One, Dr. Volkow, will be for you. And you can just split the time.

And this first one would probably be better directed to Dr. Hodes, but he is not here. So I am very curious, on the Alzheimer's front, we make considerable investments. We have got a lot of concern about just the sheer expense this disease imposes on us, not to mention the human tragedy. So how do you see the state of play?

Obviously, we have had some controversy over a drug. Personally, I will just state for the record I don't care about the cost. I care whether it works. Over time, we can bring the cost down if it works. And I know that is not your decision to make. But any thoughts you have on that area?

And Dr. Volkow, just to give you sort of a heads-up, what I wanted to get from you, I am very curious about your thoughts on marijuana use, just given the prevalence we have now. It looks to me like, honestly, the social use has outrun the science. We really don't know, to my way of thinking, the potential damage here, and the horse is already out of the barn probably. But I am curious about where you see the problem areas here, where the research is taking us.

So, with that, if I may, Dr. Tabak, let me go to you first on Alzheimer's.

Dr. TABAK. So just topline, we are funding more than 350 trials in this space now. Seventy are pharmacologic treatment and prevention trials, 120 are nonpharmacological and prevention trials, and then the remainder are related to dementia care and caregiving intervention tools. Very important, obviously.

Public-private partnership. AMPAD has identified over 558 new drug targets. The IMPACT Collaboratory is developing pragmatic trial infrastructure to really look at how we improve care for these

patients, and I am sensitive to the time. So let me turn to Dr. Volkow.

Dr. VOLKOW. Thanks very much for the question.

And indeed, the use of marijuana has gone up, particularly among those that are 18 years of age or older. And during the COVID pandemic, we have seen again this has increased, and among the areas that we are most concerned, of course, are pregnant women. And we have seen during the COVID pandemic a significant rise in the utilization of marijuana, whether it is for medical—so-called medical purposes or recreational use.

All along, we have also been very concerned about the consequences of marijuana use among particularly the developing brain, and that actually goes starting in fetal development or childhood and adolescence. And the data already show that the outcomes are much worse for women that smoke marijuana during pregnancy, and the data also show that use of marijuana in teenage years actually significantly impairs the performance of these teenagers at school.

But what is also worrisome is we have seen that significant increases in acute psychosis associated with the use of marijuana across all ages. This is in part driven by the fact that the currently available marijuana has higher content THC. So it is much more powerful. This is also associated with higher rates for accidents.

There are other areas that are not clear, but the numbers seem to suggest that there is an increased risk, for example, of suicidal behavior among people that are using marijuana regularly. The extent to which they are using marijuana to escape suicidal thinking, as opposed to marijuana causing suicidal thinking is unclear.

But we are prioritizing this area because the American public deserves to know—ultimately, they are going to be making a decision of taking marijuana for medical or nonmedical purposes—what are the potential consequences? And we, as a government, of course, need to identify what are potential adverse effects where we can put resources and do prevention interventions and their ability to support those that have become victims of its effects.

Mr. COLE. I would just urge you to do what you can, in the time I have left, to get as much information out as quickly. I think we are going to wake up some day and find out that it is a lot like tobacco. We understood a lot more about it too late, and we have been reactive legislatively over the years at the State level and the Federal level to try and deal with that. And we could have the same thing here.

I would ask this, Dr. Tabak. Again, I am not going to ask you to respond, but maybe Dr. Hodes could follow up. I am very interested in whether or not—and Dr. Collins told me one time we thought the investments we had made might bend the curve looking forward in the cost of care in this particular disease with Alzheimer's, and so I would love to know if we are making the kind of progress I know that Dr. Lowy and his folks at the National Cancer Institute have been making on that, or that is foreseeable?

Dr. TABAK. We will certainly follow up with you.

Mr. COLE. Thank you for that.

I yield back, Madam Chair.

The CHAIR. Congresswoman Roybal-Allard.

Ms. ROYBAL-ALLARD. Congressman Cole actually asked the question that I was going to ask with regards to marijuana. And I just want to add to what was already said that according to the National Poison Data System, they identified a rise in marijuana use in children 0 to 6 years old, with over 70 percent of those cases in States that legalized recreational use. And that is just a number based on those that have come to hospitals for emergency treatment.

So there is—I share the congressman’s concern on the fact that with the legalization of marijuana, there is also a decrease in the perceived harmfulness of it. And so I appreciate the research that you are doing, and I hope that at some point, as Congress considers legalizing it across the Nation, that you can give us some guidance on safeguards, and that could be put into that legislation if, in fact, that does happen.

I want to follow up on a question that was asked by Congresswoman Herrera Beutler with regards to fentanyl. Several States have adopted preventive tools such as fentanyl test strips into their overdose prevention strategies. And as you are aware, approximately half of States continue to oppose the implementation and decriminalization of fentanyl test devices.

What does research tell us about the effects of decriminalizing fentanyl test strips on opioid overdose? For example, is there a difference in the drug overdose deaths across States that have decriminalized fentanyl tests versus those that have not?

Dr. VOLKOW. And that is an important scientific question and actually one that we were looking to. Currently, we do not have that data, but we can clearly tell you from the epidemiological studies that have actually reported a significant number of overdose deaths from individuals that are taking drugs like cocaine and methamphetamine that are contaminated with fentanyl was unbeknownst to the user. So providing them with a tool that enables them to actually test the drugs that they are buying to see if they have or not fentanyl could significantly decrease the risk of overdosing.

Ms. ROYBAL-ALLARD. Drs. Tabak and Bianchi, on December 14, the congressionally directed National Children’s Study was terminated despite ongoing congressional concerns that this study was critical to assess the impact of environmental risks upon children’s health and development. To address congressional discomfort with the NIH decision, former Director Francis Collins instituted the Environmental Influence on Child Health Outcomes, known as the ECHO program.

As you know, the ECHO program made use of existing maternal-pediatric cohorts which were recruited through the National Children’s Study to address the five health outcomes of pregnancy and birth, upper and lower airway conditions, obesity, zero development, and positive health. And we are currently in the final year of the 7-year program, and before I retire from Congress this year, I would like to have some assurance that the ECHO program has either met most of the goals of the original congressionally directed study or that there is a plan in place to continue and build on the ECHO research thus far.

Since its inception, can you highlight some of ECHO's key accomplishments with respect to its observational and interventional research component, and what approaches has the ECHO program taken to ensure that its research findings are widely disseminated amongst participants, policymakers, and other stakeholders?

Dr. TABAK. So there are a number of impact, high-impact findings that I could share with you. ECHO is the first to show disparities in asthma incident rates across the United States by racial and ethnic populations in early childhood. Obviously, this might lead to solutions to address the health disparities.

We spoke earlier about particulate matter in the air. ECHO has found ultrafine particles late in pregnancy are associated with the development of asthma in the first years of life, and this obviously has the potential to inform regulation of these ultrafine particles, which are not currently regulated by the EPA.

Finally, there is an obesity study of over 37,000 babies and children from the 7-year ECHO cohorts. The obesity rates were higher among the older than younger children. The rates are higher in nonwhite races and ethnicities.

Going forward, they are expanding to include 28,000 additional women recruited during their pregnancy, and they have included a preconception pilot of 10,000 couples, which they estimate would result in about 3,000 births. So that ultimately will allow you to understand questions about health disparities and health equity, social determinants of health, as well as natural experiments or health crises as you follow these individuals longitudinally.

Ms. ROYBAL-ALLARD. My time is just about up. But I just want to know is there any plan to extend the ECHO program beyond the 2023?

Dr. TABAK. We certainly will be asking for additional support, yes.

Ms. ROYBAL-ALLARD. Thank you.

The CHAIR. Congressman Harris.

Mr. HARRIS. Thank you very much. We have a lightning round here.

Dr. Lowy, listen, I want to thank the NCI for actually issuing a Notice of Special Interest to promote research in understanding the mechanisms by which cannabis and cannabinoids can affect cancer biology, cancer inception, cancer treatment and resistance, management of cancer symptoms, et cetera.

Dr. Volkow, is this ready, shoot, aim? I mean, we are basically approving a medicine because, as you said, so-called medical marijuana around the country without having done these studies yet. We don't know what the effect on tumors are of widespread marijuana use.

I mean, this is a rhetorical question. It is kind of a bad idea, isn't it? Shouldn't we know the questions to whether—testicular cancer, for instance, is the instance increased by marijuana—before we actually legalize it everywhere? A rhetorical question. You don't—yes.

Dr. VOLKOW. This is why we do research.

Mr. HARRIS. That is right. Thank you very much.

Dr. Tabak, in your notes, you noticed—and your testimony—that the nutrition research is going to be kind of overseen by the Office of the Director. Do you think it would be worthwhile to study

whether SNAP purchases should be limited to the WIC nutrition-based food list in order to deal with the problems with obesity, diabetes, things like that. Do you think that would be a worthwhile thing to look at?

Dr. TABAK. It is certainly something to look at.

Mr. HARRIS. I think it is about time we do that. And we know from the COVID pandemic that obesity is a real problem in America. It leads to serious morbidities and mortalities, and yet as the Government through SNAP program, we kind of encourage obesity by allowing the purchase of things like soda and chips and things like this.

Dr. Tabak, also because we talked about Alzheimer's research. I know that the Institute on Aging did not directly fund the Aduhelm research, but the FDA decision—and again, the firing of the CEO of the company. The FDA decision to take the particular track they have toward payment for it, do you think that is going to have a relatively chilling effect on privately funded Alzheimer's research going into the future?

Dr. TABAK. Well, this is something that the NIH has no authority on.

Mr. HARRIS. Well, I know. But NIH obviously cares about the broad spectrum of Alzheimer's research, both NIH funded directly and the fact that the private sector is an important R&D sector. Does it give you a little heartburn that there might be a pullback on privately funded research due to that CMS decision?

Dr. TABAK. Partnerships with industry are very important to moving our agenda forward.

Mr. HARRIS. Yes, that is what I imagine. Just one brief last question, Dr. Fauci. *Ad majorem dei gloriam*. Not everyone is going to know what that refers to, but you and I do know what that refers to.

You are respected as kind of the scientific voice for the country. Does the physical and genetic life of a human being begin at conception? Does the physical and genetic life of a human being—not a human person, a human being—begin at conception?

Dr. FAUCI. I don't know if I—

Mr. HARRIS. I will—you can do it as a QFR if you want, you can respond to that, but I will ask that question as a follow-up.

I yield back, Madam Chair.

The CHAIR. Mr. Pocan.

Mr. POCAN. Thank you, Madam Chair, and thanks for the second round.

I also want to thank Dr. Volkow for the work at NIDA that you have been doing around research around kratom. I think the vast majority of States it is legal. My State, it is not, in Wisconsin. And I have worked with Republicans and Democrats to try to change that. But I think even the way you describe it on your website, you have always been an advocate for additional research.

We know that it has helped many people to get off of opioids. Unfortunately, we are in the tens of millions of people there. But there are thousands and thousands of people who this has worked for quite well.

And I just want to say thank you. You don't even have to answer a question. I just wanted to make sure I acknowledge the work that you are doing.

I do want to ask Dr. Tabak a question. So you are a dentist, in addition to being a scientist, and I know that healthcare providers often take the Hippocratic Oath or a similar commitment to medical ethics. Do pharmaceutical companies have a similar obligation to prioritize the well-being of the patients they serve, even if it means putting the greater good ahead of their own profits?

Dr. TABAK. I am not aware of what their standards are.

Mr. POCAN. Would you think that would be a good standard?

Dr. TABAK. Of course.

Mr. POCAN. Of course. Could you say that again?

Dr. TABAK. Yes, of course.

Mr. POCAN. Thank you. Okay. I just wanted to make sure I had that.

And the reason I asked that—and I think I got a little ahead of myself, and Dr. Fauci, I had answer the other question on all the money that NIH is providing to the promising next generation pan-coronavirus vaccines is really a question currently with a drug—and I am probably going to kill the name because they do that to us—Xtandi? If I am saying it correct?

So, right now, this is a prostate cancer medicine marketed in the U.S. by a subsidiary of a Japanese pharmaceutical company, Astellas. They charge U.S. taxpayers and consumers two to four times the price of that than other countries, despite U.S. taxpayers having funded the invention of this through NIH.

Now this question is simple, the first one. Has it changed in the last decade no drug approved by the FDA has not had NIH investment? Is there a drug yet that is approved by the FDA in recent memory that has not had NIH investment?

Dr. TABAK. Not to my knowledge.

Mr. POCAN. So, specifically, to this drug, we are honestly price gouging. We are getting ripped off right and left, in my opinion, by pharmaceutical companies in so many cases. This drug in particular, under the Bayh-Dole Act, when the U.S. Government and taxpayers fund an invention, they have rights to that invention, including the right to march in and license competition when U.S. taxpayers are price gouged.

You have gotten a letter from a number of elected officials on this drug, but this is just one of many that I think we could point out and have a long conversation on. Will you step in, as NIH, and be responsible stewards of medical and pharmaceutical inventions that uses tax dollars to help develop, ensuring that taxpayers aren't being forced to pay twice, once on the front end through NIH and then once again through these higher prices, more than other people in the world?

Are you willing to start seriously looking at doing march-in rights on these types of drugs?

Dr. TABAK. So, as you know, it is a complex space. And up until now, neither NIH nor other agencies that have looked at this have thought that price, per se, met the criteria that are needed for march-in, which depend more on the availability of the drug. So, for example, if there are no manufacturing plants that are avail-

able to manufacture a drug, that would be an example of perhaps where march-in would be used. In this case, the barrier is strictly a financial one.

We are just as concerned about high prices as any other person or agency, but we need to ensure that we are using the right tool for the right job. The request that you refer to is under consideration, and we are looking at it both specifically and in the context of a broader plan that the Department has for lowering drug prices.

Mr. POCAN. I just hope we consider this. I sat down with someone recently who every year I meet with on his particular ailment, and his health is going down and down. And recently, there is a drug that he told me he had to—he was considering passing up that was \$50,000. He had to do twice a year for his health.

And I have watched his condition, and I just think it is time. This is something that, again, I think in the future, we will look back why we didn't address this, and I think we have had the tools to. And if you need additional tools, please let some of us know. We would love to give you those tools.

Very quick, in 18 seconds, if possible. Dr. Lowy, I know the Cancer Moonshot were getting additional dollars, and that is great. How about some of the smaller cancers, things like the neuroendocrine tumor of the pancreas, those sorts of things? Are they also going to be able to see a good chunk of that money and the help from that money?

Dr. LOWY. Rare cancers are, of course, very important. They represent about 20 percent of cancer, and the people who get them, it is just as serious as common cancers. So we, of course, thanks to the generosity of your committee, are in a position where we can study rare cancers.

In addition, we can look at potential interactions, if you will, where findings in one kind of cancer might have implications for another. And very importantly, conducting clinical trials. So people with rare cancers, certainly all of our childhood cancer treatment and those trials involve our rare cancers. And then many of our trials really now are eligible for people who have particular molecular abnormalities. They are multi-arm trials, and so the remaining people with rare cancers who are eligible for those.

Thank you very much.

Mr. POCAN. No, thank you.

And thank you for the extra time. I appreciate it, Madam Chair. The CHAIR. Congressman Fleischmann.

Mr. FLEISCHMANN. Thank you again, Madam Chair. And this has been really a truly outstanding hearing. So substantive.

What a privilege, Dr. Lowy. Thank you again for all you are doing to combat cancer. I think this is something—I am part of the Cancer Caucus. Lost both parents to cancer, one when I was very young. But this is something that I think really our investments with you all are really proving to be great.

I keep with my good friend Dr. Jordan Berlin at Vanderbilt. Sometimes we will just pick up the phone and start talking about stomach cancer or other different types of cancer, and the research is just truly incredible, as are the results. So keep up the good fight, sir. Thank you.

If I may, on a different topic, organ transplant shortages. There is an unfortunate and overwhelming shortage of health organs in this country. Statistics show that over 100,000 men, women, and children are currently on the National Transplant Waiting List. Our traditional cadaveric organ donation process has become increasingly inadequate to meet the needs.

A question for Dr. Tabak and Dr. Gibbons, if I may? Given the recent efforts in xenotransplantation, does the NIH have any plans to develop protocols and research into this area, given the shortage of organs readily available for patients in need?

Dr. TABAK. Well, let me turn to Dr. Gibbons specifically.

Dr. GIBBONS. Certainly from the standpoint of the National Heart, Lung, and Blood Institute, there is still—this is an area that has been investigated pretty much for decades, and certainly, there have been some progress made, particularly related to newer technologies in genetic engineering, gene editing technologies that are maybe—at least on the horizon that there may be some feasibility here.

However, I think we do need to be sure that the zeal with which this is being implemented is done in keeping with that science. And so it is quite clear that there still needs to be a lot more work done before this is really translated into clinical practice and still some major issues that may need to be addressed with regard to still acute rejection and what have you.

Perhaps Dr. Fauci would be willing to comment on this as well, but this is an area that, as you say, has been on the horizon for many years. There are some opportunities for progress, but it is still early days.

Mr. FLEISCHMANN. Thank you, Dr. Gibbons. And yes, I am solicitous of anyone who would like to answer the question.

Dr. FAUCI. Well, I don't know if I could add much more than what Dr. Gibbons said, except that there are a lot of problems with xenotransplantation. I think we just recently had the experience of the transplant of a pig heart in an individual, and what happened was that there was a pig virus in the organ that was transplanted. And it was very likely that with the immunosuppression following the transplantation that you reactivated a cytomegalovirus from the pig, which might have actually caused the death of the individual.

So it is a very important goal because of the reasons that you delineated in your question about the shortage that we have, and it is an area that continues to, as Dr. Gibbons mentioned, perhaps a lot more understanding about gene editing of the particular xeno that is going to be transplanted might actually make it much better. But there is a lot of work that needs to be done.

Mr. FLEISCHMANN. Thank you, Doctor.

Madam Chair, I will yield back. Thank you.

The CHAIR. Ms. Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Madam Chair.

And actually, I had not seen the end of that story. I knew that that transplantation had taken place, and I was watching it with great interest. Let this be a reminder that when it comes to certain organs like the one this gentleman needed or other organ donation, both deceased and living donation remains a really viable option.

And not enough of us do it, and there are a lot of people waiting. So that was my point of personal privilege.

On the maternal and child front, I was thinking I was going to ask Dr. Bianchi, but I think I am going to ask Dr. Tabak, and it is with regards to ARPA-H. I wanted to know if ARPA-H will be providing funding for pediatric research, and just kind of ask for that commitment that it not be left behind.

Dr. TABAK. Well, obviously, we don't know what ARPA-H will be funding yet. That will really be driven by the inaugural Director and program managers that he or she hires and—

Ms. HERRERA BEUTLER. And the Members of Congress that bird dog that new directive with regard to pediatric research.

Dr. TABAK. And certainly, I can't imagine that we would let children behind.

Ms. HERRERA BEUTLER. Thank you. I appreciate that.

Now, to Dr. Bianchi. I wanted a quick follow-up on research with regard to stillbirths, and do we know more about this? Are we able to treat this better?

Dr. BIANCHI. Thank you for your question.

And just for those people who don't know, stillbirth refers to spontaneous death of a fetus after 20 weeks in the womb, and it is a tragedy, and it is something that we still don't know a lot about. What we do know is about 20 percent of the stillbirths are caused by an extra chromosome. Presumably, there are some additional genetic causes that involve only one gene or a cluster of genes.

And one of the things that we have funded in the past year in conjunction with the Human Genome Institute is an expert curation panel on gene mutations as a cause of stillbirth. So we know how to sequence the genome. We know that in the past year, there has been tremendous progress in the sequencing of the human genome, but what you need to know is how to interpret that information.

And so we are funding an expert panel of computer scientists, maternal fetal medicine specialists, geneticists, et cetera, to look at these mutations and then determine which ones of them may be associated with stillbirth. But adverse outcomes of pregnancy are a very, very high priority for our institute and preventing those adverse outcomes.

Ms. HERRERA BEUTLER. Appreciate that. I wanted to talk with Dr. Volkow about research with regard to drug use. Washington State is—practically speaking, you can do drugs, just about anything, in front of an officer. You still can't technically sell drugs over a certain amount, but it is pretty—they call it the "wild west" for a reason. And my big concern, a number of years ago, we legalized recreational marijuana use, and the data on that is rolling in, and it is not promising.

And when you add to it any type of substance, I am curious whether or not you all are following the different States with regard to these lax regulations. I don't even know how to talk about it. But essentially, some States allow you to do this. Are you following the population trends in these States?

Dr. VOLKOW. Yes, absolutely. I think it is a unique opportunity that we have to understand how the different policies implemented

by the State affect the outcomes in children, adolescents, and adults, and in this case, we know, for example, that the policy implementation as it relates to cannabis has significantly impacted the adverse effects of cannabis utilization. So we expect that unfortunately similar trends may start to emerge as other drugs by other States are legalized.

Ms. HERRERA BEUTLER. Well, and I think one of the things, we were talking about fentanyl and overdose deaths and those increasing. This isn't a one—there is multi-legs to this stool in terms of the problem. There is certainly homelessness and the challenge on that front, affording a home in my area. But that is different from drug legalization and how we approach people who have substance use disorder.

And that is different from I think the predatory nature of gangs who bring drugs up from Mexico and make their own pills, and those pills—and then we have got children who come through the pandemic, and they are dealing with mental health challenges. And their friend says, “Here, I have got a pill.” For however much money, you can take it. And it is laced with fentanyl, and we lose that young person.

Those are all happening right now. But I think the one thing we have a little control over is at least getting the data, and I am very, very hopeful that your look at this is going to provide information for lawmakers. It is very important.

Dr. VOLKOW. Yes. We need to do it because we need to identify what areas are challenging and how to intervene. And this is the way that we are right now, for example, monitoring the increased overdose deaths that we are seeing in teenagers.

And these overdose deaths are likely to be driven, as I mentioned before, by the combination of illicit prescription drugs, manufactured drugs, by fentanyl. So it is not teenagers looking for heroin or fentanyl. It is teenagers not knowing that they purchased an Adderall pill or a Vicodin that contains fentanyl, and then they overdose.

Ms. HERRERA BEUTLER. Yep. Thank you, Madam Chair.

The CHAIR. Congressman Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair.

Dr. Fauci, I wanted to ask your insights on when we will no longer call the current COVID public health emergency a pandemic. Are there criteria? Are there benchmarks? What kind of a process will we go through to make that determination?

Dr. FAUCI. There is really no firm, widely acceptable definition. When one talks about pandemic, you talk about a highly transmissible infection that is essentially widely distributed throughout the globe.

I have spoken about this recently. When you are in the acute fulminant stage of pandemic the way we were in the United States just a few months ago, you might remember we had 900,000 cases a day, tens of thousands of hospitalizations, and we were averaging 3,000 deaths a day. That is a really highly fulminant stage of a pandemic.

We come down to a low level. Now we are, unfortunately, ticking up a bit. But when you get down to a level where it isn't disrupting society. It isn't causing deaths that stress your hospital system,

and you have a level of infection that, for example, might be comparable to what you see with respiratory syncytial virus or parainfluenza, even though it is prevalent throughout, it wouldn't be considered a pandemic in the classic sense.

But there is a lot of gray zone about the definition. So I don't think you are going to see all of a sudden one day there is going to be a declaration that the pandemic is over. It will likely be that it is no longer in the pandemic phase and it is more of an endemic kind of infection that you could live with.

Right now, we are not there. I mean, if anybody asked that question, that is for sure.

Mr. MOOLENAAR. And then from the public health emergency and the legal definitions in States and throughout the country, where do we stand with that, given sort of the open-ended nature of that?

Dr. FAUCI. Yes. I am not sure I can answer that with any authority, Congressman, because that is not essentially what we do here at the NIH. But there will be a time, obviously, when an examination of the level of infection and the level of impact in the country will then dictate whether or not it is pulled back as an emergency, but I don't think I can be able to give you a really good answer on that.

Mr. MOOLENAAR. Okay, thank you. And then, on the vaccines for COVID, I think people are weary of this the last couple of years, they followed the recommendations of vaccines, boosters. But I think there is a certain weariness in the American public.

What is your sense and recommendation going forward with respect to vaccinations, what a definition of "fully vaccinated" would be?

Dr. FAUCI. Yes. Well, it is very clear right now, if you look at the need for vaccination, I mean, if you look at the hospitalizations and deaths of those who are unvaccinated compared to those who are vaccinated and boosted, the data are stunning. They are striking, the difference. That is point number one.

But I think the question you are asking, in the era of Omicron, it is very clear that a booster is needed, a third shot. If you look at both the durability of protection, there is no doubt not only to natural infection from which you recover, but also from vaccination over a period of time, there is a waning of immunity. And the data—and other countries like Israel have really good data that when you get X number of months out even from the third shot, you then get an increased risk, particularly among the elderly and particularly among those with underlying conditions, of hospitalizations and death.

So, right now, we are in a situation, as you recall, that the FDA and the CDC have said that people 50 years of age or older are eligible for a fourth shot of an mRNA vaccine. Not only the third boost, the fourth shot. Right now, the advisory committee to the FDA met and are looking at what the recommendations are going to be as we get to the fall. Namely, what is going to happen when we get to September and October?

It is very likely that all of us who have been vaccinated will have a diminution of the level of protection after a certain number of months, and it is likely that they would be recommended for everyone to get a boost then. And then it will be determined has that

got to be every year, the way we do with flu? And we don't know that right now because of the fact that we are having different variants.

But right now we are in an Omicron era, and the vaccines that we all got work pretty well so long as you do get a boost. I think sometime in the middle of the summer, we are going to know what the cadence is going to be about how often we are going to have to vaccinate people.

Mr. MOOLENAAR. Okay. Thank you.

Madam Chair, I yield back.

The CHAIR. Thank you. With that, let me turn to my ranking member, my colleague here for any closing remarks.

Mr. COLE. Thank you very much, Madam Chair.

And I want to thank all of you, frankly, for not only being here and being so generous with your time, but for what each and every one of you do. I am a huge believer in what has been done at the NIH, and as I said in my opening remarks, it is one of the things that the chair and I share in common, and it has been one of the things, honestly, that has made it easier for us to get to contentious issues. When we disagree about something, we say, well, let us just send the extra money to the NIH. I mean, we agree on that.

So you have been the beneficiaries of stalemates in other areas perhaps. But the work that goes on is really extraordinarily important, and the one pledge I will make to each of you and to my good friend the chair is we are going to try to continue to do what we have been doing since 2015. And that is make sure that you have resources above the rate of inflation to continue to expand your mission.

I do, as I said, Madam Chair, share your concerns, have concerns of my own about the ambitious funding of ARPA-H in the President's budget. And simply because I think that may come, but I think it is a little bit soon, in my opinion, for us to do that now until we have a better sense of the structure and, honestly, resolve some questions that some of our colleagues on other committees have or differences.

And again, this is not a partisan issue. I find a wide spectrum of opinions in each party as to how to structure this, where it should go, what the appropriate level of funding is. So at least for me personally, we are just not prepared to make that big an investment. And particularly if it comes at the cost of being able to continue the regular and steady increases that we have had for 7 or 8 years at NIH.

I think that has been a good course for the country. I think it has paid off. I think you have used the resources well, and I am grateful for that.

I am also particularly grateful for the role that the NIH and I think some of the things this subcommittee did pre-pandemic, how it positioned all of you to help the country during the COVID crisis. I still always point out to my constituents at home what an enormous difference it made to have 3 vaccines in 10 months and what an extraordinary accomplishment that was. And it was a public-private partnership.

If the resources aren't there early and often, you don't have the resources. You don't have the labs. You don't have the researchers.

You have to—to my friend Mr. Pocan's point, you have to think about this as part of national defense, a point that I have made plenty of times. We have lost a million Americans in a year, or 18 months or so. That is an extraordinary thing.

But it would have been a lot more had the investments not been made early and we not had the exceptional capabilities that we have at NIH and through our biomedical research community and had we not mobilized and dealt with this. And this won't be the last one we see. We know that the biosphere will continue to throw things at us, and we have to have this capability at all times.

So I want to particularly end by thanking my good friend the chair. She has been a wonderful advocate for the NIH, long before I was in Congress and on this committee. Has played an important role from when she first arrived at the farthest distant chair to now her pinnacle not only as the chair of this very important subcommittee, but more importantly, as the chair of the entire committee.

And that has been an advantage, I think, for folks engaged in biomedical research because she has been a tireless advocate, and she is in a position not only within this committee, but the entire committee to do that.

And I also would be remiss not to tip my hat to our friends on the other side of the Rotunda, Senator Murray and Senator Blunt, who also have been extraordinary advocates. I think we have had an unusual collection of four folks who all wanted to move in the same direction, and again, it hasn't mattered very much who was the President or which party happened to be in power at a given time. And I think that is a tribute to all of you and the work that you do that you can unite us in that way.

And that really does need to continue going forward because I think this is an indispensable national priority that I think we just got a serious lesson how important these investments are and need to continue to be.

Last point, again, you can't just do it at the chair and the ranking member level. You have got to have a lot of members that are interested in doing this, too, and we do on both sides of the aisle. So we are going to try to continue down that course. Continue to make the resources available to you. Do what we are required to do in terms of asking tough questions or holding you accountable.

But again, I think there are lots of critics, but I will just go back and look at what was done over the last 2 years and the speed of which it happened and the lives that were saved, I think, as a consequence of what you did, not to mention all the other things that happened to be going on out there simultaneously. It is not like you stop everything in cancer research or Alzheimer's or whatever. Those are important missions, and they go on as well.

But to mobilize the way you did, again, in cooperation with the broader biomedical research community, public and private alike, is something that I hope you regard as with a great deal of personal pride. Because, again, you all deserve it, and you all are dealing with the ramifications of this awful pandemic and everything from mental health to depression to drug addiction, the consequences of this thing, which our chair has looked at through a

series of really good hearings and put a lot of stress and strain on what we need to do.

So, Madam Chair, thank you for your leadership in this, and I look forward to continue working with you.

Yield back.

The CHAIR. Thank you so much, and thanks to the ranking member. I think we are both so really proud of the support that we have been able to really to reach out and get in this. The ranking member said there are just that on this committee and just that on the House side, on the Senate side, there really is such an interest in our looking at the discovery to cure, which is what you are engaged in on a daily basis.

And what we have been able to be able to provide for NIH research, the \$15,000,000,000, almost 50 percent over the past 7 years, we are really very proud of that. And it is also why we speak about critical—to strike a balance, to strike a balance and to continue to support important research really in all areas.

And the concept of ARPA-H is very, very exciting. It needs to get lifted off the ground. We have started in that direction, but we need to get a sense and again create that balance and not leave behind areas of research that we need to try to be pursuing.

I am very serious about wanting to review funding across the institutes and the centers, and what that has been over time because I want to see that we are creating opportunities across the 27 institutes so that each of the areas is rising to its potential and what we can do to alleviate some of the pain associated with illnesses or diseases that you know don't rise to that top level.

And Dr. Tabak, given what you said, if there were more research in some of these areas, they could then be in that category where it is time to move because of the discoveries that have been made.

I thank you, and we appreciate so much everything that you do to deal with scientific breakthrough. And the reason why we are so concerned around this is because of the—you save lives and you protect families, and that requires sustained investment, sustained investment over time. So we will look at that balance of effort.

Also there are two or three things that I just wanted to mention. It started—there has been a kind of a conversation. I go back to what I said. I think that we were able to move as quickly as we did on COVID was because of the years of investment in research, and it allowed us to spring forward when this horrific pandemic was upon us.

And I get annoyed when I see pharmaceutical companies who won't recognize the work of NIH scientists who were instrumental in moving forward. We know the power and the strength of the NIH, and it is—that is something that we really need to think through of this is taxpayer research, and we are so deeply invested. We want to continue to be deeply invested that to think about areas of cure where people can't get access to it because it is priced out of the market. They can't get access.

My family could afford what I needed for ovarian cancer. Not every family can do that. That doesn't mean that women should die because they just don't have the financial wherewithal, especially when we see an industry which is just making money hands over fist.

Talk about balance, we need to do that. We need to be able to negotiate price. We need to establish some parameters around where we need to go and bring down the cost so that people can afford to survive.

So this is—I also just want to say, and I would like to hear your voices. Not now, obviously. We are well over time here today. But the pandemic is still with us. It is with us here, and it is with us overseas. And I view us as having a moral obligation for us to have a COVID supplemental bill, which allows us to continue to provide the vaccines and the treatment that people need here, and we have an obligation to make sure that we are looking at what you said, Dr. Fauci, is we have the doses. But the delivery system of getting the shots into arms and creating an opportunity for those countries who can do it to be involved in the manufacture.

It doesn't have to be—those patents don't have to be on a permanent basis, but by God, they should be there now and allowing people to be able to survive. We are not safe unless we do something about curtailing the effort overseas.

I just say to you, Dr. Lowy, and I am going to submit the question because immunotherapies are there, but they work, they don't work. There are correlative studies. I would love to get your view of how that is being used and how we can move forward.

I am just going to make this last statement. For the record, it is clear that the leaked Supreme Court decision that would overturn Roe will have an effect—negative, I believe—on maternal mortality. So, and I believe that women will be harmed by this decision.

I think that that is something that we need to take a look at and need to examine in a scientific way and not on the basis of politics or ideology, but we need to understand what that means to women's health.

For all that you do every day, and we are so grateful, and please understand I think that this is a committee that wants to see you being able to think outside of the box, take your talent and make sure that we are finding that discovery to cure.

Thank you. And with that, this hearing is adjourned. Thanks so much.

[Answers to submitted questions follow:]

Committee on Appropriations
Labor, Health & Human Services, and Education Subcommittee
FY 2023 Budget Request for the National Institutes of Health
May 11, 2022

Questions for the Record

Dr. Lawrence A. Tabak, Acting Director, National Institutes of Health
Dr. Diana Bianchi, Director, Eunice Kennedy Shriver National Institute of Child Health and Human Development
Dr. Anthony S. Fauci, Director, National Institute of Allergy and Infectious Diseases
Dr. Gary H. Gibbons, Director, National Heart, Lung, and Blood Institute
Dr. Douglas R. Lowy, Acting Director, National Cancer Institute
Dr. Nora D. Volkow, Director, National Institute on Drug Abuse

Submitted by Chair DeLauro

Cancer Immunotherapy

Dr. Lowy, immunotherapy has revolutionized cancer treatment. Thousands of patients are living longer, and with fewer side effects, because of this exciting field of research. But immunotherapies don't work for everyone, and we often don't know why. Clinical trials can tell us whether a treatment works, but not necessarily why some patients benefit and others don't. As I understand it, one way to get at that question is through correlative studies that accompany the clinical trials. These studies examine what's happening to a patient's cells while they're going through the treatment, and they can offer clues as to why a treatment succeeded or failed. That information could be very helpful in determining which treatments to offer individual patients.

Question:

Dr. Lowy, would you please tell us more about the value of correlative studies and what NCI is doing to support them?

NIH Response:

The tremendous advances in cancer immunotherapy are a result of long-term investments in basic research on the immune system. The National Cancer Institute (NCI) has been at the forefront of these efforts for decades, playing a leading role in the development of the field by supporting critical basic research into the immune system and cancer. NCI continues to support a wide range of research efforts necessary to understand the complex factors that determine whether a particular cancer immunotherapy will be effective in some patients but not others, and to explore why some patients develop toxic side effects and how to predict and mitigate them.

The NCI Experimental Therapeutics Clinical Trials Network and the National Clinical Trials Network conduct studies on immunotherapy agents and novel treatment combinations, including those with immunotherapies, and consistently incorporate research on biomarkers and other

studies to better understand why these therapies work for some patients and not others. These data have implications not only for precision medicine in specific cancer populations but may also be relevant to multiple trials across the cancer immunotherapy field.

In addition, as part of the Cancer MoonshotSM initiative, NCI established the Cancer Immune Monitoring and Analysis Centers (CIMACS) and the Cancer Immunologic Data Commons (CIDC).¹ This network carries out comprehensive molecular analysis of clinical trial specimens for biomarkers and pathways associated with response to immunotherapy. It also conducts correlative studies and profiling of tumors and immune cells for NCI-funded early trials of immunotherapy. The CIDC component of this network has enabled the establishment of a database to facilitate the sharing of clinically annotated biomarker data and assay performance guidelines with the research community in a coordinated manner. As of 2022, data from over 4,600 specimens from 11 clinical trials are housed in the CIDC database. Also as part of the Cancer Moonshot initiative, the collaborative Immuno-Oncology Translational Network (IOTN)² is working to accelerate the discovery of new immune targets and immunotherapies for cancer treatment, and it includes the IOTN Research Projects for Mitigating Immune-Related Adverse Events to identify strategies for eliminating or reducing harmful side effects potentially caused by immunotherapies.

NCI is currently developing a Funding Opportunity Announcement (FOA) for Cancer Adoptive Cellular Therapy Networks (Can-ACT) for Adult³ and Pediatric⁴ Cancers, along with funding for a Coordinating Center.⁵ This initiative will fund projects seeking to advance new cell therapy concepts to clinical testing, while also conducting research to advance the clinical use of cell therapies, such as the development of biomarkers to guide therapeutic use and methods for measuring the efficacy of cell therapies.

NCI will continue to prioritize the incorporation of correlative studies as part of immunotherapy trials through existing funded networks. The institute also continues to explore approaches that support and streamline the initiation of these studies to ensure they are carried out in a timeframe that aligns most efficiently with the corresponding trials, while also protecting the integrity of the peer review process.

National Commission on Lymphatic Diseases

Dr. Tabak, I would like to thank you for the inclusion of lymphedema and lymphatic diseases in NIH's Research, Condition, and Disease Categorization for fiscal year 2021, although my understanding is that those estimates are not yet public but will be made available shortly. This is a first step in identifying the gaps and opportunities in NIH-funded research in this area.

¹ cimac-network.org

² <https://www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative/implementation/adult-immunotherapy-network#nbsplthe-immuno-oncology-translational-network-iotn>

³ <https://grants.nih.gov/grants/guide/notice-files/NOT-CA-22-074.html>

⁴ <https://grants.nih.gov/grants/guide/notice-files/NOT-CA-22-075.html>

⁵ <https://grants.nih.gov/grants/guide/notice-files/NOT-CA-22-076.html>

The fiscal year 2022 House LHHS appropriations report directed NIH to establish a National Commission on Lymphatic Diseases. This commission would make recommendations on how NIH can strengthen and grow its portfolio of research related to lymphatic diseases.

Question:

Would you please provide the Committee with an update on the establishment of the National Commission on Lymphatic Diseases as directed in the Fiscal Year 2022 appropriations bill?

NIH Response:

The National Heart, Lung, and Blood Institute (NHLBI), the National Cancer Institute (NCI), and other Institutes and Centers (ICs) coordinate a robust portfolio of multidisciplinary lymphatics research across the National Institutes of Health (NIH). The NIH ICs supporting lymphatic disease research coordinate and collaborate as part of a Trans-NIH Lymphatic Coordinating Committee (TNLCC), which serves to explore and make recommendations regarding coordination of lymphatic disease research across the NIH. NIH supports the patient and research community's request for a more open national body aimed at advancing research in lymphatics disease and is working to develop a blueprint for considering a new structure in compliance with the Federal Advisory Committee Act of 1972 (5 U.S.C. App.2) (FACA). NHLBI will convene a Working Group to report to the NHLBI Advisory Council that will include external stakeholders to provide guidance and recommendations on how best to thoughtfully establish and implement a new structure. Input from scientific leaders and patient representatives will help ensure an efficient and effective planning process.

NIH has begun a planning process that leverages an initial analysis of the new Research, Condition, and Disease Categories (RCDC)⁶ categories on lymphatics research and lymphedema, which are operational now, and the most recent summaries on lymphatics science. The new RCDC categorization allows stakeholders and the public to view funded lymphatic research projects by fiscal year, and to access the details of each research project, including published results and patents, through the NIH Research Portfolio Online Reporting Tool (RePORT).⁷ Through this process, we will evolve a collective approach toward setting a mission, strategic objectives, and structural format for a working group that engages researchers, patients, clinicians, and other stakeholders to help advance lymphatics research. NIH is planning a Fall 2022 workshop that will engage the lymphatics research and patient communities to review the state of the science in this area and discuss how to advance it. Input from this workshop will be shared with the Advisory Council Working Group.

⁶ report.nih.gov/funding/categorical-spending/

⁷ reporter.nih.gov/

Submitted by Rep. Lucille Roybal-Allard***Alternative to Animal Testing & Research Metrics
Question for Dr. Lawrence Tabak***

In 2021, the ICCVAM Metrics Workgroup published a report titled “Measuring US Federal Agency Progress Toward Implementation of Alternative Methods in Toxicity Testing” which recommended that agencies use quantitative and qualitative metrics in implementation alternatives to animals in toxicity testing. Quantitative metrics include counting entities or actions, such as the number of animals used in toxicity testing or number of educational opportunities (e.g., training, webinars, and publications) provided. Qualitative metrics include the development or implementation of alternatives, or the provision of educational opportunities that raise awareness regarding alternatives.

Question:

1. Have you collected the metrics that are being used to evaluate the trends in animal use at NIH and NIH’s progress in using alternatives? What are these metrics? Please detail the specific metrics and best practices each member agency should use/establish to measure progress on alternatives to animals.

NIH Response:

The Interagency Coordinating Committee on the Validation of Alternative Methods (ICCVAM) Metrics Workgroup⁸ (MWG), was established in early 2020 and is comprised of representation from nine federal agencies or institutes (Consumer Product Safety Commission, U.S. Department of Agriculture, U.S. Department of Defense, Department of Interior, Department of Transportation, U.S. Environmental Protection Agency (EPA), U.S. Food and Drug Administration, National Institute of Environmental Health Sciences (NIEHS), and National Institutes of Health (NIH)). In February 2021, the MWG published “Measuring U.S. Federal Agency Progress Toward Implementation of Alternative Methods in Toxicity Testing”,⁹ and in September 2021, presented the MWG recommendations to the Scientific Advisory Committee on Alternative Test Methods (SACATM). Consistent with the ICCVAM Strategic Roadmap,¹⁰ the MWG found that no one set of metrics can be used by all ICCVAM member agencies¹¹ and recommended that each agency develop its own metrics that are relevant and practical to their unique regulatory domain. Agencies are actively working to develop specific strategies to address metrics of animal use and implementation of alternatives. The MWG recommended the use of both quantitative and/or qualitative metrics, when relevant and practical, to assess progress and provided examples of approaches that could be used for establishing agency-specific metrics. One example of agency-specific metrics is provided by the U.S. EPA on their

⁸ ntp.niehs.nih.gov/go/903258

⁹ ntp.niehs.nih.gov/iccvam/docs/about_docs/iccvam-measuringprogress-feb2021-fd-508.pdf

¹⁰ ntp.niehs.nih.gov/whatwestudy/niceatm/natl-strategy/index.html?utm_source=direct&utm_medium=prod&utm_campaign=ntpgolinks&utm_term=natl-strategy

¹¹ ntp.niehs.nih.gov/whatwestudy/niceatm/iccvam/iccvam-agencies/index.html

website: “Strategic Vision for Adopting New Approach Methodologies – Metrics”.¹² Additional agency progress in this area will be provided in the ICCVAM Biennial Report for 2020-2021 (anticipated publication August 2022; copy to be provided when available), where relevant articles contain the specific metadata tag “#metrics”. Further, ICCVAM has established a new workgroup called the Consideration of Alternative Methods Workgroup (CAMWG) to follow up on the recommendations of the MWG and, with input from appropriate stakeholders, develop a white paper on approaches that could potentially be used to foster the consideration and use of alternative methods to replace, reduce, or refine live animal use by organizations currently using animals for testing. Finally, one of two major topics for this year’s SACATM meeting (September 21-22, 2022) will be “Implementing the Strategic Roadmap: Incorporation of alternatives and associated metrics.” The draft agenda includes metrics case studies from multiple agencies and input from various industry sectors on approaches to metrics.

It is important to note that the above efforts concern toxicology testing, which by statute is distinct from other areas of biomedical research that the NIH funds. Toxicity testing includes internationally standardized and validated methods adopted in policy and practice by regulatory bodies that are intended to assess chemical and drug safety for specific human health or ecological endpoints. In contrast, biomedical research conducted and funded by the NIH covers a broad area of discovery science dedicated to understanding disease mechanisms and developing treatments. Developing alternative methods for codified toxicity testing methods is thus more achievable due to the consistency of testing protocols and availability of historical data from many years of testing, allowing comparison of the new alternative approach to the existing animal test.

NIH continues to invest in identifying and developing appropriate biological models to maximize research translation, including those focused on human-relevant non-animal approaches. The goal of increasing NIH’s portfolio of non-animal models provides researchers with a complementary tool for existing animal models. Researchers are leveraging new technology through *in vitro* methods including human derived induced pluripotent stem cell (iPSC) lines, organoids, tissue bioprinting and tissue chips, and computational modeling.

While non-animal models may prove to be appropriate method for some research questions, they may also fail to provide the necessary insight into all biological processes and disease pathways (e.g., multicellular/multisystem signaling and states that develop over time) and predicting the full spectrum of variability in outcomes in human systems. Accordingly, NIH is establishing a new internal coordinating group to articulate the value and limitations of these non-animal approaches to proactively establish a targeted portfolio of areas in which further investment holds promise. NIH efforts are designed to provide an honest assessment of scientific opportunity, which builds on the NIH Advisory Committee to the Director (ACD) Working Group on Enhancing Rigor, Transparency, and Translatability in Animal Research findings.¹³

***Analyzing Transgenerational Health Effects of Environmental Exposures
Question for Dr. Lawrence Tabak***

¹² www.epa.gov/pesticide-science-and-assessing-pesticide-risks/strategic-vision-adopting-new-approach-0

¹³ www.acd.od.nih.gov/documents/presentations/06112021_RR-AR%20Report.pdf

Research has established that the exposure to endocrine-disrupting chemicals (EDCs) is linked to several public health impacts- including obesity, infertility, and cancer. Such exposures may have heritable effects, impacting the health of not only the exposed individual, but also their children and future generations. Diethylstilbestrol, or DES, is the canonical example of an endocrine disruptor that was prescribed to pregnant women in the mid-20th century. It was later found to have various adverse health effects in the offspring of these women - including rare cancers and reproductive health issues. The NCI Combined DES Cohorts Follow-up Study is a nationwide research study following more than 21,000 women and men to learn about the long-term health effects of DES exposure. Since 1992, NCI investigators at five field study centers have investigated health outcomes associated to DES exposure in three generations of DES-exposed and unexposed study participants.

Question:

1. Can you describe NIH's plans for ongoing or new cohort studies that can address transgenerational effects of EDC exposures, including the continuance of the DES longitudinal cohort?
2. How does NIH plan to incorporate the results of these cohort studies into future research?

NIH Response:

1. In 1992, the National Cancer Institute (NCI), together with collaborators at five research centers, began a long-term study of individuals prenatally exposed to DES, the DES Follow-up Study.¹⁴ Participants were initially drawn from eight different medical centers and consisted of five individual cohorts of people. Researchers queried participants in the combined cohort about cancer and other health outcomes in their daughters and sons (grandchildren of the women who were administered DES in pregnancy), and in 2000, NCI began actively following the daughters of the DES daughters, or third-generation women. For the study findings to be valid, enrollment is limited to participants who have been part of existing cohorts. For that reason, the DES Follow-up Study does not accept new participants.

Extensive research has been conducted on prenatal DES exposure and health outcomes in DES daughters (see Hoover et al., NEJM) and sons. This research demonstrated in the DES exposed women, in addition to clear cell adenocarcinoma, increased risks of infertility, spontaneous abortion, preterm delivery, loss of second-trimester pregnancy, ectopic pregnancy, preeclampsia, stillbirth, early menopause, grade 2 or higher cervical intraepithelial neoplasia and breast cancer at 40 years of age or older. While not as pervasive as in women, the health effects of DES in sons include an increased risk of urogenital anomalies and a possible increased risk of testicular cancer. More recent research shows the possibility that individuals exposed to DES have an increased risk of high cholesterol, hypertension, coronary artery disease, and heart attack, as well as pancreatic disorders. DES daughters have more than twice the risk of early menopause (menopause beginning before age 45) as unexposed women, and there is some evidence

¹⁴ dceg.cancer.gov/research/what-we-study/des-study

that psychosexual outcomes like sexual orientation may have been affected by prenatal exposure.

Researchers continue to monitor disease risk in DES daughters and sons as they age. In addition, NCI conducted a pilot study to collect biological specimens in postmenopausal DES daughters. Differences in estrogen metabolite concentrations were demonstrated, suggesting that prenatal exposure to this endocrine disruptor may influence estrogen metabolism many years later. The cancer risks for exposed sons are also being studied, as are possible health effects among the DES grandchildren. For example, DES granddaughters began their menstrual periods later and were more likely to have menstrual irregularities than unexposed women of the same age (that is, women whose mothers did not have prenatal exposure to DES). The NCI Study also suggested that infertility was greater among DES granddaughters than among unexposed women of the same age¹⁵ and that they may have an increased risk of preterm delivery.¹⁶ The risk of hypospadias was increased in the DES grandsons. However, some of these associations are based on small numbers of events and were not statistically significant.

While the NCI has focused on DES effects in humans, the National Institute of Environmental Health Sciences (NIEHS) is leading animal studies to investigate DES exposure and its effects on health. NIEHS researchers developed a rodent model of prenatal DES exposure that has been useful in replicating and predicting adverse health effects. This experimental model has been used worldwide to study mechanisms involved in DES-related toxicity and the adverse effects of less potent environmental estrogens.

NCI and NIEHS, whose Sister Study has information on prenatal DES exposure in women, are currently collaborating to analyze data on DNA methylation (a mechanism used by cells to control gene expression) between women who were and were not exposed to DES *in utero*. This collaboration stemmed from the recent Breast Cancer and the Environment Workshop hosted by the NCI director, the Division of Cancer Epidemiology and Genetics (NCI), and the NIEHS. These studies include some of the only data in humans on the effects of a known exposure on epigenetic changes. While preliminary, the findings suggest that some of the epigenetic changes observed in the animal model are reproduced in humans.

2. NCI is continuing to study new information on prenatal DES exposure and the following health outcomes and biomarkers:
 - Benign breast disease
 - Health effects among women whose mothers were exposed to DES in utero (the Third Generation Study or the granddaughters' study)
 - DNA methylation patterns, in collaboration with researchers at the NIEHS

¹⁵ pubmed.ncbi.nlm.nih.gov/16723367/

¹⁶ pubmed.ncbi.nlm.nih.gov/30594671/

- Expanded blood study among the DES daughters based on pilot findings, in collaboration with Boston University; this work has experienced delays due to the COVID-19 pandemic and is expected to start in the coming year

***Physician-Scientist Workforce
Question for Dr. Lawrence Tabak***

In 2014, the NIH released the Physician-Scientist Workforce (PSW) Report to assess the composition of the physician biomedical workforce and issue recommendations to sustain a robust and diverse PSW. The PSW-Working Group analyses showed that there were approximately 9,000 physician-scientists in the NIH-funded workforce between 2008-2012, including 4,192 with an MD, 4,086 with an MD/PhD, 341 nurse-scientists, 253 veterinarian-scientists, and 161 dentist-scientists. Additionally, the PSW report provided 9 recommendations for all clinically-trained investigators, including veterinarian-scientists, dentist-scientists, and nurse-scientists.

Question:

1. Can you provide an update on actions that the Institutes and Centers have taken to bolster the physician-scientist workforce either by implementing the 2014 report's recommendations or otherwise, including outcomes data on the Medical Scientist Training Program (MSTP), and the Stimulating Access to Research in Residency (StARR) program?

NIH Response:

The National Institutes of Health (NIH) is dedicated to strengthening and diversifying the biomedical research workforce, including for physician scientists. As part of this effort, NIH continues to address recommendations described in a 2014 report focused on the physician-scientist workforce from the NIH Advisory Committee to the Director (ACD).¹⁷ As the report notes and NIH agrees with, "findings which lead to advances in practice are driven largely by the work of investigators with a variety of degrees, of whom those with clinical training contribute essential knowledge and skills." Investing in research conducted by physician-scientists is vital to discovery and innovation; these researchers help transform clinical observations into hypotheses and research findings into medical advances.

Selected examples of steps taken across NIH to address the ACD recommendations include the following:

- Supporting individual F30 fellowship dual-doctoral degree training at institutions with and without NIH funded Medical Scientist Training Programs.^{18,19}

¹⁷ acd.od.nih.gov/documents/reports/PSW_Report_ACD_06042014.pdf

¹⁸ grants.nih.gov/grants/guide/pa-files/PA-16-305.html

¹⁹ grants.nih.gov/grants/guide/pa-files/PA-16-306.html

- Evaluating career development (K)-award programs including the K08 Mentored Clinical Scientist Development Award and the K23 Mentored Patient-Oriented Research Career Development Award.^{20,21}
- Reissuing the Pathway to Independence Award (K99/R00) funding opportunity announcement with modifications to emphasize eligibility of physician-scientists.²²
- Piloting institutional Research in Residency Programs with potential individual Transition Scholar support during fellowship at same or new institution.
- Releasing a Request for Information titled “RFI Strategies to Enhance Diversity in the Physician-Scientist Workforce”.²³
- Leveraging the existing resources of the Clinical and Translational Science Award (CTSA) Program²⁴ to obtain maximum benefit for training and career development of clinician scientists, including administrative supplements supporting dentists on KL2, new collaborations between CTSA and the National Institute of Biomedical Imaging and Bioengineering NIBIB to support biomedical engineers²⁵, and collaboration with One Health alliance to support veterinarians.²⁶
- Increasing the amount of loan repayment (from a maximum award amount of \$35,000/year to \$50,000/year) to more realistically reflect qualified educational debt burden.
- Continuing to support T35 NRSA Short-Term Institutional Research Training Grant that provides short-term research training for students in health professional schools during the summer in focused, often emerging scientific areas.²⁷

Selected examples of programs specifically for physician scientists include:

- Research Experiences to Enhance Clinician-Scientists' Participation in NIDCDs Research (R25).²⁸
- Clinical Scientist Institutional Career Development Program Award (K12).²⁹
- The GEMSSTAR grant for early career medical/surgical specialists to transition to aging research (R03).³⁰
- The Stimulating Access to Research in Residency (StARR) (R38) and Stimulating Access to Research in Residency Transition Scholar (StARRTS) (K38) programs developed to support physicians with in-depth research opportunities during residency and subsequent clinical fellowship or early career faculty appointments.^{31,32}

²⁰ grants.nih.gov/grants/guide/pa-files/PA-20-203.html

²¹ grants.nih.gov/grants/guide/pa-files/PA-20-206.html

²² researchtraining.nih.gov/index.php/programs/career-development/K99-R00

²³ grants.nih.gov/grants/guide/notice-files/NOT-OD-16-027.html

²⁴ ncats.nih.gov/ctsa/about/training

²⁵ grants.nih.gov/grants/guide/pa-files/PA-18-426.html

²⁶ www.ctsaonehealthalliance.org/resources/call-mentored-opportunities-ctsa-translational-research-fellows

²⁷ grants.nih.gov/grants/guide/pa-files/PA-18-404.html

²⁸ grants.nih.gov/grants/guide/pa-files/PA-21-188.html

²⁹ researchtraining.nih.gov/programs/career-development/K12

³⁰ grants.nih.gov/grants/guide/rfa-files/RFA-AG-23-031.html

³¹ grants.nih.gov/grants/guide/rfa-files/RFA-HL-18-023.html

³² grants.nih.gov/grants/guide/rfa-files/RFA-HL-20-006.html

In the 2014 report,³³ the ACD recommended that NIH sustain support for training of dual-degree (M.D./Ph.D.) physician scientists. In December 2021, NIH reported on the success of those trainees over time.³⁴ The post focuses on 33,067 predoctoral trainees, including M.D./Ph.D. (or equivalent) who were enrolled in NIH-funded institutional training programs and voluntarily reported their age, gender, race, and ethnicity. The cohort consisted of trainees affiliated with either the Medical Scientist Training Program (MSTP supported by the National Institute of General Medical Sciences)³⁵ (n=3,265) or other T32 pre-doctoral training programs (n=29,802) who began their training programs (i.e., matriculation year) between 1975 and 1998. As the post describes, trainees enrolled in MSTP programs were more successful in serving as principal investigators in subsequent research project grant awards, but only after at least 15 years had elapsed. This may reflect, in part, the time needed for clinical training. Furthermore, as noted in a report available from the American Association of Medical Colleges,³⁶ many M.D./Ph.D. researchers have funding from sources other than NIH (see survey results on p. 33-37 and Figure 19). These outcomes are encouraging, and considerations are underway to expand the MSTP to minority-serving institutions.

The R38 StARR provides tailored research training and skill building. The flexibilities built into the request for applications led to NIH receiving diverse proposals, including on the research time requested. The researchers also expressed strong interest in future career development. Furthermore, Clinician-investigators generated through the StARR R38 program will be able to apply for the recently issued StARRTS (K38). StARRTS K38 Transition Scholar grantees will receive support for continued research and career development opportunities in basic, clinical and/or translational research thereby providing enhanced potential to accelerate the transition to independent research careers.

***Physician-Scientist Workforce
Question for Dr. Diana Bianchi***

Overactive bladder is a form of urinary incontinence that affects more than 38 million Americans, and 1 in every 3 older adults. Overactive bladder is more common with aging and in women. Recent studies on anticholinergic medications, which are commonly prescribed drugs to treat overactive bladder, have shown that these medications have a negative impact on cognition and may lead to the development of Alzheimer's disease and related dementia. As the population ages, the potential adverse impact on the nation's elderly will only increase.

Question:

1. Is the NICHD studying these medications or working collaboratively with other Institutes to determine the safety and efficacy of anticholinergic medications, and any association they may have with cognitive decline and Alzheimer's disease and related dementia?

³³ acd.od.nih.gov/documents/reports/PSW_Report_ACD_06042014.pdf

³⁴ nexus.od.nih.gov/all/2021/12/01/measuring-success-for-pre-doctoral-trainees-an-initial-glimpse

³⁵ www.nigms.nih.gov/Training/InstPredoc/Pages/PredocOverview-MSTP.aspx

³⁶ www.aamc.org/data-reports/workforce/report/national-md-phd-program-outcomes-study

2. Can you please discuss what NICHD initiatives are being pursued to determine the safety of these medications and to develop alternative treatments that are safe and effective for treating overactive bladder?

NIH Response:

Overactive bladder occurs when the bladder is triggered to empty at the wrong time, leading to a sudden urge to urinate that a person may have difficulty suppressing. The symptoms of overactive bladder include urinary frequency, urinary urgency, and urge incontinence.

The National Institutes of Health (NIH) supports studies on a range of issues related to the causes, prevention, and treatment of overactive bladder. This includes research on the safety of long-term use of anticholinergic medications commonly prescribed to treat overactive bladder and the associated risk of cognitive impairment and dementia as well as research to advance safe and effective alternative treatments for overactive bladder.

NIH Response Question 1-

Within the NIH, the National Institute on Aging (NIA) is currently funding several studies on the safety of long-term use of anticholinergic medications and the risk of cognitive impairment and dementia in older adults with overactive bladder. This includes a clinical trial testing whether discontinuing use of anticholinergics improves cognition and lowers the risk of Alzheimer's disease and related dementias.³⁷ NIA is also funding a clinical trial to test a mobile app that integrates a personalized anticholinergic risk calculator, targeted multimedia such as videos and blogs to educate users regarding anticholinergics, and a conversation starter to help a patient self-initiate ending anticholinergic prescriptions in collaboration with a healthcare provider.³⁸ This trial will explore the impact of the app on prescription anticholinergic exposure among older adults and on cognitive function and quality of life. Other research studies currently funded by NIA seek to assess severe adverse events associated with the interaction of cholinesterase inhibitors used to treat Alzheimer's with anticholinergic medications;³⁹ test mechanisms of neurotoxicity from anticholinergics;⁴⁰ evaluate extended cognitive, urinary, and functional trajectories in older incontinent women without pre-existing dementia who use anticholinergic medication;⁴¹ utilize a novel model to investigate anticholinergic drug induced dementia;⁴² improve how older adults living with dementia, their caregivers, and clinicians make decisions about using anticholinergic medicines;⁴³ and test electronic health record-based tools that engage caregivers to help primary care providers reduce medication overload and deprescribe medications that can worsen cognitive burden in patients with mild cognitive impairment, Alzheimer's disease, and related dementias.⁴⁴ In addition, a recent NIA-funded study found that exposure to strong anticholinergics increased the risk of transitioning from normal cognition to

³⁷ reporter.nih.gov/search/Shaj-qYerkm0U6DRn1S6tg/project-details/10129872

³⁸ clinicaltrials.gov/ct2/show/NCT04121858

³⁹ reporter.nih.gov/search/pZSsBABfW0K-DPFctVqRcQ/project-details/10212709

⁴⁰ reporter.nih.gov/search/Ggd69UkxpkGGqF5IAEfYrg/project-details/10168318

⁴¹ reporter.nih.gov/search/0lm26jQsukuQXix5r_QvGw/project-details/10343015

⁴² reporter.nih.gov/search/0lm26jQsukuQXix5r_QvGw/project-details/10258975

⁴³ reporter.nih.gov/search/Ggd69UkxpkGGqF5IAEfYrg/project-details/9926791

⁴⁴ reporter.nih.gov/project-details/10370471

mild cognitive impairment.⁴⁵ Another recent NIA-funded study that evaluated adverse outcomes of anticholinergic medicines in patients with dementia and overactive bladder⁴⁶ found an increased risk of mortality associated with non-selective antimuscarinic (a subtype of anticholinergic drugs) medications in older adults with dementia.⁴⁷

NIH Response Question 2-

NIA is also funding several studies to advance safe and effective alternative treatments for overactive bladder. One NIA-funded research study is assessing brief mindfulness and non-invasive brain stimulation to reduce symptoms of urgency incontinence in women.⁴⁸ In addition, a recent NIA-funded study found that a slow-paced breathing intervention practiced over 12 weeks was associated with a modest improvement in perceived stress in women with overactive bladder symptoms, but it was no more effective than a control intervention (listening to calming music) for reducing urinary symptoms.⁴⁹ NIA also recently funded a study testing a novel, non-invasive nerve stimulation device for in-home treatment of overactive bladder.⁵⁰

In addition, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) continues research into the causes and treatment of overactive bladder. NIDDK-supported projects include those evaluating the efficacy of interventions and treatment approaches for urinary incontinence in older and minority women, including group-based, community-based, and online approaches. Other projects are aimed at finding ways to better assess bladder function, psychological contributors, potential biomarker signatures, and clinically useful patient subtypes.

NIH is committed to continuing to fund research to improve the lives of people living with overactive bladder and will continue to fund research towards prevention of cognitive impairment in this, and other, areas of investigation.

***Spina Bifida and Neurogenic Bowel
Question for Dr. Diana Bianchi***

Spina Bifida is a neural tube defect that happens in the first 4 weeks of pregnancy. Most people with Spina Bifida have issues with fecal incontinence – which results in a lower quality of life. More specifically, individuals are unable to control bowel and bladder discharge resulting in involuntary loss of urine or feces. Fetal incontinence is an incapacitating symptom that inhibits those with Spina Bifida from achieving independence. However, there is no tested protocol to treat neurogenic bowel dysfunction.

Questions:

1. What clinical factors predict improved bowel continence?

⁴⁵ www.ncbi.nlm.nih.gov/pmc/articles/PMC6036636/

⁴⁶ reporter.nih.gov/search/-xMveMuhZUWqFIMIntQeIw/project-details/9377896

⁴⁷ pubmed.ncbi.nlm.nih.gov/32026255/

⁴⁸ reporter.nih.gov/search/PWzY007ysEW1d1WslGSukQ/project-details/10259722

⁴⁹ www.ncbi.nlm.nih.gov/pmc/articles/PMC6842393/

⁵⁰ reporter.nih.gov/search/rmFNoL91xkamsqkLW-QEQ/project-details/10219001

2. Is there a difference in the neurogenic bowel in individuals with child onset neurogenic bowel and those with an acquired neurogenic bowel, for example, adults with spinal cord injuries? If so, do these differences impact interventions to achieve continence?
3. What modifiable factors have the largest effect of closing the health disparity gap of fecal incontinence?
4. Is there currently any NIH funded research that is testing specific protocols to treat neurogenic bowel?

NIH Response:

The National Institutes of Health (NIH) is currently funding studies to understand and treat neurogenic bowel. It is recognized as a significant issue for individuals with spinal cord injuries. For example, researchers funded by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) are studying advances in neuromodulation therapies to improve bowel and bladder function. In another study supported by the National Institute of Neurological Disorders and Stroke (NINDS), researchers are using an animal model to understand the mechanisms resulting in the dysregulation of the gastrointestinal tract following spinal cord injury. NINDS also supports a small business award for preclinical development of a neuromodulation device to prevent both urinary and fecal incontinence in subjects with spinal cord injury. A long-term goal of the project is to adapt the device, an implant that stimulates the pudendal nerve to regulate defecation and urination, for use in humans with spinal cord injuries.

There are health disparities with spina bifida, and researchers are working on closing that gap. Hispanic women have the highest rate of having a child affected by spina bifida, when compared with non-Hispanic White and non-Hispanic Black women. A study funded by the National Institute of Nursing Research (NINR) is investigating the interactions of age, gender, race and ethnicity with self-management and health status of adolescents and young adults with spina bifida. This research will identify predictors of successful self-management, better health status, and quality of life in youth with spina bifida to facilitate the development of precision health strategies that engage youth and their families in preventive health behaviors.

Colorectal Cancer

Question for Dr. Douglas Lowy

Colorectal cancer is the second leading cause of cancer death in the United States. It is estimated that in 2022, 151,030 Americans will receive a colorectal cancer diagnosis. While colorectal cancer incidence rates in individuals over 50 have largely stabilized or declined due to significant advancements in preventive screening, incidence rates for early-onset colorectal cancer (individuals diagnosed at ages 20 to 49) have been consistently increasing. The Committee is concerned that colorectal cancer is trending to be the leading cause of cancer death for Americans ages 20-49 by 2030. 3 of 4 early-onset colorectal cancer patients have no family history of the disease and over 60% of early-onset colorectal cancer patients are diagnosed at a late stage. There are several racial/ethnic disparities in colorectal cancer screening and outcomes. Black individuals have the highest incidence and mortality and face lower survival than white individuals. American Indian/Alaskan Natives also have elevated rates and deaths compared to the general population

and represent the only racial/ethnic group for whom colorectal cancer mortality rates are not declining. Racial and ethnic minorities are also more likely than white individuals to present with late-stage, incurable disease. Notably, the sharpest increase in metastatic, early-onset colorectal cancer is among people 20 to 39 years old, especially Black and Hispanic individuals. Mortality rates across all ages for late-stage colorectal cancer have remained stagnant due to minimal progress in treatments for colorectal cancer patients.

Questions:

1. How are NIH and NCI prioritizing research on colorectal cancer? What plan is guiding the agencies' decision making? Please provide copies of any plan if there is one guiding research to combat colorectal cancer and cancer more generally.
2. Given the increasing incidence of early-onset colorectal cancer in people under the age of 50, how does the NIH and NCI plan to ensure that its research will play a role in better understanding & eventually preventing early onset colorectal cancer?
3. Given the health disparities outlined in the above, how does the NIH and NCI plan to ensure that its research will play a role in reducing health disparities seen with colorectal cancer?
4. Is the NIH/NCI funding any research into social determinants of health given the disparities in colorectal cancer and the increasing incidence of early onset colorectal cancer?
5. While many other cancers have seen the development of a number of new treatments & therapeutics, there has been a lack of effective, new treatments developed to treat colorectal cancer in recent years. Could you please articulate what research is funded by NIH and NCI to ensure that the building blocks of the – or the actual – next breakthrough colorectal cancer treatment are under development today?
6. Can you please provide how NIH and NCI are engaging with the colorectal cancer community, including colorectal cancer patients, patient organizations, industry, academic researchers and community-based providers?

NIH Response:

1. The National Cancer Institute's (NCI) strategy to advance progress against cancer is based on careful planning, coordination, collaboration, and fiscal stewardship of federal resources. NCI is committed to funding highly meritorious ideas that can lead to scientific discoveries to prevent more cancers and improve the lives of all those who have been affected by cancer. NCI's strategic planning aligns with its mission, priorities, and scientific opportunities. Each fiscal year NCI prepares an Annual Plan and Budget Proposal for submission to the President and to Congress. The plan describes NCI's scientific priorities and identifies promising research opportunities. The Annual Plans are accessible on NCI's website.⁵¹

In addition to the development of the Annual Plan, NCI utilizes a variety of scientific planning approaches and regularly convenes experts from across the cancer research community to explore and identify research opportunities across the research continuum, including focusing on opportunities to advance progress in areas relevant to many cancer types, such as immunotherapy or cancer disparities, or against specific cancer types. Recent and ongoing efforts to identify

⁵¹ www.cancer.gov/about-nci/budget/about-annual-plan

research opportunities span cancer types and research areas. Examples include ad hoc working groups that report to NCI's Clinical Trials and Translational Research Advisory Committee (CTAC) focusing on glioblastoma and radiation oncology;⁵² NCI's National Clinical Trials Network (NCTN) Steering Committees,⁵³ which advise the NCTN by planning for and prioritizing the development of new NCI-supported clinical trials, including colorectal cancer (CRC) and other gastrointestinal cancer trials;⁵⁴ a 2020 Think Tank focused on early onset CRC (discussed in more detail below);⁵⁵ and many workshops and symposia to gather expert opinions and discuss research opportunities across a variety of cancer research topics.⁵⁶

NCI also plays an important and unique role in advancing basic cancer research that seeks to understand the fundamental biological mechanisms underpinning all cancers, enabling new approaches to cancer prevention, detection, diagnosis, treatment, and survivorship across cancer types and populations. Basic science is traditionally not a focus for the private sector, making federal investments in basic science even more critical. Virtually all major clinical advances against cancer, including the molecularly targeted therapies, immunotherapies, and interventions to prevent cancer, had their origins in earlier discoveries made through basic research. Many of these discoveries were made in areas such as cell biology, molecular biology, genetics, and immunology, where practical applications to cancer medicine could not readily be conceived.

NCI has additional significant cross cutting research approaches that contribute to clinical advances against various types of cancer, including NCI- Molecular Analysis for Therapy Choice (MATCH) Trial and the RAS Initiative, which are explained in greater detail in response to question four.

2. We share your concern regarding increases in CRC diagnoses among young adults. NCI and other Institutes and Centers (ICs) at the National Institutes of Health (NIH), continue to support critical research efforts to address these challenges.

NCI is working to bring national attention to early onset CRC, including through a focus on cancer mortality among younger patients in the 2019 Annual Report to the Nation on Cancer.⁵⁷ Additionally, in September 2020, NCI and the National Institute of Environmental Health Sciences (NIEHS) convened the "Early Onset CRC Think Tank" meeting⁵⁸ in partnership with the research and advocacy community, including speakers and attendees from Fight CRC, the National Colorectal Cancer Roundtable, and the American Cancer Society. The meeting identified several promising research opportunities for the scientific community to address the rising incidence rate of CRC among those younger than 50 years.⁵⁹ NCI is also studying CRC

⁵² deainfo.nci.nih.gov/advisory/ctac/workgroup/archive/index.htm

⁵³ www.cancer.gov/about-nci/organization/ccct/steering-committees/nctn

⁵⁴ www.cancer.gov/about-nci/organization/ccct/steering-committees/nctn/gastrointestinal

⁵⁵ www.cancer.gov/about-nci/organization/dcb/news/early-onset-crc

⁵⁶ prevention.cancer.gov/news-and-events/meetings-and-events/liver-fibrosis-cancer-events.cancer.gov/detd_celltherapyconf; ncifrederick.cancer.gov/events/conferences/3rdNCICHHD; www.cancer.gov/research_areas/childhood/childhood-cancer-data-initiative/symposium

⁵⁷ pubmed.ncbi.nlm.nih.gov/31145458/

⁵⁸ events.cancer.gov/sites/default/files/assets/crs-eocr/F:O-CRC%20Think%20Tank%20Agenda.pdf

⁵⁹ www.futuremedicine.com/doi/pdf/10.2217/crc-2020-0028

within the Early Onset Malignancies Initiative⁶⁰ to investigate why certain racial and ethnic populations are at increased risk of developing cancer at an early age.

NIEHS is also exploring the potential environmental and modifiable risk factors contributing to the increased risk of sporadic CRC in younger patients through its Carcinogenicity Health Effects Innovation program.⁶¹ Differences in sporadic CRC genomes from various age groups are being compared to gain insight, and new experimental model systems are being developed to address this public health issue.

Additionally, through the Cancer MoonshotSM NCI is supporting research on Lynch syndrome, an inherited disorder in which affected individuals have a higher-than-normal chance of developing CRC and other cancers, often before the age of 50. Projects are focused on designing, testing, and implementing evidence-based strategies to identify those at risk for Lynch syndrome and other inherited cancer syndromes to inform appropriate clinical management.⁶²

Importantly, in May 2021, the U.S. Preventive Services Task Force (USPSTF) released new guidelines that recommend screening for CRC in adults starting at age 45, five years earlier than previously recommended. The new recommendation is largely informed by a report USPSTF commissioned from NCI,⁶³ which included new analyses by race and with elevated risk scenarios to reflect population trends in CRC incidence.⁶⁴ The recommendation for earlier screening is expected to decrease the incidence and mortality of CRC in the United States compared to beginning screening at 50 years.⁶⁵

3. NCI is addressing cancer disparities on numerous fronts—from basic research on the biology associated with disparities and large comprehensive studies examining the factors that contribute to disparities to community-level programs that aim to overcome barriers to cancer care and population-based registries that help to document the extent of the problem and highlight areas for further study.

Increasing colorectal screening rates is included in 1 of the 10 recommendations of the Blue Ribbon Panel for the Cancer Moonshot and considered and adopted by the National Cancer Advisory Board. NCI is supporting several projects to address disparities in uptake of CRC screening through the Cancer Moonshot “Accelerating Colorectal Cancer Screening and Follow-up through Implementation Science”¹⁰ (ACCSIS) program, which seeks to identify the most effective interventions aimed at increasing CRC screening and follow-up. The first phase of these projects focused on pilot studies that demonstrated the feasibility and potential effectiveness of multilevel interventions for increasing colorectal cancer screening and follow-up. The coordinating center and five research sites across the country have moved to phase two of the project, which involves testing the implementation and impact of the interventions in populations with low CRC screening rates.

⁶⁰ www.cancer.gov/about-nci/organization/ccg/research/structural-genomics/early-onset-disparities

⁶¹ www.niehs.nih.gov/research/atnichs/dntp/strategic-plan/health_index.cfm

⁶² www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative/implementation/hereditary-cancers

⁶³ uspreventiveservicestaskforce.org/uspstf/document/draft-modeling-report/colorectal-cancer-screening3

⁶⁴ www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/colorectal-cancer-screening3#bootstrap-panel--7

⁶⁵ uspreventiveservicestaskforce.org/uspstf/draft-recommendation/colorectal-cancer-screening3

NCI's Screen to Save initiative,⁶⁶ launched by the NCI Center to Reduce Cancer Health Disparities (CRCHD), also aims to increase CRC screening rates in people aged 45 and older from racially and ethnically diverse communities and in rural areas nationwide. Through Screen to Save, community health educators provide culturally tailored, evidence-based CRC information, education, and screening resources within racially and ethnically diverse and rural communities. As a parallel effort to the ACCSIS initiative, the "Dissemination of a Colorectal Cancer Screening Program Across American Indian Communities in the Southern Plains and Southwest United States" consortium⁶⁷ was established to address the need for improved evidence-based CRC screening interventions among American Indians (AI), a critically underserved population. The long-term goal of this initiative is to enhance health equity and increase survival among AIs by improving care coordination for CRC. The project is leveraging the tribes' and researcher team's previous successes with dissemination and implementation science to test the effectiveness of a comprehensive, multi-level, and multi-component intervention to facilitate and navigate average and high-risk AI men and women, aged 50-75 years, to obtain a CRC screening exam.

In fiscal year (FY) 2021, CRCHD launched a new program, Connecting Underrepresented Populations to Clinical Trials (CUSP2CT).⁶⁸ The goal of this program is to increase referral and accrual of historically underrepresented populations to NCI-supported clinical trials in NCI's Community Oncology Research Program (NCORP) and other NCI clinical trials networks through implementation and evaluation of culturally tailored outreach and education. NCI's commitment to expanding clinical trial participant demographics to better represent the U.S. population and better reflect broad health outcomes is also reflected in NCI's FY 2023 Annual Plan highlighted opportunity "Clinical Trials: Bringing Cancer Research to All Possible Participants."⁶⁹

4. Efforts to reduce cancer disparities are not only focused on understanding the causes of disparities but also on developing and testing interventions to eliminate disparities. Access to care is affected by socioeconomic and policy-level factors that are beyond the control of the cancer research community. NCI-funded researchers are working to better understand and to identify other ways to improve outcomes for groups disproportionately affected by various types of cancer.

In addition to the research and ongoing efforts referenced in response to question three, NCI supports research in this area by developing and facilitating access to funding opportunities, training, and data resources that are relevant across cancer types, including CRC. NCI's Division of Cancer Control and Population Sciences has ongoing funding opportunity announcements (FOAs)⁷⁰ that will help to better capture and address patient's social risks and needs. For instance, applications are currently being solicited for a Request for Application

⁶⁶ www.cancer.gov/about-nci/organization/crhd/inp/screen-to-save; text--Screen%20to%20Save%20aims%20to%20Native%20Hawaiians%20and%20other%20Pacific

⁶⁷ cancercontrol.cancer.gov/hdnc/native-american-health/colorectal-cancer-screening-american-indian

⁶⁸ grants.nih.gov/grants/guide/rra-files/RA-CA-21-057.html

⁶⁹ cancer.gov/research/annual-plan/scientific-topics/clinical-trials

⁷⁰ healthcaredelivery.cancer.gov/social-risks/

(RFA) on cancer control research in persistent poverty areas.⁷¹ The RFA will provide resources to support transdisciplinary teams in collaboration with communities and clinics to develop a cancer prevention and control research program, and provide training to junior investigators, that focuses on and serves populations in persistent poverty census tracts. This initiative will build capacity in persistent poverty census tracts to foster cancer prevention and control research (across cancer types) and promote the implementation of programs and practices in communities to alleviate the effects of persistent poverty.

NCI-supported community-based studies through the NCORP clinical trials network are also helping to address cancer disparities by increasing participation by minorities and patients from underserved populations in clinical cancer research. In addition, because the centers involved are often part of communities in which health care disparities are more common, NCORP cancer care delivery studies are ideally suited to test interventions designed to address cancer disparities. NCORP funds 12 Minority/Underserved Community Sites, whose patient populations are comprised of at least 30 percent racial/ethnic minorities or rural residents.

5. NCI supports a robust research program in CRC and funds a breadth of basic and applied research efforts necessary for the development of tailored approaches to prevention and therapeutics for CRC and other cancer types.

The Specialized Programs of Research Excellence (SPOREs), a key component of NCI's Translational Research Program supports research on gastrointestinal (GI) cancers (colon, rectum, stomach, esophagus, small intestine, liver, gallbladder and other digestive organs). Currently, there are 10 academic institutions receiving SPOREs grants that focus on GI cancers. The Case Western Reserve University GI Cancers SPORE⁷² puts forward three cutting edge translational research projects that deal with new approaches for reducing deaths from colon cancer. One of the four projects supported by this grant focuses on developing new strategies for CRC prevention through targeting the 15-PGDH tumor suppressor pathway discovered by the SPORE investigators. Another project targets elucidating the biological basis for colon cancer disparities among African Americans, based on the innovative discovery by the SPORE investigators of somatic mutations that uniquely target cancers arising in this population. A third project targets developing new therapeutic approaches for colon cancers with PIK3CA mutations, based on the project investigator's novel finding that these cancers are addicted to glutamine. The New York University (NYU) Cancer Health Disparity SPORE⁷³ aims to elucidate gut microbial factors associated with poorer colon cancer outcomes in African Americans. This microbiome study of colon cancer disparities will comprehensively investigate the gut microbiome and its role in shaping the tumor immune microenvironment.

NCI is also committed to expanding clinical trial participant demographics to better represent the American population and better reflect broad health outcomes. Over the last two decades, the proportion of racial and ethnic minority patients enrolled in NCTN and National Community Oncology Research Program clinical trials has nearly doubled. Several clinical trials are

⁷¹ grants.nih.gov/grants/guide/notice-files/NOT-CA-22-030.html

⁷² trp.cancer.gov/spores/abstracts/case_gi.htm#top

⁷³ trp.cancer.gov/spores/abstracts/nyu_p20.htm

currently underway evaluating combinations of therapies to treat CRC, including immunotherapy approaches.⁷⁴

NCI also supports several cross-cutting research efforts that span several cancer types or are “site agnostic”, such as the NCI-MATCH trial and the NCI RAS Initiative. NCI-MATCH is one of the first major clinical trials to match people who have cancer with treatment based on genetic changes in their tumor rather than their type of cancer. This trial has shown that targeting genetic changes in a tumor may be an effective way to treat cancer across the various tumor types, and that such trials can be implemented effectively in the community oncology setting, with the trial available across hundreds of NCORP sites.

More than 30 percent of all human cancers – including 95 percent of pancreatic cancers and 45 percent of CRC — are driven by mutations of the *RAS* family of genes. NCI established the RAS initiative in 2013 to explore innovative approaches for attacking the proteins encoded by mutant forms of RAS genes and to ultimately create effective, new therapies for RAS-related cancers, such as CRC. This NCI-supported effort to understand RAS has informed the development of the first targeted therapy to inhibit a certain RAS mutation common in a subset of lung cancers, and this is an active area of preclinical and clinical research to extend the benefit of RAS inhibitors to patients with other RAS-driven cancers like CRC and pancreatic cancer. In May 2021, the U.S. Food and Drug Administration (FDA) approved the first KRAS-blocking drug, sotorasib (Lumakras), which is an effective treatment that counteracts the cancer-fueling actions of mutant KRAS proteins.

NCI supported basic research has enabled the Institute to be at the forefront of the rapidly advancing field of cancer immunology. The field has produced several new immunotherapies that increase the strength of immune responses against tumors. For example, NCI supported basic research has led to the identification of two biomarkers that can help determine which patients are more likely to respond to checkpoint inhibitor immunotherapy: PD-L1 and a genetic feature called microsatellite instability. Patients whose cancers have these biomarkers are more likely to respond to certain checkpoint inhibitors than patients whose cancers lack them. This is particularly relevant for patients with CRC that is characterized by microsatellite instability, a common genetic feature for patients with the inherited Lynch Syndrome, where there is elevated risk of developing CRC, and other cancer types, at a younger age.

6. NCI’s Office of Advocacy Relations (OAR) works directly with patients, advocates, and advocacy organizations in a variety of ways to engage the CRC community in research. Patients and individual advocates participate in different activities across NCI to improve understanding, opportunities, and progress in cancer research, and ensure the collective patient perspective is integrated into NCI’s efforts. For example, these individuals participate in scientific peer review, review clinical trial protocols, and serve on different scientific working groups and NCI advisory boards.

⁷⁴ clinicaltrials.gov/ct2/show/NCT02997228; clinicaltrials.gov/ct2/show/NCT04094688; clinicaltrials.gov/ct2/show/NCT02912559; clinicaltrials.gov/ct2/show/NCT04068103; clinicaltrials.gov/ct2/show/NCT05174169; clinicaltrials.gov/ct2/show/NCT04751370

OAR coordinates one of these advisory boards, the NCI Council of Research Advocates (NCRA), which is the only federal advisory committee comprised of cancer research advocates. NCRA provides the NCI Director with advice on issues affecting cancer research from patient and advocate perspectives, and colorectal cancer advocates have participated with NCRA for many years. In fact, the current President and CEO of Fight Colorectal Cancer, Anjee Davis, was appointed to serve on NCRA in 2019, and was named Chair in 2020.

NCI has also collaborated with Fight CRC in other ways for nearly two decades. Fight CRC staff have worked on NCI Steering Committees and advisory boards, joined scientific planning meetings, and met with NCI leadership to discuss priorities in colorectal cancer research. Fight CRC leadership most recently met with former NCI Director Dr. Ned Sharpless in February 2022. Another meeting between NCI and Fight CRC leadership is being planned for summer 2022 (date TBD).

OAR staff have spoken at several external meetings hosted by Fight CRC, including those focused on Fight CRC's advocate training program, to help patients and advocates understand how they too can engage in NCI's research activities. OAR has also facilitated other speaking engagements for NCI program staff to share information about NCI's colorectal cancer research activities directly with patients and advocates who participate in Fight CRC events.

In 2019, OAR worked with Fight CRC to identify staff from NCI's Division of Cancer Biology (DCB) and NCI's Division of Cancer Prevention (DCP) to participate in Fight CRC's Early-Age Onset Colorectal Cancer Working Group.⁷⁵ That group continues to meet in 2022. In 2020, OAR staff worked with NCI program staff to engage patients and advocates, including staff from Fight CRC, in a trans-NIH Early Onset CRC Think Tank,⁷⁶ described in more detail above, in response to question two.

OAR staff also currently participate in an external, multidisciplinary group of patients, advocates, clinicians, and researchers charged with exploring how to improve clinical trials for patients with colorectal cancer. The group is coordinated by the Colorectal Cancer Alliance.

Another way that NCI engages with community providers is through the FORTE (Five- or 10-Year Colonoscopy for 1-2 Non-Advanced Adenomatous Polyps) study,⁷⁷ which will help to determine if certain people can wait for a follow-up colonoscopy after a routine screening colonoscopy. It is a randomized clinical trial for people who have one or two small, noncancerous polyps (adenomas) removed during a routine screening colonoscopy. Such people usually get repeat colonoscopies five years and 10 years later (the current standard of care for people who have had one or two benign polyps removed). FORTE will help determine if these people can wait 10 years before a follow-up test.

Additionally, NCI has funded several small business innovators developing screening technologies for CRC through the congressionally mandated Small Business Innovation Research (SBIR) program. An example of SBIR-funded technology addressing CRC is the SCSR Fecal Cell Isolation System, developed by Noninvasive Technologies, LLC. The SCSR Fecal Cell Isolation System is a non-invasive screening test for colon cancer that isolates colonic

⁷⁵ fightcolorectalcancer.org/crc-research/advisory-committees/eao-crc-wg/

⁷⁶ <https://www.cancer.gov/about-nci/organization/dcb/news/early-onset-crc>

⁷⁷ www.cancer.gov/types/colorectal/research/forte-colorectal-cancer-prevention

cells from human stool and examines them for disease-related genetic markers and cell-surface markers. The system typically yields several million cells per gram of stool sample, enabling downstream analyses including cell culture, nucleic acid analysis, cell-surface analysis, and biopsy-free cell-based archiving of a patient's natural history.

***Down Syndrome and the INCLUDE Initiative
Question for Dr. Lawrence Tabak***

Research has identified a wide range of diseases and conditions that persons with Down syndrome are protected from, such as autoimmune disorders, and others that they are at significantly increased risk for, like Alzheimer's Disease. Because of the long-term implications of this research, not only for the Down Syndrome community, but also for the wider communities that are impacted by these conditions, this committee has consistently recognized the importance of the trans NIH INCLUDE initiative being led by the Office of the Director.

Questions:

1. Can you provide an update on OD level coordination among all involved INCLUDE institutes?
2. In the FY22 LHHS Report the Committee asked the NIH to prioritize efforts to address the persistent health disparities and lower life expectancy facing African Americans with Down syndrome. Can you please provide the committee with a brief update on current and planned activities and investments to address these disparities?

NIH Response:

NIH Response Question 1:

The NIH-wide INCLUDE Project is committed to advancing research on Down syndrome (DS) and conditions affecting individuals with DS by supporting an interdisciplinary approach to research and scientific funding. To achieve this approach, the Office of the Director (OD) collaborates with experts from across 18 Institutes and Centers (ICs), including some that have not traditionally supported research in DS to systematically address co-occurring health conditions common in DS. The OD and the ICs work together to identify promising areas of research for the INCLUDE Project, coordinate funding opportunities for new studies, and drive engagement with investigators, clinicians, and individuals with DS and their families. The OD works closely with the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD), the National Heart, Lung, and Blood Institute (NHLBI), and the National Institute on Aging (NIA) to develop the overall direction and goals for the INCLUDE Project and to manage the day-to-day activities of the program.

Working across the NIH to support high-quality, interdisciplinary science is a priority for the OD and all ICs involved in the INCLUDE Project. Increases in funding for DS research provided by the INCLUDE Project have catalyzed new investments in DS research across NIH. The OD will

continue to coordinate with INCLUDE Project leaders and experts across the agency to advance research that will improve the lives of individuals with DS and their families.

NIH Response Question 2:

NIH recognizes that there are health disparities and a lower life expectancy for African Americans with Down syndrome (DS). Although the lifespan has more than doubled for White Americans with DS, the same is not true for African Americans with the condition.

As part of the NIH-wide INvestigation of Co-occurring conditions across the Lifespan to Understand Down syndrome (INCLUDE) initiative, NIH has taken several steps to increase the representation of participants in DS-related research and among the investigators studying DS. One of the components of INCLUDE is building a large cohort of individuals with DS across the lifespan for comprehensive analysis and biomarker evaluation, and we are engaging investigators with access to more diverse populations to enhance the cohort that is being gathered for study. The INCLUDE Data Coordinating Center is also engaged in supporting data collection, analysis, and sharing from diverse cohorts with DS. Furthermore, in 2021, INCLUDE hired an Outreach Coordinator with deep roots in the Down syndrome community, to lead the development of a communication and outreach plan. This plan will outline unique opportunities the INCLUDE Project will pursue to amplify communications, ensure representation and diversity in DS research by reaching new communities, and engage new and early-stage investigators through websites, workshops, and resources for scientists and clinicians.

Moreover, NIH has also recently issued and/or re-issued 13 new funding opportunity announcements (FOAs) for DS-related research, with several others under development. For those projects that are enrolling individuals with DS, they are required to include a *Recruitment Plan to Enhance Diversity*, which should include outreach strategies and activities designed to recruit potential participants who are from diverse backgrounds, including participants from underrepresented racial and ethnic groups. In addition, several FOAs are focusing on training for junior investigators at undergraduate, graduate, post-doctoral, and junior faculty levels in order to build the pipeline of investigators; some are focusing on students at institutions that do not receive substantial funding from the NIH and are more likely to attract underrepresented groups, and others are geared toward diversity trainees. In addition, the NIH-supported DS registry, DS-Connect®, connects families with DS with research opportunities of interest to them. Along with the INCLUDE Project, this registry is embarking on a marketing and outreach campaign designed to increase the diversity of the participants with Down syndrome.

In addition, the NIH will host a virtual two-day workshop in September 2022 entitled “Building a Diverse Community for Down Syndrome Research.” As part of the preparation for this workshop, the NIH conducted two informative listening sessions. One listening session with families focused on their experiences as members of Black and other underrepresented communities and barriers to participating in research. The second session with researchers focused on approaches to enhancing diverse research participation. The collective goal of these activities is to increase the diversity of those with DS participating in research, including African Americans and other underrepresented groups, in order to address the health disparities that

impact their quality of life. Finally, in 2022, the INCLUDE Project will publish the next iteration of the NIH INCLUDE DS Research Plan, detailing a vision for the goals and objectives for NIH funded DS research until 2028. Approaches to increase diversity among DS research participants, for a better understanding of health disparities among individuals with DS, and for expanding the pipeline of new and early-stage investigators with a diversity of expertise and perspectives will be integrated throughout the plan.

Submitted by Rep. Barbara Lee

Question for Dr. Lawrence A. Tabak

- A cross-sectional study found that NIH funded 529 clinical research studies focused on AA and NHPI participants between 1992 and 2018, composing only 0.17% of the total NIH budget. According to the same study, the proportion of the NIH budget has only increased from 0.12% before 2000 to 0.18% after 2000.
- NIH published an RFI: “Seeking Stakeholder Actionable Input to Improve Research on Health and Well-being for Asians, Native Hawaiians, and Pacific Islanders.” (Notice No. NOT-CA-22-047, Feb. 14, 2022).
- How do you plan on expanding and supporting clinical research studies focused on AA and NHPI populations, and other underserved and underrepresented populations?

NIH Response:

The National Institutes of Health (NIH) recognizes the unique health disparities that underserved and underrepresented populations face and is committed to improving research efforts, including for Asians Americans (AA), Native Hawaiians, and Pacific Islanders (NHPI).

NIH’s commitment to prioritize AA and NHPI clinical research continues across NIH Institutes and Centers (ICs). The following are examples of key initiatives and Funding Opportunity Announcements that NIH has launched to increase research studies focused on underserved populations, including AA and NHPI:

- In 2021, NIH established the Asian American Pacific Islander Health Scientific Interest Group (AAPI-HSIG).⁷⁸ The group provides a forum to foster scientific communications, share and disseminate information, facilitate collaborations, provide education and assess research needs, aiming to stimulate research and to improve the health and well-being of AA and NHPI populations. On May 4-5, 2022, the group hosted the Inaugural Annual NIH AA and NHPI Health Research Conference: Mechanisms and Translational Research to Improve Health and Therapeutic Outcomes for AA and NHPI Populations. The event was able to bring together leading scientific and regulatory experts in the field of AA and NHPI research from government, academia, and the community.
- In response to the disproportionate impact of COVID-19 on racial and ethnic minorities, and other vulnerable communities, NIH established the Community Engagement Alliance (CEAL)⁷⁹ Against COVID-19 Disparities and the Rapid Acceleration of Diagnostics Underserved Populations (RADx-UP⁸⁰) initiatives. CEAL provides science-based information through active community engagement and outreach with a goal of

⁷⁸ oir.nih.gov/signs/AAPI-HSIG

⁷⁹ <https://covid19community.nih.gov/>

⁸⁰ www.nih.gov/research-training/medical-research-initiatives/radx/radx-programs#radx-up

addressing mistrust surrounding COVID-19 clinical trial research and vaccine uptake, and RADx-UP focuses on increasing access to and uptake of COVID-19 testing. Both Initiatives are building and maintaining partnerships with trusted community leaders and organizations as part of their protocols for inclusive participation and collaboration. CEAL and RADx-UP provide ongoing support for engaging with communities, including AA and NHPI, to ensure the successful implementation of community-engaged research and outreach, and to ensure that the community voices are reflected across projects. CEAL research teams focusing on Asian Americans, Native Hawaiians and Pacific Islanders include those in Arkansas, California, the DC Metro Area, Mississippi, New Mexico, New York, Pennsylvania, and Texas. CEAL established an Asian American, Native Hawaiian, and Pacific Islander *Special Interest Group* to provide specific leadership to these CEAL teams to support successful implementation of the community-engaged research and outreach activities. A RADx-UP project in Hawaii has developed culturally resonant community-engagement strategies to increase the reach and uptake of COVID-19 testing to better understand SARS-CoV-2 infection patterns among Pacific Islanders. Another RADx-UP project is investigating the impact of COVID-19 on Southeast Asian Americans to inform best practices around testing and vaccination.

- In collaboration with other NIH ICs, the NIMHD developed the NIH Minority Health and Health Disparities Strategic Plan (2021-2025).⁸¹ The plan includes goals and strategies that can guide research and activities to address disparities in underserved populations with health disparities including Asian Americans and Native Hawaiians and Pacific Islanders.
- The National Heart, Lung, and Blood Institute (NHLBI), in partnership with eight other NIH ICs, convened a workshop on Identifying Research Opportunities for Asian American, Native Hawaiian, and Pacific Islander Health.⁸² The workshop assembled national experts from multiple disciplines to review current research and identify knowledge gaps, potential barriers, and opportunities for prevention research to promote health equity for AA and NHPI populations. In addition, the workshop reported a general lack of fundamental disaggregated epidemiological data on prevalence, incidence, and factors of risk and resilience across most disease or health conditions and social determinants of health as a major theme.
- In February 2022, NIH issued a Notice of Special Interest titled: Epidemiologic studies in Asian Americans, Native Hawaiians, and Pacific Islanders (Parent R01 Clinical Trial Not Allowed)⁸³ to stimulate novel epidemiological research to address key knowledge gaps within and between subpopulations of Asian Americans, Native Hawaiians, and Pacific

⁸¹ <https://www.nimhd.nih.gov/docs/nimhd-strategic-plan-2021-2025.pdf>

⁸² <https://www.nhlbi.nih.gov/events/2021/identifying-research-opportunities-asian-american-native-hawaiian-and-pacific-islander>

⁸³ <https://grants.nih.gov/grants/guide/notice-files/NOT-HL-23-001.html>

Islanders. The objective is to encourage fundamental epidemiological research geared toward understanding the inter-relationships of biological, lifestyle/behavioral, environmental, and sociocultural factors and how these factors may impact health disparities and outcomes in AA and NHPI subpopulations.

- The Building Population Health Research Capacity in the U.S. Affiliated Pacific Islands (U24 – Clinical Trial Not Allowed)⁸⁴ initiative was created to build the capacity of organizations in the US-Affiliated Pacific Islands to conduct ongoing population health research in this region. The US-Affiliated Pacific Islands (USAPI) consist of the U.S. territories of American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands, as well as three sovereign states that have a Compact of Free Association with the U.S. – the Federated States of Micronesia, Republic of the Marshall Islands, and Republic of Palau. The United States is responsible for health, education, defense, and other essential operations for these six jurisdictions, and residents of these jurisdictions and are among the NIH-designated populations with health disparities (i.e., Other Pacific Islanders).
- The National Cancer Institute (NCI) supports multidisciplinary research to understand the underlying social, cultural, clinical, environmental, or biological factors responsible for the increase in chronic liver diseases and liver cancer and the mechanisms that explain documented liver cancer disparities by race and ethnicity in the United States. Liver cancer rates are highest among Asians, particularly among Laotians, Vietnamese, and Cambodians with the lowest survival rates.

Question for Douglas R. Lowy

- Cancer is the 2nd leading cause of death for Asian Americans in 2021.
- One of the National Cancer Institute's FY23 goals is to conduct more research in diverse communities.
- How does NCI plan to address the high rates of cancer related deaths in Asian American communities?

NIH Response:

The National Cancer Institute's (NCI) scientific priorities span the cancer continuum and include a special focus on ending cancer disparities and making health equity a priority. A diverse group of leaders across the NCI work collaboratively to ensure that NCI maintains a robust and responsive research portfolio to study and address cancer disparities.

⁸⁴ <https://grants.nih.gov/grants/guide/pa-files/par-20-048.html>

In the United States, the overall cancer death rate has declined since the early 1990s,⁸⁵ and although cancer incidence and mortality overall are declining across all population groups, certain groups, including Asian Americans, continue to be at a higher risk of developing, or dying from, some cancers. It is important to note that Asian Americans are a fast-growing and heterogeneous group, making up approximately six percent of the U.S. population, and representing a vastly diverse group in terms of ethnicity, language, immigration patterns, cultural beliefs, English proficiency, health outcomes, and socioeconomic status.⁸⁶ In addition, more than 40 ethnic subgroups are included within Asian American, Native Hawaiian, and Pacific Islander populations, yet population level data for these groups are often aggregated, masking health disparities and their drivers.

Research has shown differences relative to health outcomes for the various Asian American groups. For example, cervical cancer incidence appears lower when aggregated for all Asian Americans, compared to non-Hispanic White Americans; however, when looking at specific Asian ethnic groups, we observe that rates are much higher in Vietnamese and Cambodian but lower in Chinese and Asian Indian women.⁸⁷ These observations provide a foundation for additional studies to examine these health disparities.

For almost 30 years, NCI has been supporting important foundational research in the Multiethnic Cohort (MEC) Study, established in Hawaii and southern California, to study risk factors for cancer and other chronic diseases.⁸⁸ The study represents the most ethnically diverse cancer cohort in existence. The MEC is a tremendous resource to the research community and has paved the way for health disparity researchers to examine environmental risk factors in various ethnicities and races, comprised almost entirely of five ethnic/racial populations: Whites, Japanese Americans, Native Hawaiians, African Americans, and Latinos. Data from the MEC is cited in many other NCI-supported investigator-initiated research grants, further highlighting the significant impact and reach of this long-term cohort study.

NCI recently released a Notice of Special Interest (NOSI) for Epidemiologic Studies in Asian Americans, Native Hawaiians, and Pacific Islanders,⁸⁹ and has also issued new funding opportunity announcements (FOAs) designed to provide flexible funding opportunities for research with an overarching goal focused on understanding or addressing cancer disparities.⁹⁰ Other current funding announcements that address health disparities research touch on the etiology of health disparities among immigrant populations⁹¹ and basic research in cancer health disparities.⁹² The basic research opportunity encourages grant applications from investigators interested in conducting basic, mechanistic research into the biological/genetic causes of cancer disparities. It is also designed to facilitate the growth of a nationwide cohort of

⁸⁵ www.cancer.gov/research/progress/annual-report-nation

⁸⁶ dceg.cancer.gov/about/diversity-inclusion/inclusivity-minute/2022/disaggregated-asian-american-data

⁸⁷ pubmed.ncbi.nlm.nih.gov/26766789/

⁸⁸ reporter.nih.gov/search/bXeSsjBjrUurUHa3XsF8AQ/project-details/10245003

⁸⁹ grants.nih.gov/grants/guide/notice-files/NOT-HL-23-001.html

⁹⁰ grants.nih.gov/grants/guide/pa-files/PAR-22-114.html?cid=eb_govdel

⁹¹ grants.nih.gov/grants/guide/pa-files/PAR-21-080.html

⁹² grants.nih.gov/grants/guide/pa-files/PAR-21-322.html

scientists with a high level of basic research expertise in cancer disparities who can expand available resources and tools, such as biospecimens, models, and methods that are necessary to conduct basic research in cancer disparities.

In addition to these funding opportunities, NCI continues to invest in infrastructure to support disparities research. NCI's Center to Reduce Cancer Health Disparities (CRCHD) is central to NCI's efforts to reduce the unequal burden of cancer in our society, supporting research to study the complex and interrelated factors that contribute to disparities in underrepresented populations.⁹³ Importantly, NCI is currently supporting planning grants for Specialized Programs of Research Excellence (SPORE) programs in cancer disparities.⁹⁴ The aim is to build programs to improve the prevention, early detection, diagnosis, and treatment of cancers that disproportionately affect specific racial and ethnic minority populations so that those institutions may then compete for SPORE funding in future years. NCI's Community Oncology Research Program (NCORP) is committed to integrating health disparities research questions across all studies in the NCORP network, with 14 specifically designated Minority/Underserved Community Sites that accrue study participants to NCI-supported clinical trials.⁹⁵

Additionally, in March 2021, the NCI participated in an NIH multidisciplinary workshop to review current research, knowledge gaps, opportunities, barriers, and approaches for prevention research for Asian American, Native Hawaiian, and Pacific Islander populations.⁹⁶ The workshop identified two recurring themes, areas in which NCI already focuses – limited data on epidemiology and risk factors as well as disaggregating data by subgroup. NCI remains committed to actively engaging community partners to better understand the real-life experiences and cultural and historical context among different Asian American ethnic groups. Promising approaches for future research include developing collaborations with community partners, investing in infrastructure support for more cohort studies, enhancing existing data sources to enable data disaggregation, and incorporating novel technology for objective measurement. NCI will continue to support research in this area through the examples listed above as well as identifying future opportunities.

Question for Douglas R. Lowy

- Colorectal cancer is the second leading cause of cancer death in the United States. There are several racial/ethnic disparities in colorectal cancer screening and outcomes. Black individuals have the highest incidence and mortality and face lower survival than white individuals. American Indian/Alaskan Natives also have elevated rates and deaths compared to the general population and represent the only racial/ethnic group for whom colorectal cancer mortality rates are not declining.

⁹³ www.cancer.gov/about-nci/organization/crchd/about-health-disparities

⁹⁴ grants.nih.gov/grants/guide/rfa-files/RFA-CA-17-033; grants.nih.gov/grants/guide/rfa-files/RFA-CA-19-034

⁹⁵ ncorp.cancer.gov/findasite/minority-sites.php

⁹⁶ www.nhlbi.nih.gov/events/2021/identifying-research-opportunities-asian-american-native-hawaiian-and-pacific-islander

- Racial and ethnic minorities are also more likely than white individuals to present with late-stage, incurable disease. Notably, the sharpest increase in metastatic, early-onset colorectal cancer is among people 20 to 39 years old, especially Black and Hispanic individuals. Mortality rates across all ages for late-stage colorectal cancer have remained stagnant due to minimal progress in treatments for colorectal cancer patients.
- Given the health disparities outlined in the above, how does the NIH and NCI plan to ensure that its research will play a role in reducing health disparities seen with colorectal cancer?
- Is the NIH/NCI funding any research into social determinants of health given the disparities in colorectal cancer and the increasing incidence of early onset colorectal cancer?
- Can you please provide how NIH and NCI are engaging with the colorectal cancer community, including colorectal cancer patients, patient organizations, industry, academic researchers and community-based providers.

NIH Response:

1. The National Cancer Institute (NCI) is addressing cancer disparities on numerous fronts—from basic research on the biology associated with disparities and large comprehensive studies examining the factors that contribute to disparities to community-level programs that aim to overcome barriers to cancer care and population-based registries that help to document the extent of the problem and highlight areas for further study.

Increasing colorectal screening rates is included in 1 of the 10 recommendations of the Blue Ribbon Panel for the Cancer MoonshotSM and considered and adopted by the National Cancer Advisory Board. NCI is supporting several projects to address disparities in uptake of colorectal cancer (CRC) screening through the Cancer Moonshot “Accelerating Colorectal Cancer Screening and Follow-up through Implementation Science” (ACCSIS)¹⁰ program, which seeks to identify the most effective interventions aimed at increasing CRC screening and follow-up. The first phase of these projects focused on pilot studies that demonstrated the feasibility and potential effectiveness of multilevel interventions for increasing colorectal cancer screening and follow-up. The coordinating center and five research sites across the country have moved to phase two of the project, which involves testing the implementation and impact of the interventions in populations with low CRC screening rates.

NCI’s Screen to Save initiative,⁹⁷ launched by the NCI Center to Reduce Cancer Health Disparities (CRCHD), also aims to increase CRC screening rates in people aged 45 and older from racially and ethnically diverse communities and in rural areas nationwide. Through Screen to Save, community health educators provide culturally tailored, evidence-based CRC information, education, and screening resources within racially and ethnically diverse and rural communities. As a parallel effort to the ACCSIS initiative, the “Dissemination of a Colorectal Cancer Screening Program Across American Indian Communities in the Southern Plains and Southwest United States” consortia⁹⁸ was established to address the need for improved evidence-based CRC screening interventions among American Indians (AI), a critically underserved population. The long-term goal of this initiative is to enhance health equity and increase survival

⁹⁷ www.cancer.gov/about-nci/organization/crhd/imp/screen-to-save#:~:text=Screen%20to%20Save%20aims%20to,Native%20Hawaiians%20and%20other%20Pacific

⁹⁸ cancercontrol.cancer.gov/hdhe/native-american-health/colorectal-cancer-screening-american-indian

among AIs by improving care coordination for CRC. The project is leveraging the tribes' and researcher team's previous successes with dissemination and implementation science to test the effectiveness of a comprehensive, multi-level, and multi-component intervention to facilitate and navigate average and high-risk AI men and women, aged 50-75 years, to obtain a CRC screening exam.

In fiscal year (FY) 2021, CRCHD launched a new program, Connecting Underrepresented Populations to Clinical Trials (CUSP2CT).⁹⁹ The goal of this program is to increase referral and accrual of historically underrepresented populations to NCI-supported clinical trials in NCI's Community Oncology Research Program (NCORP) and other NCI clinical trials networks through implementation and evaluation of culturally tailored outreach and education. NCI's commitment to expanding clinical trial participant demographics to better represent the U.S. population and better reflect broad health outcomes is also reflected in NCI's FY 2023 Annual Plan highlighted opportunity "Clinical Trials: Bringing Cancer Research to All Possible Participants."¹⁰⁰

2. Efforts to reduce cancer disparities are not only focused on understanding the causes of disparities but also on developing and testing interventions to eliminate disparities. Access to care is affected by socioeconomic and policy-level factors that are beyond the control of the cancer research community. NCI-funded researchers are working to better understand and to identify other ways to improve outcomes for groups disproportionately affected by various types of cancer.

In addition to the research and ongoing efforts referenced in response to question one, NCI supports research in this area by developing and facilitating access to funding opportunities, training, and data resources that are relevant across cancer types, including CRC. NCI's Division of Cancer Control and Population Sciences has ongoing funding opportunity announcements (FOAs)¹⁰¹ that will help to better capture and address patient's social risks and needs. For instance, applications are currently being solicited for a Request for Application (RFA) on cancer control research in persistent poverty areas.¹⁰² The RFA will provide resources to support transdisciplinary teams in collaboration with communities and clinics to develop a cancer prevention and control research program, and provide training to junior investigators, that focuses on and serves populations in persistent poverty census tracts. This initiative will build capacity in persistent poverty census tracts to foster cancer prevention and control research (across cancer types) and promote the implementation of programs and practices in communities to alleviate the effects of persistent poverty.

NCI-supported community-based studies through the NCORP clinical trials network are also helping to address cancer disparities by increasing participation by minorities and patients from underserved populations in clinical cancer research. In addition, because the centers involved are often part of communities in which health care disparities are more common, NCORP cancer care delivery studies are ideally suited to test interventions designed to address cancer disparities.

⁹⁹ grants.nih.gov/grants/guide/rfa-files/RFA-CA-21-057.html

¹⁰⁰ cancer.gov/research/annual-plan/scientific-topics/clinical-trials

¹⁰¹ healthcaredelivery.cancer.gov/social-risks/

¹⁰² grants.nih.gov/grants/guide/notice-files/NOT-CA-22-030.html

Twelve Minority/Underserved Community Sites, whose patient populations are comprised of at least 30 percent racial/ethnic minorities or rural residents, are funded within NCORP.

3. NCI's Office of Advocacy Relations (OAR) works directly with patients, advocates, and advocacy organizations in a variety of ways to engage the CRC community in research. Patients and individual advocates participate in different activities across NCI to improve understanding, opportunities, and progress in cancer research, and ensure the collective patient perspective is integrated into NCI's efforts. For example, these individuals participate in scientific peer review, review clinical trial protocols, and serve on different scientific working groups and NCI advisory boards.

OAR coordinates one of these advisory boards, the NCI Council of Research Advocates (NCRA), which is the only federal advisory committee comprised of cancer research advocates. NCRA provides the NCI Director with advice on issues affecting cancer research from patient and advocate perspectives. Anjee Davis, President and CEO of Fight CRC, was appointed to serve on NCRA in 2019, and was named Chair in 2020.

NCI has also collaborated with Fight CRC in other ways for nearly two decades. Fight CRC staff have worked on NCI Steering Committees and advisory boards, joined scientific planning meetings, and met with NCI leadership to discuss priorities in colorectal cancer research. Fight CRC leadership most recently met with former NCI Director Dr. Ned Sharpless in February 2022. Another meeting between NCI and Fight CRC leadership is being planned for summer 2022 (date to be determined).

OAR staff have spoken at several external meetings hosted by Fight CRC, including those focused on Fight CRC's advocate training program, to help patients and advocates understand how they too can engage in NCI's research activities. OAR has also facilitated other speaking engagements for NCI program staff to share information about NCI's colorectal cancer research activities directly with patients and advocates who participate in Fight CRC events.

In 2019, OAR worked with Fight CRC to identify staff from NCI's Division of Cancer Biology (DCB) and NCI's Division of Cancer Prevention (DCP) to participate in Fight CRC's Early-Age Onset Colorectal Cancer Working Group.¹⁰³ That group continues to meet in 2022. In 2020, OAR staff worked with NCI program staff to engage patients and advocates, including staff from Fight CRC, in a trans-NIH Early Onset CRC Think Tank.¹⁰⁴

OAR staff also currently participate in an external, multidisciplinary group of patients, advocates, clinicians, and researchers charged with exploring how to improve clinical trials for patients with colorectal cancer. The group is coordinated by the Colorectal Cancer Alliance. Another way that NCI engages with community providers is through the FORTE (Five- or Ten-Year Colonoscopy for 1-2 Non-Advanced Adenomatous Polyps) study,²⁸ which will help to determine if certain people can wait for a follow-up colonoscopy after a routine screening colonoscopy. It is a randomized clinical trial for people who have one or two small, noncancerous polyps (adenomas) removed during a routine screening colonoscopy. Such people

¹⁰³ fightcolorectalcancer.org/crc-research/advisory-committees/eao-crc-wg/

¹⁰⁴ www.cancer.gov/about-nci/organization/dcb/news/early-onset-crc

usually get repeat colonoscopies five years and 10 years later (the current standard of care for people who have had one or two benign polyps removed). FORTE will help determine if these people can wait 10 years before a follow-up test.

Additionally, NCI has funded several small business innovators developing screening technologies for CRC through the congressionally mandated Small Business Innovation Research (SBIR) program. An example of SBIR-funded technology addressing CRC is the SCSR Fecal Cell Isolation System, developed by Noninvasive Technologies, LLC. The SCSR Fecal Cell Isolation System is a non-invasive screening test for colon cancer that isolates colonic cells from human stool and examines them for disease-related genetic markers and cell-surface markers. The system typically yields several million cells per gram of stool sample, enabling downstream analyses including cell culture, nucleic acid analysis, cell-surface analysis, and biopsy-free cell-based archiving of a patient's natural history.

Question for Dr. Bianchi

- Overactive bladder is a form of urinary incontinence that affects more than 38 million Americans, and 1 in every 3 older adults. Recent studies on anticholinergic medications, which are commonly prescribed drugs to treat overactive bladder, have shown that these medications have a negative impact on cognition and may lead to the development of Alzheimer's disease and related dementia
- Given the potential adverse impact on the nation's elderly that will only increase as our population ages, is the NICHD studying these medications or working collaboratively with other Institutes to determine the safety and efficacy of anticholinergic medications, and any association they may have with cognitive decline and Alzheimer's disease and related dementia?
- Can you share what NICHD initiatives are being pursued to determine the safety of these medications and to develop alternative treatments that are safe and effective for treating overactive bladder?

NIH Response:

Overactive bladder occurs when the bladder is triggered to empty at the wrong time, leading to a sudden urge to urinate that a person may have difficulty suppressing. The symptoms of overactive bladder include urinary frequency, urinary urgency, and urge incontinence.

The National Institutes of Health (NIH) supports studies on a range of issues related to the causes, prevention, and treatment of overactive bladder. This includes research on the safety of long-term use of anticholinergic medications commonly prescribed to treat overactive bladder and the associated risk of cognitive impairment and dementia as well as research to advance safe and effective alternative treatments for overactive bladder.

Within the NIH, the National Institute on Aging (NIA) is currently funding several studies on the safety of long-term use of anticholinergic medications and the risk of cognitive impairment and dementia in older adults with overactive bladder. This includes a clinical trial testing whether

discontinuing use of anticholinergics improves cognition and lowers the risk of Alzheimer's disease and related dementias.¹⁰⁵ NIA is also funding a clinical trial to test a mobile app that integrates a personalized anticholinergic risk calculator, targeted multimedia such as videos and blogs to educate users regarding anticholinergics, and a conversation starter to help a patient self-initiate ending anticholinergic prescriptions in collaboration with a healthcare provider.¹⁰⁶ This trial will explore the impact of the app on prescription anticholinergic exposure among older adults and on cognitive function and quality of life. Other research studies currently funded by NIA seek to assess severe adverse events associated with the interaction of cholinesterase inhibitors used to treat Alzheimer's with anticholinergic medications;¹⁰⁷ test mechanisms of neurotoxicity from anticholinergics;¹⁰⁸ evaluate extended cognitive, urinary, and functional trajectories in older incontinent women without pre-existing dementia who use anticholinergic medication;¹⁰⁹ utilize a novel model to investigate anticholinergic drug induced dementia;¹¹⁰ improve how older adults living with dementia, their caregivers, and clinicians make decisions about using anticholinergic medicines;¹¹¹ and test electronic health record-based tools that engage caregivers to help primary care providers reduce medication overload and deprescribe medications that can worsen cognitive burden in patients with mild cognitive impairment, Alzheimer's disease, and related dementias.¹¹² In addition, a recent NIA funded study found that exposure to strong anticholinergics increased the risk of transitioning from normal cognition to mild cognitive impairment.¹¹³ Another recent NIA-funded study that evaluated adverse outcomes of anticholinergic medicines in patients with dementia and overactive bladder¹¹⁴ found an increased risk of mortality associated with non-selective antimuscarinic (a subtype of anticholinergic drugs) medications in older adults with dementia.¹¹⁵

NIA is also funding several studies to advance safe and effective alternative treatments for overactive bladder. One NIA-funded research study is assessing brief mindfulness and non-invasive brain stimulation to reduce symptoms of urgency incontinence in women.¹¹⁶ In addition, a recent NIA-funded study found that a slow-paced breathing intervention practiced over 12 weeks was associated with a modest improvement in perceived stress in women with overactive bladder symptoms, but it was no more effective than a control intervention (listening to calming music) for reducing urinary symptoms.¹¹⁷ NIA also recently funded a study testing a novel, non-invasive nerve stimulation device for in-home treatment of overactive bladder.¹¹⁸

In addition, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) continues research into the causes and treatment of overactive bladder. NIDDK-supported

¹⁰⁵ reporter.nih.gov/search/Shaj-qYerkm0U6DRn1S6tg/project-details/10129872

¹⁰⁶ clinicaltrials.gov/ct2/show/NCT04121858

¹⁰⁷ reporter.nih.gov/search/pZSsBABfW0K-DPFCtVqRcQ/project-details/10212709

¹⁰⁸ reporter.nih.gov/search/Ggd69UkxpkGGqF5IAEfYrg/project-details/10168318

¹⁰⁹ reporter.nih.gov/search/0lm26jQsukuQXix5r_QvGw/project-details/10343015

¹¹⁰ reporter.nih.gov/search/0lm26jQsukuQXix5r_QvGw/project-details/10258975

¹¹¹ reporter.nih.gov/search/Ggd69UkxpkGGqF5IAEfYrg/project-details/9926791

¹¹² reporter.nih.gov/project-details/10370471

¹¹³ www.ncbi.nlm.nih.gov/pmc/articles/PMC6036636/

¹¹⁴ reporter.nih.gov/search/-xMveMuhZUWqFIMIntQelw/project-details/9377896

¹¹⁵ pubmed.ncbi.nlm.nih.gov/32026255/

¹¹⁶ reporter.nih.gov/search/PWzY007ysEW1d1WslGSukQ/project-details/10259722

¹¹⁷ www.ncbi.nlm.nih.gov/pmc/articles/PMC6842393/

¹¹⁸ reporter.nih.gov/search/rmFNOL91xkamsqkLW-QEQ/project-details/10219001

projects include those evaluating the efficacy of interventions and treatment approaches for urinary incontinence in older and minority women, including group-based, community-based, and online approaches. Other projects are aimed at finding ways to better assess bladder function, psychological contributors, potential biomarker signatures, and clinically useful patient subtypes.

NIH is committed to continuing to fund research to improve the lives of people living with overactive bladder and will continue to fund research towards prevention of cognitive impairment in this, and other, areas of investigation.

Submitted by Rep. Pocan***Pelvic organ prolapse (for Dr. Bianchi)***

Pelvic organ prolapse is a common problem, affecting one in three women who has given birth. Being pregnant and having a vaginal delivery can damage the pelvic muscles and nerves, allowing organs to drop. This is particularly true for women who have had a large baby, had many babies, or needed forceps to deliver during a challenging birth. One out of eight women undergo surgery for prolapse at some point in their life. Non-surgical treatments for pelvic organ prolapse require frequent health care visits, and surgical treatments are imperfect, with 20% of women experiencing recurrences within 10 years.

Question:

1. Are there current research initiatives being pursued that show promise in the development of improved preventative actions during the post-partum period and improved interventions for the effective treatment of pelvic organ prolapse?

NIH Response:

Pelvic floor disorders, including pelvic organ prolapse, are common among women and these conditions afflict both women who have and have not given birth. The *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) is working to address these issues.

The majority of NICHD sponsored research on pelvic organ prolapse is through the Pelvic Floor Disorders Network (PFDN), a multi-center network which was established by NICHD in 2001 in response to an increasing awareness by the public and by health professionals of the need for more objective data to guide both surgical and non-surgical care for this large and growing clinical problem. The overall objective of the PFDN is to facilitate interactions between a network of academic centers with the recruitment capabilities and research expertise needed to perform studies that will provide efficient, high quality, evidence-based clinical answers to both providers and women. Studies include both careful analysis of standard treatment outcomes as well as testing new therapies and approaches to move the research agenda forward in novel directions for clinical benefits.

PFDN research over the past few years has demonstrated that:

- vaginal mesh used to lift the uterus proves superior to native tissue repair for the surgical treatment of pelvic organ prolapse at five years follow-up examination;
- pain with sexual activity improves after surgical treatment of pelvic organ prolapse;
- the ability to fabricate support tissue from vaginal biopsies of the patient could be incorporated into surgical repairs;
- patient characteristics and MRI findings are risk factors for failure of pelvic organ prolapse surgery;

- current definitions of success or failure may result in the overestimation of surgical failure rates following pelvic organ prolapse, potentially explaining, in part, the low retreatment rates after pelvic organ prolapse surgery.

In addition, ongoing PFDN research includes a comparative effectiveness study that is evaluating three surgical treatments for prolapse. This study will determine the advantages and/or disadvantages, risks and benefits, and the effect on quality of life of each surgery when used to repair vaginal vault (apical) prolapse. Another study is examining the long-term efficacy and safety outcomes (up to 10-years) of a native tissue repair and a mesh hysteropexy, a method used to lift the uterus. NICHD has also funded non-network research on pelvic organ prolapse. Ongoing NICHD funded studies include understanding the mechanisms and impact of pregnancy-induced adaptations in pelvic floor muscles, improving the outcomes of urogynecologic meshes in diabetic women, and developing a new non-surgical treatment option for pelvic organ prolapse.

NICHD will continue to support this important research, as well as the work of PFDN, which was renewed for another 5-year cycle to begin in July 2022.

Submitted by Rep. Katherine Clark***ARPA-H*****Questions:**

1. Given the difficulty that federal agencies continue to have in hiring talented scientists and researchers, would you agree that ARPA-H should be physically located where a talent pool already exists?
2. What type of collaboration with state and local governments, academia, hospitals, and life sciences industries would make ARPA-H successful? How important is the local density of those stakeholders to ARPA-H's mission?
3. When considering physical resources, would you say that it is important to site ARPA-H in an area where it can easily scale up, as in, a region with plenty of life science lab space built or under construction?

NIH Response:

ARPA-H will recruit top talent from industry, academia, non-profit organizations, and government. It will depend on world-class program managers who will join for limited periods of time and will be chosen because they bring bold ideas. While it is important that they can effectively identify a problem, they must also be able to stimulate solution development through their program design and serve as effective team players. ARPA-H expects the program manager's role to be an exciting opportunity to make an impact because they will have broad autonomy to recommend funding and manage program successes as they will be responsible for developing the research requirements, goals, and milestones. They will be hired based on expertise, outside of the box thinking, and ideas that align with the ARPA-H director's vision and the organization's strategic vision.

ARPA-H's success is predicated on attracting exceptional staff as program managers as well as contracting, human resources, stakeholder engagement, and other professionals. The organization's structure is designed to be flat in order to empower every employee to be an engine of innovation. Solving problems in the health care space requires the best minds and best ideas regardless of geography.

President Biden will appoint an ARPA-H director who will be responsible for administration and operation of ARPA-H and will report to the Secretary of HHS. HHS is in the process of standing up the new agency and is developing plans for its operations and functions. Currently, no commitments as to the physical location of ARPA-H have been made as the decision will be the prerogative of the inaugural director.

Biomedical Workforce Diversity

Question:

1. According to your agency's personnel demographics, only 1.4% of senior investigators identify as Black.¹¹⁹ This concerns me because the pandemic has revealed the risks of such gaps. As the world's largest funder of biomedical research, the NIH should invest greater resources into diversifying the scientific workforce. How will the NIH use its requested increase of \$110 million for Research Management and Support and increase of \$185 million for the Office of the Director to address these gaps?

NIH Response:

Most new Senior Investigators at the National Institutes of Health (NIH) are promoted from the intramural tenure-track. Approximately two-thirds of tenure-track Investigators will eventually become Senior Investigators. Historically, this has been true for tenure-track investigators, regardless of race. The number and percentage of tenure-track Investigators who are Black (non-Hispanic) has increased from six (2.7 percent) in 2016 to 18 (7.7 percent) in 2021. The NIH Intramural Research Program has several ongoing programs that have enhanced the diversity of the applicant pool for tenure-track investigator positions, including the Earl Stadtman Investigator Program, the Lasker Clinical Research Scholars Program, and the Distinguished Scholars Program. These programs are managed by the Office of Intramural Research (OD/OIR) and funded by contributions from all NIH Institutes and Centers (ICs) with Intramural Research Programs. These three programs include expanded advertisement of tenure-track positions, including to groups who are underrepresented in the sciences, and annual NIH-wide searches for tenure-track investigators.

2. Over the course of this pandemic, feelings of burnout were worse for female academics, who often disproportionately bear family caregiving responsibilities such as child care.¹²⁰ How has the NIH accounted for the impact of the scientific workforce's radically different experiences during the pandemic -- especially given that it has a disparate impact on women and communities of color?
 - a. What is the agency's plan to support these scientists so that they do not leave the workforce?

NIH Response:

The National Institutes of Health (NIH) is concerned and mindful about how the spread of coronavirus disease 2019 (COVID-19) negatively affected the extramural biomedical research workforce. NIH conducted two large-scale surveys, one of institutional leaders and one of scientists (opened in the fall of 2020 with results published in March 2021) to

¹¹⁹ <https://oir.nih.gov/sourcebook/personnel/irp-demographics/intramural-research-program-personnel-demographics-end-fy21>

¹²⁰ <https://www.nature.com/articles/d41586-021-00663-2>

objectively document COVID-19 pandemic's impact.¹²¹ The results provided valuable insights into the well-being of the extramural biomedical research workforce, including as it relates to underrepresented and vulnerable groups. Institutional leaders reported concerns about research functions, research productivity, and financial challenges.¹²² Scientists reported concerns about career trajectory, mental well-being, and research productivity.

Most institutional leaders reported implementing COVID-19 monitoring measures, but only a minority provided or expanded facilities for childcare. Scientists reported that key factors affecting their career trajectory included the ability of researchers to apply for grants, caretaking responsibilities, lost access to research facilities and to collaborators, which together may have adversely affected the ability to generate preliminary data. Parents with young children reported the greatest decreases in research productivity, while women were more likely than men to report that caretaking made it substantially more difficult to complete their work responsibilities.

NIH recognizes the challenges the scientific workforce has faced during the COVID-19 public health emergency and, as such, is continuing to invest in the future through initiatives that strengthen and diversify the biomedical research workforce. NIH will continue to follow grant and application data closely, and importantly data so far are also not showing any marked changes in the high-level demographics of designated principal investigators on R01-equivalent and RPG applications submitted before and during the pandemic.¹²³

Selected examples of steps NIH has taken include:

- Policy flexibilities, including grant award extensions (both funded and unfunded for fellowship and career development awards) to address COVID-19-related research delays.¹²⁴
- Extensions of eligibility for early career scientists including for both the K99/ R00 Pathway to Independence Award applicants and for early-stage investigators.^{125,126}
- Automatic one-year extensions of early-stage investigator status for childbirth.¹²⁷ In FY 2020, an automatic extension of one year was also implemented for childbirth within the four-year K99 eligibility window.¹²⁸

¹²¹ nexus.od.nih.gov/all/2020/10/05/encouraging-participation-in-upcoming-nih-surveys-to-identify-impacts-of-covid-19-on-extramural-research

¹²² nexus.od.nih.gov/all/2021/03/25/the-impact-of-the-covid-19-pandemic-on-the-extramural-scientific-workforce-outcomes-from-an-nih-led-survey

¹²³ nexus.od.nih.gov/all/2022/04/08/another-look-at-applications-submitted-during-the-pandemic-part-4

¹²⁴ grants.nih.gov/policy/natural-disasters/corona-virus.htm

¹²⁵ grants.nih.gov/grants/guide/notice-files/NOT-OD-22-062.html

¹²⁶ nexus.od.nih.gov/all/2021/09/17/clarifying-nih-approach-to-granting-esi-extensions/

¹²⁷ grants.nih.gov/grants/guide/notice-files/NOT-OD-18-235.html

¹²⁸ grants.nih.gov/grants/guide/pa-files/pa-18-592.html

- Support for early career investigators with high potential to re-enter an active research career after an interruption for family responsibilities or other qualifying circumstances.¹²⁹
 - Administrative supplements that promote the continuity of research during critical life events, including caregiving.^{130,131}
 - Funding for Childcare Costs for Ruth L. Kirschstein National Research Service Awards for Individual Fellows and Trainees.^{132,133}
3. The FIRST Program is a critical initiative in the NIH Common Fund designed to recruit and retain researchers and faculty from diverse backgrounds. Planned for FY21 to FY23, additional funding was requested by the administration for this program for its final round of awards. Given the important impact of the FIRST Program, will the NIH commit to continuing the program for another fiscal year?
- a. What concrete steps will you take to directly grow a diverse biomedical research workforce?

NIH Response:

The NIH Common Fund's Faculty Institutional Recruitment for Sustainable Transformation (FIRST) program aims to create scientific environments at NIH-funded institutions that cultivate and benefit from a full range of talent through recruitment of a critical mass of early-career faculty with a demonstrated commitment to inclusive excellence. Program evaluation of culture change, faculty success, and professional development will provide an evidence base for wider adoption of the cohort hiring approach at academic institutions across the nation. The FIRST program is initiating new awards to hire faculty cohorts in Fiscal Years (FY) 2021, 2022, and 2023; each award will be supported for five years with the final year of support for the third group of awards in FY 2027. Additionally, a coordination and evaluation center award was issued in FY 2021; support for this initiative is planned to continue through FY 2029. Each funded FIRST award will recruit a cohort of 12 (on average) early career investigators who are committed to diversity, equity, and inclusion. The larger impact of the FIRST program will occur through widespread dissemination and broad adoption of evidence-based strategies that support cultures of inclusive excellence, ultimately fostering greater diversity in the biomedical research workforce.

4. For decades, the NIH has supported activities that emphasize the need for diversity in the biomedical research workforce. But by your agency's own admission¹³⁴, these efforts

¹²⁹ grants.nih.gov/grants/guide/pa-files/PA-18-592.html

¹³⁰ grants.nih.gov/grants/guide/notice-files/NOT-OD-20-054.html

¹³¹ grants.nih.gov/grants/guide/notice-files/NOT-OD-20-055.html

¹³² grants.nih.gov/grants/guide/notice-files/NOT-OD-21-074.html

¹³³ grants.nih.gov/grants/guide/notice-files/NOT-OD-21-177.html

¹³⁴ <https://www.nih.gov/about-nih/who-we-are/nih-director/statements/nih-stands-against-structural-racism-biomedical-research>

have been insufficient and led to the creation of the UNITE Initiative, which addresses structural racism within the NIH-supported and greater biomedical research community. After releasing a request for information, the agency elicited opinions and conducted listening sessions for a report that was expected for March of this year. What is the status of this report and when can the public expect to see it? Are there details from that report that you can share on how the NIH will address systemic barriers present in its culture towards diversity and inclusion in the workforce?

NIH Response:

An update and initial analysis on the status of the NIH UNITE Request for Information (RFI) Report was provided during the December 10, 2021, Advisory Committee to the Director (ACD) Meeting, where it was announced that the RFI final report would be available to the public in 2022.¹³⁵ In preparation for the June 10, 2022 ACD Meeting, updates are planned to confirm that the RFI final report will be publicly released in summer 2022. The UNITE external listening sessions summaries are posted and publicly available on the UNITE website (where the RFI final report will also be posted).

¹³⁶ These activities were for information gathering purposes only; however, NIH will use the information collected to inform recommendations to promote and advance diversity and inclusion in the NIH workforce and broader biomedical community.

Hearing Loss and Dementia

Question:

1. Research funded by the National Institute on Aging indicates that even mild to moderate hearing loss can increase one's risk of dementia by two to three-fold.¹³⁷ These studies may have uncovered an important connection but we need major investments in solutions. What is the NIH doing to advance scientific research in treating hearing loss to prevent or slow down the onset of dementia?
 - a. To build on that further, what is the NIH doing to advance new treatments for hearing loss in light of the fact that no drug therapies currently exist for the 37 million American adults suffering with this disease?
 - b. Is there more we could be doing to foster collaboration between the government and the private sector to accelerate next generation therapies for this growing public health challenge?

NIH Response:

Hearing loss is independently associated with dementia, and researchers do not yet know whether the two are causally linked or whether there are other reasons that could lead to

¹³⁵ https://www.acd.od.nih.gov/documents/presentations/12102021_UNITE.pdf

¹³⁶ <https://www.nih.gov/ending-structural-racism/unite-events#past>

¹³⁷ <https://www.nia.nih.gov/news/whats-connection-between-hearing-and-cognitive-health#:~:text=NIA%2Dfunded%20research%20has%20indicated,older%20adults%20with%20normal%20hearing.>

declining cognition, such as social isolation due to hearing loss or poor test scores resulting from an inability to hear well enough to correctly complete cognitive tests. Furthermore, it is unknown whether treating hearing loss in its early stages decreases the risk of developing dementia. The National Institute on Aging (NIA) supports a number of studies focused on hearing health, particularly as hearing relates to cognitive outcomes. For example, the Aging, Cognition, and Hearing Evaluation in Elders randomized trial will help establish whether an intervention including hearing needs assessment, fitting of hearing devices, and education/counseling can reduce cognitive decline and the risk of Alzheimer's disease and Alzheimer's disease-related dementias in cognitively normal older adults. In another study, investigators are characterizing hearing loss and care in a diverse community and testing the effects of a communication intervention that integrates over-the-counter assistive technology on disruptive behavior in persons with dementia, as well as on caregiver burden. A third study is investigating the association between hearing loss, communication impairment, and hearing aid use with health care outcomes such as 30-day readmission, length of stay, and hospitalization in older adults. NIA also funds several prospective epidemiologic studies that are examining the complexity of comorbid factors that contribute to, or that mitigate the association of hearing loss to dementia. Additionally, NIA studies are investigating brain changes in older adults that may underlie relationships between hearing loss and dementia. These studies also examine the temporal relationships between brain changes, hearing loss, and changes in cognitive function. Similarly, the National Institute on Deafness and Other Communication Disorders (NIDCD) funds research in age-related hearing loss in persons with Alzheimer's disease and related dementias and its impact on cognitive decline. NIDCD recently provided supplemental support to a study to determine if auditory (hearing) neural health affects the quality of auditory information received from cochlear implants, which in turn affects the cognitive status of older adult cochlear-implant users.

NIH Response Part a:

The National Institute on Deafness and Other Communication Disorders (NIDCD) supports innovative basic, clinical, and translational research to improve hearing technologies and to develop new treatments for hearing loss. FDA-regulated cochlear implants and hearing aids are effective interventions to treat hearing loss in adults, and NIDCD continues to fund research to optimize those technologies. NIDCD also supports an initiative to make hearing technology more accessible and affordable for adults. As of Fiscal Year (FY) 2021, the NIDCD has supported over 60 research projects focused on improving access and affordability in hearing health care for adults, including ways to predict, improve, and measure hearing health care outcomes; testing ways to promote hearing health care access and use in primary care; investigating how to improve delivery of care in community settings to people with hearing loss; and reducing disparities in access to hearing health care.

Hearing loss is difficult to treat because the sensory cells, called hair cells, in the inner ear that are responsible for hearing cannot be repaired or replaced in humans. Further, the neurons that are connected to the hair cells begin to atrophy once the cells die and connections to the brain are lost. Treatment development is further complicated because of the many causes of hearing loss, including genetics and environmental damage like noise. NIDCD funds numerous cell-based and animal studies trying to understand the

many molecular players that drive hair cell development and replacement in order to regenerate the missing hair cells using drugs or gene therapy. Basic research studies are also underway to examine how to repair and reform the lost connections between hair cells and the nerves.

NIH Response Part b:

NIDCD supports private-sector research and development through the Small Business Innovation Research (SBIR) and Small Business Technology Transfer programs (STTR). In FY 2021, NIDCD supported 19 Phase II SBIR/STTR projects and supplements, 17 of which focused on new assessments, devices, treatments, and rehabilitation strategies for individuals with hearing loss.

NIDCD also serves on the U.S. Department of Defense's (DOD) Hearing Restoration Research Program Programmatic Panel. The DOD, the Department of Veterans Affairs (VA), and NIDCD are working together to align efforts on preventing noise-induced hearing loss, and basic, clinical, and translation research to develop new treatments for hearing loss and balance impairment caused by injury to the inner ear.

2. There are some silver linings from this pandemic, such as how we leveraged NIH's infrastructure and muscle to swiftly develop transformative COVID vaccines and therapeutics. I see promise in an agency-wide concerted effort to treat neurological conditions like Alzheimer's, which affects 5.8 million Americans and is projected to nearly triple to 14 million by 2060.¹³⁸ How does the NIH plan on applying lessons from the pandemic to high-risk, high-reward basic science moving forward? Could the NIH stand to update its mechanisms to dole out funding faster?

NIH Response:

During the pandemic, the National Institutes of Health (NIH) worked closely with partners in and out of government to leverage existing infrastructure and newly available funding to pivot rapidly in response to the pandemic. These efforts (and many others) reflect more than grants, contracts, and dollars; they led to meaningful *results* within a remarkably short time.¹³⁹ NIH is actively considering ways to apply lessons learned during this time to improve its policies and practices to support the most meritorious science going forward.

One strategy to consider is using a unique type of legal funding instrument, called "Other Transactions," to support research when appropriate. As described in an NIH Open Mike blog,¹⁴⁰ "through unconventional processes, Other Transactions allow us to address rapidly evolving research areas, especially those that are multi-disciplinary or relate to

¹³⁸

<https://www.cdc.gov/aging/aginginfo/alzheimers.htm#:~:text=In%202020%2C%20as%20many%20as,were%20living%20with%20Alzheimer's%20disease.&text=Younger%20people%20may%20get%20Alzheimer's,14%20million%20people%20by%202060.>

¹³⁹ nexus.od.nih.gov/all/2022/05/26/a-reflection-on-impact

¹⁴⁰ nexus.od.nih.gov/all/2022/03/23/its-not-a-grantits-not-a-contractits-an-other-transaction/

urgent public health situations when the future direction of the science is constantly changing and unknown. NIH staff can also help bring experts together in novel ways through Other Transactions awards, such as through engaging non-traditional partners, companies, advocates, and individuals. And, similar to our role with contracts and cooperative agreements, we can take a more active and substantive collaborative role in scientific design and program management, beyond traditional grant administrative and oversight functions.”

The process for awarding Other Transactions is rapid and flexible, which is important when the grant timeline will not work. For instance, NIH used this funding mechanism to rapidly support several programs in response to the COVID-19 public health emergency, including:

- Accelerating COVID-19 Therapeutic Interventions and Vaccines (ACTIV)¹⁴¹
- Community Engagement Alliance (CEAL)¹⁴² Against COVID-19 Disparities
- Researching COVID to Enhance Recovery (RECOVER)¹⁴³

Other Transactions, together with grants and contracts, enable NIH to continue supporting exciting, high impact, cutting-edge areas of research. NIH will continue to ensure stewardship, oversight, and accountability of NIH funds.

Women’s Health

Question:

1. My understanding is there eight main areas of health that solely, predominantly, or differently impact women, ranging from autoimmune conditions where 80% of patients are women to Alzheimer’s where three-fourths of patients are women and 90% of caretakers are women to gynecological cancers where 1 in 2 women diagnosed with ovarian cancer die, especially among Black and Brown women, to cardiovascular disease that leads to heart attacks of which women 55 and under are twice as likely to die from. With only 4% of all healthcare R&D and 11% of NIH funding directed specifically towards women’s health, what can you share with us today about your work to increase research investment into these health inequities and disparities facing women and minorities?

NIH Response:

Women’s health remains an important area of research interest for the National Institutes of Health (NIH). The mission of the National Institute on Minority Health and Health Disparities (NIMHD) is to lead scientific research to improve minority health and reduce health disparities. Together with the NIH Office of Research on Women’s Health (ORWH), NIMHD ensures that NIH Institutes’ and Centers’ (ICOs) activities “take into account women and minorities and are

¹⁴¹ www.nih.gov/research-training/medical-research-initiatives/activ

¹⁴² covid19community.nih.gov

¹⁴³ recovercovid.org

focused on reducing health disparities,” in compliance with the 21st Century Cures Act requirement [Public Law 114-255, Sec. 2031(c)]. In the NIH Wide-Strategic Plan,¹⁴⁴ Fiscal Years 2021-2025, NIH identified enhancing women’s health as a priority area and an NIH-wide theme. Women from racial and ethnic minority groups are disproportionately affected by several diseases and health conditions, and experience multiple health disparities in diseases such as diabetes, lupus, and cardiovascular disease, as compared to non-Hispanic White women. Cancer health disparities, especially breast and gynecologic cancers, are of increasing concern. Further, in recent years, research findings have highlighted the critical need for enhanced research and outreach activities to understand and address the stark racial and ethnic disparities in maternal morbidity and mortality. African American or Black and American Indian and Alaska Native women, for example, not only have higher rates of pregnancy-related complications but are also two to three times more likely than White women to experience maternal mortality.

In collaboration with other NIH ICOs, NIMHD developed the NIH Minority Health and Health Disparities Strategic Plan (2021-2025).¹⁴⁵ The plan includes goals and strategies that can guide research and activities to address disparities in women’s health, including, for example, research that aims to:

- Uncover contributors of maternal mortality and severe maternal morbidity in the United States over the next 10 years and develop interventions to address the disparities between African American or Black and American Indian and Alaska Native women compared with White women.
- Understand the underlying etiologic pathways for the higher rates of systemic lupus among African American women and Latinas compared to White women by 2030.
- Support the development of one synthetic or hybrid data set which conforms to FAIR (findable, accessible, interoperable, and reusable) open data principles and models racially and ethnically diverse communities to test methods and metrics and address possible biases due to underrepresentation of minorities and women.

Additionally, this section highlights examples of research and activities that support research on disparities in women’s health.

- Meeting women where they are: Multilevel intervention addressing racial disparities in maternal morbidity and mortality study¹⁴⁶ will scale a community, provider, and system-level intervention to reduce African American maternal morbidity and mortality disparities and will test the intervention using data from all Medicaid insured women who deliver in Michigan from 2016-2019 and 2021–2024 (approximately 540,000 births, including 162,000 births to African American women).

¹⁴⁴ www.nih.gov/sites/default/files/about-nih/strategic-plan-fy2021-2025-508.pdf

¹⁴⁵ www.nimhd.nih.gov/docs/nimhd-strategic-plan-2021-2025.pdf

¹⁴⁶ reporter.nih.gov/search/rM9PQWWAvkOCVInoiVFdg/project-details/10398257

- Characterizing Disparities and Elucidating Opportunities across the Cervical Cancer Continuum among Native American Women study¹⁴⁷ has considerable potential to provide comprehensive illustration of the specific pathways through which failures occur among American Indian and Alaska Native women across the cervical cancer continuum and will inform cost-effective and data-driven strategies for intervention that can mitigate the pervasive health disparities witnessed among this underserved population.
- A Widespread Self-Management Education Program to Reduce Health Disparities in African American Women with Systemic Lupus Erythematosus (SLE) study¹⁴⁸ recently ended in May, but it examined the benefits of the Chronic Disease Self-Management Program (CDSMP) to improve outcomes and reduce health care utilization in African American women with lupus. The potential for immediate wide-scale delivery of the CDSMP reaching African American women with SLE may contribute to reducing health disparities by lessening the individual and societal burden caused by this disease.
- NIH Implementing a Maternal health and PRenancy Outcomes Vision for Everyone (IMPROVE)¹⁴⁹ initiative supports research focused on reducing preventable causes of maternal deaths and improving health for women before, during, and after delivery. IMPROVE includes a special emphasis on health disparities and disproportionately affected populations.
- The National Heart, Lung, and Blood Institute (NHLBI)'s Maternal Health Community Implementation Project (MH-CIP)¹⁵⁰ engages communities through strategic coalitions to pilot test the implementation of proven interventions in vulnerable populations that are disproportionately affected by maternal morbidity and mortality.
- The Understudied, Underrepresented, and Underreported in biomedical research (U3) framework was developed by ORWH to address the lack of research on persistent disparities in women's health and healthcare by supporting research and evidence-based programs in this area. The U3 program also highlights the intersectional experiences of women, exploring the ways in which socially determined categories – like race and gender – overlap and interact to create different outcomes for individuals and communities. For biomedical research to best benefit the whole population, the research participant population should reflect the diversity of the patient population. However, many clinical studies continue to underrepresent women of color and other underserved populations. ORWH's U3 Administrative Supplement⁸ provides support for NIH researchers from a variety of disciplines who are committed to advancing health equity by bringing women of U3 populations into focus within the research lens.

¹⁴⁷ reporter.nih.gov/project-details/10020805

¹⁴⁸ reporter.nih.gov/project-details/9932814

¹⁴⁹ <https://www.nih.gov/research-training/medical-research-initiatives/improve-initiative>

¹⁵⁰ <https://www.maternalhealthcip.org/>

⁸ <https://orwh.od.nih.gov/womens-health-research/interdisciplinary-research/u3-interdisciplinary-research/orwh-u3>

Submitted by Rep. CHERI BUSTOS***INCLUDE Initiative***

I am the Co-Chair of the Congressional Down Syndrome Taskforce with Congresswoman Cathy McMorris Rodgers. I want to thank NIH for their continued work on the INCLUDE initiative to research Down Syndrome and its co-occurring conditions.

In addition, I want to thank Chairwoman DeLauro and Ranking Member Cole for providing an additional \$10 million to the initiative last year. People with down syndrome have higher rates of certain health conditions, but are highly protected from others. For instance, people with Down Syndrome have high rates of cognitive decline and heart defects but infrequently develop breast or prostate cancer. Given the scope of this unique disease spectrum the committee requested that INCLUDE be a trans-NIH initiative led by the Office of the Director.

So, the research under the INCLUDE initiative is essential to improving our biomedical understanding towards improving health outcomes of people with down syndrome and the general public.

Question:

1. Dr. Tabak and Dr. Bianchi, can you discuss the INCLUDE initiative's successes to date, and the potential research and clinical applications that we might expect in the near future?

NIH Response:

Down syndrome (DS) is the most common genetic cause of intellectual disability and individuals with DS often have an increased risk of developing several co-occurring medical conditions such as heart, sleep, and communication problems. Additionally, approximately half of individuals with DS develop Alzheimer's disease. However, with treatment and appropriate care, many individuals with DS lead fulfilling and productive lives. Therefore, research leading to reliable, accessible treatments and guidance for clinical and community care are critical.

The INCLUDE Project is a NIH-wide initiative that aims to understand critical health and quality-of-life needs for individuals with DS. Now entering its fifth year, the INCLUDE Project continues to expand its research portfolio by releasing innovative funding opportunities and building the field of investigators by enhancing career pathways for trainees, early-stage investigators, and established investigators with expertise related to conditions commonly experienced by individuals with DS. Since its launch in Fiscal Year (FY) 2018, the INCLUDE Project has funded approximately 200 research studies spanning all three components of the initiative: basic science studies on chromosome 21, large cohort development for individuals with DS, and the inclusion of individuals with DS in clinical trials.

The studies supported by the INCLUDE Project are building on countless basic scientific discoveries to make promising contributions to the field and develop an understanding of both the biological and genetic underpinnings of DS and the conditions commonly experienced by

individuals with DS. The goal of the NIH-wide program is to prevent these conditions from reducing the capacity of people with DS to lead healthy and optimal lives. To support basic science and foundational investigations into DS, the INCLUDE Project has already driven advances in data sharing and storage infrastructure to increase collaboration, rigor, and transparency in DS-related research. The INCLUDE Data Coordinating Center¹⁵¹ offers free, accessible tools, including the INCLUDE Data Hub,¹⁵² to bring together and share information and resources for researchers to study DS, a relatively rare condition difficult to study in large populations, more quickly. Basic science research and data tools will increase the potential for DS research to enhance the quality of life for individuals with DS and their families.

The INCLUDE Project also aims to establish needed knowledge and infrastructure for advancing treatments and other clinical therapies inclusive of people with DS. In FY 2021, the INCLUDE Project supported seven clinical studies investigating potential treatments for critical and co-occurring conditions associated with DS. These studies aim to assess treatments for sleep apnea, ADHD, and to evaluate the impact of hypoglossal nerve stimulation on cognition and language. Early results show promise for each potential therapy, despite setbacks caused by the COVID-19 pandemic. The NIH anticipates increasing its support for clinical trials in the coming years, including support for a trial to examine the effect of anti-amyloid drugs in individuals with DS.

As the INCLUDE Project continues to support the highest quality, targeted research designed to address critical health and quality-of-life needs for individuals with DS and their families, the applications for such research will lead to even greater improvements to care.

¹⁵¹ includedcc.org/

¹⁵² portal.includedcc.org/

Submitted by Rep. Watson Coleman

Endometrial Cancer Research

Progress is being made in the battle against cancer, with the incidence and mortality rates for many cancers dropping significantly. However, with endometrial cancer there are not the same declines, in fact the American Cancer Society statistics show that over the last 10 years there has been more than a 140% increase in endometrial cancer incidence and mortality. There are also significant disparities in endometrial cancer treatment and outcomes. The NCI just announced last week the results of a study that showed deaths from uterine cancer are rising in the United States and are highest among non-Hispanic Black women. Previous studies have shown that Black women are also much less likely to receive evidence-based care and are two times more likely to die from endometrial cancer than White women.

Question:

2. **What research activities is NCI pursuing or may be planning to pursue to improve endometrial cancer early diagnosis, treatment and outcomes for Black women and all women impacted by this disease?**

NIH Response:

The National Cancer Institute (NCI) supports a robust research program in gynecologic cancers (cervical, endometrial, ovarian cancers, and others) including research aimed at addressing disparities for racial/ethnic and underserved populations who disproportionately suffer from these cancers for several reasons.

NCI recently published a study¹⁵³ which found that endometrial/uterine cancer deaths overall increased sharply by 1.8 percent per year from 2010 to 2017 in all racial and ethnic groups. Black women are twice as likely to die of uterine cancer compared to other racial and ethnic groups. Most of the increase in mortality is attributable to non-endometrioid uterine cancer, an aggressive subtype, which disproportionately affects Black and Hispanic women. Non-endometrioid cancer mortality increased 3.5 percent per year for Black women and 6.7 percent for Hispanic women between 2010 and 2017.

NCI is supporting the Epidemiology of Endometrial Cancer Consortium (E2C2),¹⁵⁴ which is dedicated to studying the etiology of endometrial cancer through collaboration among investigators. E2C2 published a study which found that anti-inflammatory drugs may decrease risk of endometrial cancer in women who are overweight and with obesity. In fiscal year (FY) 2021, Brigham and Women's Hospital was awarded NCI funding to use E2C2 to study genomic

¹⁵³ pubmed.ncbi.nlm.nih.gov/35511145/

¹⁵⁴ epi.grants.cancer.gov/eccc/

variation and distinct risk factor profiles across tumor subtypes and the role of underlying tumor biology that may contribute to disparities in mortality between Black and White women.¹⁵⁵

There are no validated screening tests for uterine cancer currently and clinical work-up of patients with symptoms (post-menopausal bleeding) are invasive. NCI is conducting studies to demonstrate that tampons may be used to collect samples for testing to detect molecular markers associated with uterine cancer. Early studies^{156,157,158} have been conducted in mainly White populations, but efforts are now underway to expand this work through the Discovery and Evaluation of Testing for Endometrial Cancer in Tampons (DETECT) Study.¹⁵⁹ NCI is collaborating with the University of Alabama at Birmingham to enroll a racially diverse population of people undergoing surgical removal of the uterus for endometrial cancer or benign reasons. This study will provide evidence to inform the development of early detection strategies based on self-collected samples for uterine/endometrial cancer screening, with the ultimate goal of reducing racial disparities. DETECT will also evaluate predictors of endometrial cancer recurrence and survival to better understand differences in uterine cancer deaths by race.

Similarly, investigators supported by NCI's Early Detection Research Network designed the PapSEEK test for early detection of endometrial cancers.¹⁶⁰ This test identifies cancer-related alterations in DNA obtained from cells collected during a routine Pap test to detect some endometrial cancers at earlier, more treatable stages.

The Specialized Programs of Research Excellence (SPOREs), a key component of NCI's Translational Research Program, also supports research on gynecologic cancers. The Endometrial Cancer SPORE at MD Anderson Cancer Center¹⁶¹ conducts translational research for the prevention and treatment of endometrial cancer. Their research involves developing therapeutics for advanced and recurrent endometrial cancer, as well as for aggressive subtypes.

NCI also funds planning grants for future SPORE programs in cancer health disparities. The aim is to build programs to improve the prevention, early detection, diagnosis, and treatment of cancers that disproportionately affect specific racial and ethnic minority populations so that those institutions may then compete for SPORE funding in future years. In FY 2020, Northwestern University in Chicago was awarded a SPORE planning grant focusing on racial differences in gynecologic cancers. The Northwestern University Cancer Health Equity Research SPORE (NU-CHERS)¹⁶² will generate scientific findings and establish sustainable, collaborative, academic and community infrastructure that will serve as the foundation for a comprehensive translational cancer research program focused on gynecologic cancer health disparities, which is

¹⁵⁵ reporter.nih.gov/search/kPH-0602jEm7TGH_Ju2fsQ/project-details/10156374

¹⁵⁶ *Int J Cancer*. 2014 Oct 15;135(8):1860-8

¹⁵⁷ *Gynecol Oncol*. 2015 Apr;137(1):14-22

¹⁵⁸ *Gynecol Oncol*. 2021 Jul;162(1):128-133

¹⁵⁹ dceg.cancer.gov/research/cancer-types/endometrium-uterus/endometrium-detect

¹⁶⁰ www.cancer.gov/news-events/cancer-currents-blog/2018/liquid-biopsy-screening-test-endometrial-ovarian

¹⁶¹ trp.cancer.gov/spores/abstracts/mdanderson_gyn.htm

¹⁶² trp.cancer.gov/spores/abstracts/northwestern_p20.htm

the first of its kind in the nation. The initial translational research focus of NU-CHERS is on endometrial and ovarian cancer disparities experienced by Black women.

NCI is committed to expanding clinical trial participant demographics to better represent the American population and better reflect broad health outcomes. Over the last two decades, the proportion of racial and ethnic minority patients enrolled in NCI-funded National Clinical Trials Network (NCTN) and National Community Oncology Research Program clinical trials has nearly doubled. Several clinical trials are currently underway evaluating combinations of therapies to treat endometrial cancer, including immunotherapy approaches.¹⁶³ Additionally, in July 2021, the FDA approved a combination of an immunotherapy and a targeted therapy for advanced endometrial cancer.¹⁶⁴ NCI is hopeful that trials currently underway will lead to additional effective treatment options, including combination approaches, for all women with endometrial cancer.

COVID-19

As Dr. Tabak testified, the NIH launched a project to support research focused on the social, behavioral, and economic impacts of COVID-19, which supports research on the secondary effects of the pandemic, such as financial hardship, reduced access to health care, and school closures. Over this pandemic, young students were isolated and lacked critical social networks as schools transitioned to remote learning for the health and safety of their students. Unfortunately, this separation, in conjunction with the loss of parents or caregivers could lead to unknown long-term consequences relating to the development and mental health of the bereaved children.

Question:

1. **How will this research project specifically support young people who lost a parent/caregiver due to covid and what types of mental health supports can be put in place for these children?**

NIH Response:

The coronavirus disease 2019 (COVID-19) pandemic has been challenging for many children, due not only to the fear of contracting the virus, but also potential loss of economic, food, caregiver, housing security, or school-based support systems. An estimated 150,000 children in the United States lost at least one parent or caregiver to COVID-19 as of October 2021.¹⁶⁵ Children who lost a parent or caregiver to COVID-19 are at increased risk for serious emotional disturbances and may benefit from evidence-based interventions through school-based or community-based mental health services. COVID-19 deaths disproportionately impacted those

¹⁶³ clinicaltrials.gov/ct2/show/NCT04214067; clinicaltrials.gov/ct2/show/NCT03914612; clinicaltrials.gov/ct2/show/NCT03660826; clinicaltrials.gov/ct2/show/NCT05112601; clinicaltrials.gov/ct2/show/NCT04585958; clinicaltrials.gov/ct2/show/NCT03476681

¹⁶⁴ www.fda.gov/drugs/resources-information-approved-drugs/fda-grants-regular-approval-pembrolizumab-and-lenvatinib-advanced-endometrial-carcinoma

¹⁶⁵ Unwin et al. (2022), doi.org/10.1016/S2352-4642(22)00005-0

who were vulnerable to begin with, widening disparities particularly for Black families and other racial and ethnic minority groups.¹⁶⁶

To address these challenges, the National Institute of Mental Health (NIMH) and the NIH-wide Social, Behavioral, and Economic Impacts of the Pandemic (SBE) workgroup have called for research on rapidly deployable and scalable interventions, primarily through digital health and community-based approaches to address mental health challenges related to the pandemic, including for vulnerable populations like children who have lost their parents or caregivers.^{167,168,169} The NIH-wide SBE initiative is not a single research project, but rather a workgroup to coordinate and accelerate research in this space.

Related to this effort, NIMH and the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) released a coordinated Notice of Special Interest (NOSI) to encourage additional research focused on how school disruptions impact the mental health and cognitive, social, and emotional development of children.¹⁷⁰ NIH continues to prioritize high-quality research on supporting children who lost a parent or caregiver due to COVID-19. New research projects through the Rapid Acceleration of Diagnostics in Underserved Populations (RADx-UP) initiative, and ongoing longitudinal efforts like the Adolescent Behavior Cognitive DevelopmentSM Study (ABCD Study[®]) study include many measures of pandemic impacts, such as: infection, hospitalization, and death of the participant or their family members or caregivers; social disruptions, including school, extracurricular activities, and time with peers; as well as mental health impacts. These measures can help to improve our understanding of the direct and indirect consequences of the pandemic on children, informing the development and implementation of mental health supports. The U.S. Surgeon General's Advisory on Protecting Youth Mental Health includes specific examples of actions that families, educators, health professionals, and community organizers can take to support children's mental health.¹⁷¹

¹⁶⁶ Kidman et al. (2021), doi.org/10.1001/jamapediatrics.2021.0161

¹⁶⁷ covid19.nih.gov/news-and-stories/covid19-ripple-effects

¹⁶⁸ grants.nih.gov/grants/guide/pa-files/PAR-22-112.html

¹⁶⁹ grants.nih.gov/grants/guide/notice-files/NOT-MH-21-330.html

¹⁷⁰ grants.nih.gov/grants/guide/notice-files/NOT-MH-21-225.html

¹⁷¹ /www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

Submitted by Rep. Brenda Lawrence***Maternal Health Research***

Like many of my colleagues, I am also concerned by the maternal mortality crisis in the U.S. The COVID-19 pandemic has highlighted many of the health disparities facing minority communities across the country, and the rates of maternal mortality facing communities of color are heartbreaking. As the co-chair of the Democratic Women's Caucus and the 2nd Vice Chair of the Congressional Black Caucus, this issue is particularly personal to me.

Dr. Bianchi, I want to thank you for the work that the National Institute of Child Health and Human Development does to support moms-to-be and moms and, in particular, the focus on the importance of mental health services.

Question:

1. Dr. Bianchi, what more can we do to ensure that both moms-to-be and moms continue to have the resources they need?

NIH Response:

Wide disparities exist in maternal morbidity and mortality, with racial and ethnic minority women and women with disabilities at higher risk of pregnancy-associated death and complications. Addressing maternal morbidity and mortality is a priority for the National Institutes of Health (NIH). NIH launched the Implementing a Maternal health and Pregnancy Outcomes Vision for Everyone (IMPROVE) Initiative in 2020 to help address this public health crisis. IMPROVE is an NIH-wide initiative led by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD), the NIH Office of Research on Women's Health, and the NIH Immediate Office of the Director. In Fiscal Year 2022, \$30 million was included in the NICHD appropriation for the IMPROVE initiative. To date, IMPROVE has supported research through supplements to existing awards on how to mitigate preventable maternal mortality, decrease severe maternal morbidity, and promote health equity. NIH is working to establish Maternal Health Research Centers of Excellence in geographically diverse regions and in partnership with communities that could benefit the most. These centers will investigate biological, behavioral, sociocultural, and structural risk factors and mechanisms of the leading causes of severe maternal morbidity and maternal mortality. Community partnerships are central to the development and success of the centers. Components of the Maternal Health Research Centers of Excellence may include:

- Maternal Health Research Centers
- A data hub that would provide technical assistance for data collection and analysis and provide data sharing and coordination across centers and hubs to the extent possible
- An implementation science hub that could serve as an expert resource for the centers and other researchers and provide implementation science research training opportunities for a diverse cadre of researchers

- The formation of equitable community partnerships to develop and test multi-level strategies to address maternal morbidity and mortality

In addition, NICHD's Maternal-Fetal Medicine Units (MFMU) Network responds to the need for well-designed clinical trials in maternal-fetal medicine and obstetrics. The MFMU conducts research focusing on high-risk pregnancies, especially related to preterm births, fetal growth abnormalities, and maternal complications, and during the pandemic MFMU Network investigators pivoted research resources to help inform future studies of how COVID-19 affected maternal health and pregnancy. These clinical trials help to inform the science on maternal health, which directly impact professional society recommendations for clinical care. Moreover, the Office of Research on Women's Health at NIH has created the NIH Maternal Morbidity and Mortality (MMM) Web Portal¹⁷². The goal of this web portal is to lead the discussion at NIH and beyond on MMM and act as a centralized hub for information related to this critical public health crisis. This web portal highlights research efforts at NIH and other U.S. Department of Health and Human Services (HHS) agencies, provides key federal resources, and contains a collection of trustworthy, science-based resources relevant to maternal health across the lifespan for scientists, researchers, consumers, and advocates. Lastly, women experience depression and anxiety, as well as other mental health conditions, during pregnancy and after the baby is born. The NICHD-led Moms' Mental Health Matters initiative is designed to educate families and health care providers about who is at risk for depression and anxiety during and after pregnancy, the signs of these problems, and how to get help.¹⁷³ These are just a few specific examples of how our new initiatives and existing programs support moms-to-be.

NICHD's Research for Healthy Pregnancies

I am a firm believer that we need to do everything we can to ensure everyone has the resources and tools they need to have a healthy pregnancy. For example, that could include robust support systems and the use of doulas.

Question:

2. Dr. Bianchi, can you speak to how the NICHD's research contributes to positive advancements to benefit healthy pregnancies for moms-to-be and moms?

NIH Response:

The National Institutes of Health (NIH) is working to generate the scientific research that will lead to changes in clinical practice and results for pregnant women. For example, researchers funded by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) developed a new ultrasound imaging technique to track maternal blood flow to the placenta. This technology uses conventional ultrasound equipment to assess the

¹⁷² <https://orwh.od.nih.gov/mmm-portal>

¹⁷³ www.nichd.nih.gov/ncmh/initialives/moms-mental-health-matters/moms/Pages/default.aspx

pulsation of fetal blood through arteries at each end of the umbilical cord. This could help diagnose several common complications in early pregnancy, which could alert physicians to increased need for fetal monitoring or early delivery. In another NICHD funded study, researchers found that vaccine hesitancy is associated with distrust in medical professionals and the medical system. However, advice from medical professionals such as doulas and midwives, may be viewed as more trustworthy by those who have a general mistrust in the medical system. To study this, NICHD funded researchers found that a program that combined maternity care, substance use disorder treatment, peer and doula support, and case management in a single setting was associated with reductions in child maltreatment and placement of children in foster care, increases in prenatal visits, reductions in preterm births, reductions in intensive neonatal care, and increased engagement in substance use disorder treatment.

Furthermore, the Office of Research on Women's Health's Understudied, Underrepresented, and Underreported (U3) supplement program supports research on populations of women historically understudied, underrepresented, and underreported in biomedical research. Several projects related to Maternal Morbidity and Mortality have been funded within the program over the last five years. NIH is deploying its Pathways to Prevention Program (P2P)¹⁷⁴ to address postpartum health, disease, and death with a public workshop meant to identify research gaps and a federal partners meeting (planned for Fall 2022), where stakeholders from across the U.S. government will come together and develop plans to coordinate efforts. We expect this P2P effort to impact research and policy related to addressing the maternal health crisis for all pregnant persons, especially for those at greatest risk for poor outcomes, including Black and Indigenous individuals.

ARPA-H and Black Communities

I am excited to see the long term impacts of a program such as ARPA-H. We need to dream big to achieve big. I am also curious as to how investments in ARPA-H will positively benefit Black communities, who have far worse health outcomes than average.

Question:

3. Dr Tabak, could you explain how investments in ARPA-H will benefit Black and underserved communities, and what steps ARPA-H will take to ensure they are not left behind?

NIH Response:

The coronavirus disease 2019 (COVID-19) pandemic highlighted long-standing health disparities and disproportionate impact of illness and death in Black communities in the United States. Prior to the pandemic, Black Americans experienced higher rates of morbidity and mortality related to heart disease, cancer, diabetes, hypertension, asthma, and maternal health among other diseases and conditions. .

¹⁷⁴ prevention.nih.gov/research-priorities/research-needs-and-gaps/pathways-prevention

ARPA-H is designed to provide leadership for high-risk, high-reward biomedical and health research to speed application and implementation of health breakthroughs equitably. Equity considerations are woven throughout the ARPA-H mission as an essential element of its programs, operations, and performers. All programs and projects will consider equity in their design and implementation and stakeholders will be engaged early in program design, development, and implementation as appropriate.

To fully realize health equity, innovation needs to go beyond developing new drugs and devices, including diagnostics. Innovative solutions are needed to improve delivery of better prevention and interventions that are aligned with the needs of Black communities, and structural racism in health care delivery systems must be overcome. Meeting people where they are is essential to understanding their needs.

Health Disparities Research

I represent one of two majority-minority districts in Michigan. The COVID-19 pandemic worsened the huge health disparities experienced by Black and underserved communities. I am heartened by the Biden Administration's efforts to tackle many of these issues, with a \$350 million increase to look at health disparities.

Question:

4. Dr. Tabak, how will the National Institute on Minority Health and Health Disparities work to identify the root causes and provide us information on what changes are needed to tackle health disparities?

NIH Response:

The National Institute on Minority Health and Health Disparities (NIMHD) is committed to their mission to lead scientific research to improve minority health and reduce health disparities.

Health disparities (HD) are differences in health and health outcomes that are rooted in social disadvantage and being underserved in health care. They are multifactorial and may emerge due to differences in adverse environmental exposures, behaviors developed within societal, cultural, environmental contexts, differences in access to high quality treatment or therapy in health care systems, patient-clinician communication challenges, immigration status, violence, literacy/language fluency, transportation, stressors, and employment, as well as biological mechanisms that mediate these differences.

In collaboration with other National Institutes of Health (NIH) Institutes and Centers (ICs), NIMHD developed the NIH Minority Health and Health Disparities Strategic Plan (2021-2025).¹⁷⁵ The strategic plan describes scientific goals with related research strategies and priority areas that represent key opportunities and needs to advance minority health and health disparities research. The strategic plan represents a commitment by all of NIH to support

¹⁷⁵ www.nimhd.nih.gov/docs/nimhd-strategic-plan-2021-2025.pdf

research aimed at addressing the risk and protective factors that operate and interact on multiple levels to impact the well-being of populations experiencing health disparities.

To continue the efforts of addressing health disparities, NIMHD leads the advancement of science on minority health and health disparities through several initiatives. The NIMHD Research Framework is a model that depicts a wide array of health determinants relevant to understanding and addressing minority health and health disparities and promoting health equity. NIMHD is supporting community and digital healthcare interventions to advance research to understand the social, behavioral, and economic health impacts associated with COVID-19–related disparities among racial and ethnic minorities and other vulnerable groups. The Community Engagement Alliance (CEAL) Against COVID-19 Disparities and the Rapid Acceleration of Diagnostics for Underserved Populations (RADx-UP) are two initiatives to further address COVID-19 among the populations impacted disproportionately by the pandemic. The CEAL initiative provides science-based information through active community engagement and outreach with a goal of addressing mistrust surrounding COVID-19 clinical trial research and vaccines, and RADx-UP focuses on increasing access to and uptake of COVID-19 testing. NIMHD also supports research that advances the understanding, prevention, and reduction of pregnancy-related complications and death among racial and ethnic minority women and socioeconomically disadvantaged women, including those in rural settings. The Structural Racism and Discrimination (SRD) initiative supports observational research to understand SRD in causing and sustaining health disparities, and intervention research to address these factors to improve minority health and/or reduce health disparities. NIMHD Multiple Chronic Disease Centers is an initiative that supports regional comprehensive research centers for the prevention, treatment, and management of chronic diseases associated with health disparities. In addition, NIMHD supports cutting-edge interdisciplinary research focused on examining pathways and mechanisms through which social factors and social environments might alter gene expression and contribute to health disparities in different populations. A new NIH Common Fund the Community Partnerships to Advance Science for Society (ComPASS) program supports efforts by community organizations to develop, implement, assess, and disseminate community-led, health disparities interventions, in partnership with research organizations, that intervene upon structural factors that produce and perpetuate health disparities.

Submitted by Rep. Andy Harris***Pro-Life Concerns*****Question:**

Dr. Fauci, does the physical and genetic life of a human being begin at conception?

NIH Response:

The question of when life and personhood begin is a matter for experts in fields such as fetal development, ethics, and theology to debate. Respectfully, I defer to the experts in the aforementioned fields to provide you with a comprehensive assessment of this issue.

Fetal Tissue Research

National Institutes of Health (NIH) expects to spend \$88 million on research using human fetal tissue obtained from abortion babies in FY22. It spent \$82 million in 2020 and \$109 million in 2019.

Are you aware that, as of June 2021, there were at least 4,188 ongoing or completed clinical trials using adult stem cells listed on the NIH/FDA-approved website? Fetal tissue research, on the other hand, is ineffective. It has not produced a single clinical treatment, despite being used in clinical research since the 1920s.

Question:

Why is NIH funding fetal tissue research when ethical alternatives for research and treatment are available?

NIH Response:

The National Institutes of Health's (NIH) mission is to seek fundamental knowledge about the nature and behavior of living systems and apply that knowledge to enhance health, lengthen life, and reduce illness and disability. Under its broad research mission, and as authorized by the Public Health Service Act, NIH conducts and funds research involving the study, analysis, or use of human fetal tissue for certain diseases and conditions, including retinal degeneration, pregnancy loss, early brain development, birth defects, and infectious disease. NIH policy requires that new and competing applications include a justification for the use of human fetal tissue, including when the research goals cannot be accomplished using an alternative model. Furthermore, NIH requires that NIH-supported recipient institutions certify that they will comply with applicable legal requirements and the NIH Grants Policy Statement (NIHGPS), including Section 4.1.14, Human Fetal Tissue Research. NIH also funds research to develop, demonstrate, and validate experimental models that are alternatives to the use of human fetal tissue. NIH-supported researchers rely on a variety of resources and technologies to answer complex biological questions. For example, in Fiscal Year (FY) 2021 (the most recent year for which

final funding information is available), NIH provided \$600 million in support for human nonembryonic stem cell research projects, \$713 million for human induced pluripotent stem cell research projects, and \$34 million for human umbilical cord blood or placenta stem cell research projects.

Fetal Tissue Research

In September 2021, Judicial Watch and Center for Medical Progress released records obtained by FOIA from the National Institutes of Health (NIH) regarding a \$1.5 million grant to the University of Pittsburgh to provide fetal tissue for research related to the genitourinary tract (kidneys, bladder, ureter, urethra, etc.). The FOIA documents raise concern that the university may have violated the law by altering abortion procedures solely for the purpose of obtaining fetal tissue or that aborted babies were born alive and killed by organ harvesting.

Question:

Who is reviewing the facts related to this case, and are you confident that the aborted babies from whom the fetal tissue was obtained were not killed by having their organs harvested? How would NIH respond if it learned that fetal tissue had been obtained by harvesting organs from living babies?

NIH Response:

The National Institutes of Health (NIH) does not comment on grant compliance and oversight activities related to its supported recipient institutions and/or supported investigators.

NIH requires that NIH-supported recipient institutions certify that they will comply with applicable legal requirements and the NIH Grants Policy Statement (NIHGPS). The NIHGPS Section 4.1.14, Human Fetal Tissue Research, incorporates, by reference, the Federal statutory requirements for research with human fetal tissue (HFT).^{176, 177} Section 498A of the Public Health Service Act (PHS) Act (42 U.S.C. 289g-1) sets forth specific requirements on research involving the transplantation of HFT; and Section 498B sets forth additional restrictions on the purchase and sale of HFT (42 U.S.C. 289g-2). Additionally the HHS Regulations for the Protection of Human Subjects (45 CFR Part 46) at subpart B, which falls under the jurisdiction of the Office for Human Research Protections, regulates research conducted or supported by HHS involving HFT, among other things, and requires that such research be conducted in compliance with any applicable federal, state, or local laws and regulations regarding such activities.¹⁷⁸ Moreover, when obtaining primary HFT for research purposes, NIH expects recipients and contractors to maintain appropriate documentation, such as an attestation from the health care provider or a third-party supplier, that informed consent was obtained at the time of tissue collection. When an application involving human fetal tissue research is submitted to NIH, the authorized organization representative's signature certifies that researchers using these tissues will comply with applicable legal requirements and the NIHGPS.

¹⁷⁶ [grants.nih.gov/grants/policy/nihgps/html5/introduction.htm](https://www.grants.nih.gov/grants/policy/nihgps/html5/introduction.htm)

¹⁷⁷ [grants.nih.gov/grants/policy/nihgps/html5/section_4/4.1.14_human_fetal_tissue_research.htm](https://www.grants.nih.gov/grants/policy/nihgps/html5/section_4/4.1.14_human_fetal_tissue_research.htm)

¹⁷⁸ www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html

NIH also requires that for competing grant applications proposing the use of human fetal tissue from elective abortions, applicants must address HFT requirements by providing a justification of the use of HFT, details regarding procurement and costs, and information about how the applicant will use HFT. These additional requirements can be found in the application instructions and must be met within existing applicable page limits. See specific instructions in section R.210.4 of the Research Instructions for NIH and Other PHS Agencies, Forms Version G.¹⁷⁹

Failing to comply with NIH terms and conditions of award may cause NIH to take one or more enforcement actions in accordance with 45 CFR 75.371 and NIHGPS Section 8.5.2 Remedies for Noncompliance or Enforcement Actions: Suspension, Termination, and Withholding of Support, including disallowing costs, withholding of further awards, or wholly or partly suspending the grant, pending corrective action.¹⁸⁰ NIH may also terminate the grant in whole or in part.

Congressional Oversight:

Many of my colleagues have complained of NIH's lack of response to letter inquiries. For example, members of the House Energy and Commerce Committee minority members have sent 7 letters to NIH regarding COVID origins, and only one of these letters received a response – which was a short, minimal response.

Question:

Can the NIH commit to responding to congressional inquiries in a timely manner?

NIH Response:

The National Institutes of Health (NIH) takes congressional oversight and our responsibility as stewards of public funds very seriously. As such, NIH is working as expeditiously as possible to respond to Congressional correspondence. The origins of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) have not been identified, despite intensive efforts. This is not unusual — determining the origins of a virus can be a long and complicated process and it can be difficult if not impossible to do so with 100 percent certainty. NIH strongly supports the need for additional thorough, expert-driven, and objective investigations into the origins of SARS-CoV-2.

The United States intelligence community examined all available intelligence reporting and other information on the origins of SARS-CoV-2 and assessed that the virus probably emerged and infected humans through an initial small-scale exposure. Four out of eight intelligence community elements and the National Intelligence Council assessed that the initial SARS-CoV-2 infection was most likely caused by natural exposure to an animal infected with it or a close

¹⁷⁹ grants.nih.gov/grants/how-to-apply-application-guide/forms-g/research-forms-g.pdf

¹⁸⁰ grants.nih.gov/grants/policy/nihgps/html/5/section_8/8.5_special_award_conditions_and_remedies_for_noncompliance_special_award_conditions_and_enforcement_actions.htm

progenitor virus—a virus that probably would be more than 99 percent similar to SARS-CoV-2. The intelligence community also noted that China’s cooperation most likely would be needed to reach a conclusive assessment of the origins of SARS-CoV-2.¹⁸¹

Based on currently available epidemiological and sequencing data, additional reports suggest that the ancestral strains to SARS-CoV-2 have a zoonotic origin with the closest genetically related viruses being beta coronaviruses,¹⁸² identified in *Rhinolophus* bats in China in 2013 and Laos in 2020. So far, neither the virus progenitors nor the natural/intermediate hosts or spill-over events to humans have been identified. While the origins of the pandemic are still unknown, as mentioned above, NIH strongly supports the need for continued expert-driven, and objective investigations into the origins of the COVID-19 pandemic.

ARPA-H

Question:

If ARPA-H is truly independent of NIH leadership and guidance, why are you testifying about how it will be structured, what models it may consider, and so forth?

NIH Response:

On March 15, 2022, President Biden signed into law P.L. 117-103, the "Consolidated Appropriations Act, 2022" (Appropriations Act), which established ARPA-H within the Department of Health and Human Services (HHS) and gave the Secretary authority to transfer ARPA-H within HHS. On April 15, 2022, Secretary Becerra transferred ARPA-H authorities administratively to the NIH as authorized by the Appropriations Act, and the notice of transfer was published in the Federal Register on April 20, 2022.

As part of the establishment of ARPA-H, the Secretary is seeking to identify an interim leader prior to the appointment of an inaugural Director. Ideally, this acting deputy director would have considerable experience in government—specifically familiarity with the “ARPA” model, broad technical and management experience across several disciplines, and a proven record innovating around experimental platforms and tools to facilitate discovery, quantification, and “big validation” of fundamental measures in science.

President Biden will appoint an ARPA-H Director who will be responsible for administration and operation of ARPA-H and who will report directly to Secretary Becerra. An ideal candidate would be an extraordinary leader with a vision and proven track record for driving transformative change in health and biomedicine, a strong private sector background, and experience in academia or government. The candidate should be diplomatic, an avid advocate for ARPA-H, and have a proven ability to build partnerships.

¹⁸¹ www.dni.gov/files/ODNI/documents/assessments/Unclassified-Summary-of-Assessment-on-COVID-19-Origins.pdf

¹⁸² cdn.who.int/media/docs/default-source/scientific-advisory-group-on-the-origins-of-novel-pathogens/sago-report-09062022.pdf

ARPA-HQuestion:

The median age of R01 researchers is still increasing despite our discussion for many years now about the importance of bringing this age down due to the peak age of discovery and toward supporting high risk-high reward research. If NIH can't bring down the R01 age, why should it have any form of structural oversight to an agency whose entire purpose rests upon breaking traditional norms to achieve scientific breakthrough?

NIH Response:

The Advanced Research Projects Agency for Health (ARPA-H) is designed to make pivotal investments in break-through technologies and broadly applicable platforms, capabilities, resources, and solutions that have the potential to transform important areas of medicine and health. ARPA-H is designed to address well-defined problems through high-risk, high-reward approaches, not currently undertaken through traditional research or commercial activity. It will fund the best ideas, from a myriad of performers across all sectors regardless of career level, using many different mechanisms and do so as fast as possible, ranging from weeks to months. As such, ARPA-H is designed to break the traditional norms around biomedical funding.

ARPA-H's success is predicated on attracting talented staff, both as program managers from industry and academia, but also the support staff such as contracting, human resources, stakeholder engagement, etc. The organization's structure is meant to be flat to enable every employee to achieve its mission. Everyone at ARPA-H needs to be empowered to be an engine of innovation—not just the program managers. Solving problems in the health care space requires the best minds and best ideas.

The Secretary of Health and Human Services transferred ARPA-H authorities to the National Institutes of Health (NIH). The ARPA-H Director will report to the Secretary directly and act independently. In the transfer notice published in the Federal Register on April 20, 2022, the Secretary made clear that NIH may not subject ARPA-H to NIH policies.

Intellectual Property Management

The National Institutes of Health (NIH) of health have made a purchase order for software to support the management of intellectual property owned by the Institutes. Fulfillment of that order is well beyond the scope initially proposed by the current contractor, leaving NIH having spent significant taxpayer resources without a product that is usable NIH-wide for technology transfer. NIH had requested that the system be ready to launch by August 2019. However, the software has only been made available in a test environment, and less than 20% of anticipated users currently have access to that system. This software system is now more than two years overdue for delivery to serve the NIH's critical needs and the taxpayers who funded this project. Further, the software being developed for use across the Institutes is not implemented by a provider that

meets FedRAMP standards. FedRAMP is the “gold standard” of data security to protect government systems’ most critical and valuable information.

Question:

How much has the NIH spent to date to develop and implement the system licensed for NIH-wide technology transfer and intellectual property management related to (NIH) (PIID 5N93019P00220), and what is the expected expenditure for the remainder of the agreement? At what stage is the project currently, and what is the best delivery date estimate?

Considering foreign adversaries’ cybercrime attempts at U.S. government systems, what is the NIH’s plan for implementing procurement processes related to FEDRAMP-authorized systems? Has the NIH considered adding FedRAMP security requirements to this existing agreement (NIH) (PIID 5N93019P00220) or the software systems provided under that agreement? Does the NIH see fit to recompetitively this agreement with new requirements for providers to be FedRAMP authorized? If the NIH intends to supplement the security requirements of this system with further security protections, does NIH intend to purchase that security system or develop it in-house?

NIH Response:

Given the cyber threats of today and the federal requirements and guidance related to cloud services, the National Institutes of Health (NIH) has integrated FedRAMP into our acquisition processes for cloud contracts. Per the FedRAMP.gov website, the FedRAMP program provides “a standardized approach to security and risk assessment for cloud technologies and federal agencies.” Essentially, FedRAMP compliance confirms that a Cloud Service Provider (CSP) has implemented security best practices that have been approved by the Federal government.

The software supplied by the vendor in Purchase Order 75N93019P00220 was one part of a multi-year effort for the entire NIH Enterprise Technology Transfer (ETT) system. In the case of the NIH ETT system, the solution selected was to obtain cloud services from Amazon Web Services (AWS) via the Science and Technology Research Infrastructure for Discovery, Experimentation, and Sustainability (STRIDES) Initiative within the NIH Center for Information Technology (CIT). The software provided under Purchase Order 75N93019P00220 will sit on the cloud as part of the larger NIH ETT system. Cyber security and FedRAMP compliance are handled by AWS as part of the cloud contract, therefore FedRAMP compliance is not necessary for individual components since these are addressed by the overall ETT system’s FedRAMP compliance. NIH does not plan to recompetitively this agreement.

To date, NIH has awarded \$988,188.06 in the performance of this Purchase Order. One option period remains in the amount of \$220,289.87. The vendor developed and delivered a solution that satisfied all functional requirements of the solicitation to the NIH stage environment within the 6-month timeframe as stated in the solicitation. The solicitation did not address the time frame in which NIH will deploy the solution, only that the solution be provided by the vendor to NIH within 6 months.

NIH is working towards deploying the software to users. NIH is pleased with the performance of the system to date.

T-Cell Mediated Immunity

Recently, more than 60 members of the scientific community, including current and former HHS officials, academic researchers, and biotech executives, sent a letter to the FDA to urge the agency to assess T-cells, in addition to antibodies, in vaccine evaluations and studies. The signers of the letter argue understanding the level of T-cells produced by the COVID-19 vaccines would help public health experts and policy makers better evaluate the efficacy of the vaccines, which in turn could help strengthen the public health response to the pandemic.

Question:

To that point, how could assessing cellular immunity, particularly T-cells, enable public health experts, including epidemiologists, virologists, and physicians, to better understand questions related to vaccine schedules and vaccine effectiveness, particularly against severe disease and death?

Question:

How can NIAID effectively collaborate and partner with FDA to work to include T-cell assessment in vaccine studies and analyses? How can NIAID support efforts to integrate T-cell data into vaccine, booster, and other public health decisions at FDA and CDC?

NIH Response:

T cells are an important component of the immune response to vaccination and infection. Longitudinal assessment of T cell prevalence and function following vaccination, in association with epidemiological data, may help determine the relative strength and longevity of the immune response to vaccination. These data would help to inform decisions related to vaccine and booster schedules. National Institute of Allergy and Infectious Diseases (NIAID) investigators work to integrate T cell data into vaccine and booster research, including in clinical studies and pre-clinical challenge studies for COVID-19 vaccine candidates. The results of these clinical and pre-clinical studies may be used to support applications to the U.S. Food and Drug Administration (FDA) for emergency use authorization or approval. For example, NIAID is leading a study in fully vaccinated individuals to assess the safety and immune responses (including T cell responses) following boosting with a COVID-19 vaccine different than the one used for the initial vaccination ("mix and match"). NIAID released early data from this trial demonstrating that administering the Pfizer, Moderna, or Johnson & Johnson/Janssen COVID-19 vaccines at least 12 weeks after individuals received a different vaccine regimen enhanced the immune response to SARS-CoV-2, including the T cell response. The results of this trial were made available to FDA during FDA's decision-making process to authorize the use of a single booster dose as a heterologous booster dose in eligible

individuals following completion of primary vaccination with a different authorized or approved COVID-19 vaccine for persons 18 years of age and older. In addition, NIAID is supporting a Phase 1 clinical trial in healthy adults to assess the safety and immunogenicity of COVID-19 vaccine candidates developed by Gritstone Oncology, Inc., that utilize a strategy aimed at inducing both neutralizing antibodies and T cell responses to elicit a broad immune response against conserved viral antigens.

The NIAID Vaccine Research Center also has established the Pandemic Response Repository through Microbial/Immune Surveillance and Epidemiology (PREMISE) program. The program will use data from the measurement of T and B cell immune responses to inform the discovery and development of diagnostic, prophylactic, and therapeutic countermeasures and accelerate the global response to pandemic threats. NIAID anticipates the research conducted by PREMISE will advance our knowledge of the immune response to vaccination and infection and help inform the response to future pandemic threats.

T-Cell Mediated Immunity

A recent paper in *Science Immunology* [“*Understanding T-cell responses to COVID-19 is essential for informing public health strategies*”] discusses the need to understand the complete immune response to COVID-19 to inform public health policies and interventions. With each new variant that emerges, we see that the lack of population-level data on how our immune systems respond - not just antibodies but also T-cells - is limiting our ability to inform policies.

Question:

Given that questions about efficacy of COVID-19 vaccines and the need for boosters can only be answered by understanding both T-cells AND antibodies, how do we ensure that T-cell analysis is fully included in research decisions for vaccines and boosters going forward?

How can NIAID ensure T-cell data is incorporated into its ongoing research to combat the pandemic, including the effectiveness of vaccines and prior infection against new variants?

NIH Response:

NIAID continues to conduct and support research to improve understanding of the role of T cells in protection against COVID-19 and COVID-19 disease progression. NIAID supported a collaborative longitudinal study by researchers at Emory University and the Fred Hutchinson Cancer Research Center that demonstrated that SARS-CoV-2-specific T cells were detectable for up to eight months in patients after mild to moderate COVID-19. NIAID also supported two separate studies examining T cell responses in recovered COVID-19 patients and individuals vaccinated against COVID-19. They found robust immune responses to the original strain as well as multiple variants of SARS-CoV-2 in both groups. Additional work by NIAID researchers and grantees showed that most individuals with existing T cell responses against SARS-CoV-2 should generate a T cell response against the Omicron variant,

and that SARS-CoV-2 has thus far not evolved extensive T cell escape mutations. Other work from NIAID-supported investigators has shown that vaccine-induced T cell responses recognize the Omicron variant. In another NIH-supported study, researchers uncovered features of T cells that distinguish fatal from non-fatal cases of severe COVID-19, which could help harness knowledge of T cells to inform new potential treatments for this disease.

Question:

How can NIAID ensure T-cell data is fully integrated into its RECOVER research initiative for those suffering from prolonged symptoms following a COVID infection?

With each new variant that emerges, we see that the lack of population-level data on how our immune systems respond - not just antibodies but also T-cells - is limiting our ability to inform policies.

NIH Response:

Assessment of T cell function after SARS-CoV-2 infection may provide important clues to disease mechanisms, diagnosis, and treatment of post-acute sequelae of SARS-CoV-2 infection (PASC), including Long COVID. In recognition of this, the NIH Researching COVID to Enhance Recovery (RECOVER) Initiative includes studies of the pathobiological mechanisms underlying PASC, including studies characterizing the cellular immune response to SARS-CoV-2. Importantly, RECOVER also includes collection, analysis, and biobanking of serum and peripheral blood mononuclear cells (PBMC), including T cells, from adult and pediatric study participants during the project. A RECOVER Consortium expert committee is monitoring the state of the science regarding immunologic responses to SARS-CoV-2 infection and the best technical approaches for characterizing those responses as well as evaluating optimal approaches for cell-based assays for the RECOVER serum and PBMC samples. RECOVER core immunophenotyping laboratories will conduct the recommended T cell function assays utilizing the biobanked specimens. These analyses will provide a unique resource for correlation of PASC clinical symptoms with deep clinical phenotyping in the RECOVER cohorts as well as for studies by the broader research community.

Question:

Given that questions about efficacy of COVID-19 vaccines and the need for boosters can only be answered by understanding both T-cells AND antibodies, how do we ensure that T-cell analysis is fully included and considered in decisions related to vaccines and boosters going forward?

NIH Response:

The National Institute of Allergy and Infectious Diseases (NIAID) defers to the U.S. Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) to discuss the inclusion of these data into decisions made by these agencies on the authorization, approval,

and recommendation of COVID-19 vaccine regimens. NIAID will continue to make all data from intramural research studies investigating the immune response to primary and booster vaccines and SARS-CoV-2 infection, such as the ones described in the responses to questions 8 and 9 above, available to the FDA and CDC for their consideration.

Submitted by Rep. Chuck Fleischmann

Undiagnosed Disease Network Program

For the past decade, the UDN program has been helping patients with rare and undiagnosed conditions find answers and, for many, an informed path toward treatment. Often these families and individuals have been on a diagnostic odyssey, having seen countless medical professionals unable to give them a full picture of their rare or unknown medical condition.

Question:

3. What went into the NIH's decision to cease funds for the 12 UDN academic medical centers?
4. What is the NIH's plan on supporting the network of UDN sites once the Common Fund support expires?
5. How can we help develop a plan to sustain the work of the UDN going forward?

NIH Response:

The Undiagnosed Disease Network (UDN) was always planned for 10 years – the maximum period of support for Common Fund programs. In Phase II of the program (starting in 2018), the UDN was tasked with developing a framework to continue its mission after expiration of Common Fund support, ensuring sustained clinical utility for decades to come. For the final year of the program, the National Institutes of Health (NIH) will provide supplements and extensions to the UDN extramural clinical sites, Coordinating Center, and some Cores to ensure that all participants accepted by the end of the ninth year are evaluated as the program transitions to a larger, self-sustained network. Some sites have committed to continue enrollment during this period, and NIH is exploring means to enable other sites to continue to enroll new patients as well. The intramural Undiagnosed Disease Program, housed within the NIH Clinical Center and currently supported as a UDN clinical site, will continue to receive support and oversight from multiple NIH Institutes and Centers (ICs).

In addition, multiple NIH ICs released a notice of intent to publish a funding announcement to support a Data Management and Coordinating Center to provide infrastructure and research support for a new network of clinical sites. Clinical sites with the appropriate infrastructure, expertise, and resources needed to conduct the clinical evaluation and DNA sequencing of participants enrolled at their sites can apply for designation as a Diagnostic Center of Excellence. Diagnostic Centers of Excellence will have access to resources of the Data Management and Coordinating Center.

NIH is committed to the successful transition of UDN from the Common Fund and welcomes the opportunity to work with Congress to identify the best path forward. NIH's long-term vision is to see the Network continue to make important scientific discoveries while improving clinical practice for undiagnosed patients—regardless of geographic location or socioeconomic status. The broad impact of the UDN can be sustained through strategic partnerships with patient advocacy groups and other stakeholders and integration of the clinical strategies derived from UDN research into healthcare systems and public and private insurance policies.

Rare Cancers

My understanding is there are 380 rare cancers out of 400 total cancers, yet most of the cancer grant funding is directed to the most common cancers and few targeted treatments exist for rare cancer patients. Plus, much more can be done with data-sharing across agencies among NIH, DoD and the VA and with the use of molecular diagnostics of the patient's cancer tissue at first diagnosis that can advance research, care, and scientific understanding of what drives various forms of cancer. Without increased investment in rare cancer research, an end to the data silos, and expanded access to molecular diagnostics, we are leaving one-third of the newly diagnosed cancer patients per year completely neglected.

Question:

1. What is NIH (NCI and NCATS) doing to address this?

NIH Response:

The National Institutes of Health (NIH) remains committed to supporting research to advance the understanding of all cancers, including rare cancers, and to inform the development of targeted cancer therapies for rare cancers and rare subtypes of cancers, including pediatric cancers (all types and subtypes of pediatric cancers are considered “rare” by definition).

The cancer research community – thanks to NIH-supported developments in understanding the specific genes, proteins, and other unique molecular characteristics driving certain cancer subtypes – continues to recognize that cancer is made up of a collection of hundreds, if not thousands, of subtypes defined by these characteristics. As a result of National Cancer Institute (NCI)-supported efforts and other relevant research, “cancer” is increasingly becoming a collection of rare cancer subtypes.

This evolved understanding of cancer is reflected in NCI's current clinical trials portfolio and investments in translational and basic research, including several initiatives in the intramural Center for Cancer Research (CCR).

Increasingly, clinical trials are examining targeted therapies based on molecular subtypes. For example, NCI's National Clinical Trials Network (NCTN) is currently supporting trials assessing therapies to treat gliomas with certain genetic alterations¹⁸³ and pancreatic cancers with specific

¹⁸³ www.clinicaltrials.gov/ct2/show/NCCT00887146

gene alterations.^{184,185} NCI also supports trials that are dedicated to patients with rare tumors, including the NCTN-supported DART (Dual Anti-CTLA-4 and Anti-PD1-Blockade in Rare Tumors) Trial¹⁸⁶ and the Rapid Analysis and Response Evaluation of Combination Anti-Neoplastic Agents in Rare Tumors (RARE CANCER) Trial,¹⁸⁷ which is supported by NCI's Experimental Therapeutics Clinical Trials Network.

To ensure that researchers have a strong pipeline of therapy candidates to consider for use in clinical trials, NCI supports several initiatives to support the preclinical stage of development of therapeutics to treat rare cancers, including the NCI Experimental Therapeutics (NeXT) Program and the Pediatric Preclinical Testing Consortium (PPTC). The mission of NeXT is to advance clinical practice and bring improved therapies to patients with cancer by supporting the most promising new drug discovery and development projects. The PPTC addresses key challenges associated with the development of new therapies for children with cancer by developing reliable preclinical testing data for pediatric drug candidates that can be used to inform new agent prioritization decisions.

The first step in identifying new therapeutic targets, however, is elucidating the basic biological mechanisms that give rise to cancers. To further these research efforts, NCI supports the development of resources for broad use across the cancer research community. These resources include cell lines, organoid models, patient-derived xenograft (PDX) models, biospecimens, and other biological samples. NCI makes drug information summaries available on its website, along with extensive cancer treatment summaries. Additional resources include the Developmental Therapeutics Program, the National Clinical Trials Network (NCTN) Navigator, Patient-Derived Xenograft (PDX) Centers, PDX Finder, the NCI Mouse Repository, and the Physician Data Query (PDQ) Database. A more extensive list is available at www.cancer.gov/research/resources/.

Additionally, the Rare Tumor Patient Engagement Network, launched in fiscal year (FY) 2018 and part of NCI's CCR, leverages the resources of the NCI intramural research program and the NIH Clinical Center to bring together investigators, patients, and advocacy groups to study rare tumors. Under the umbrella of this effort, NCI launched the My Pediatric, Adolescent, and Adult Rare Tumor (MyPART) Network, a collaboration of scientists, patients, family members, advocates and healthcare providers to find treatments for rare cancers.¹⁸⁸ The MyPART Network collects samples like blood, saliva, and archived biopsy tissue from people with rare solid tumors as part of the Natural History Study of Rare Solid Tumors.¹⁸⁹ The purpose of the study is to engage rare tumor patients and their families in the research process, study how rare tumors grow, track participants' health history over a long period of time, share data with other scientists, build new ways of testing new treatments, and design new clinical trials for rare cancers. MyPART scientists also hold clinics on rare tumors to facilitate collaborations between

¹⁸⁴ www.clinicaltrials.gov/ct2/show/NCT04858334

¹⁸⁵ www.clinicaltrials.gov/ct2/show/NCT04548752

¹⁸⁶ www.clinicaltrials.gov/ct2/show/NCT02834013

¹⁸⁷ www.clinicaltrials.gov/ct2/show/NCT04449549

¹⁸⁸ www.cancer.gov/pediatric-adult-rare-tumor/

¹⁸⁹ clinicaltrials.gov/ct2/show/NCT03739827/

researchers, patients, and advocacy organizations; to date, MyPART has hosted clinics on chordomas, SDH-deficient gastrointestinal stromal tumors, and medullary thyroid cancer, and more clinics are in the planning stages. Additionally, the NCI Comprehensive Oncology Network Evaluating Rare CNS Tumors (NCI-CONNECT) program aims to advance the understanding of rare adult central nervous system (CNS) cancers by establishing and fostering patient-advocacy-provider partnerships and networks to improve approaches to care and treatment; seven clinical studies and trials are currently open through NCI-CONNECT.¹⁹⁰

NCI recognizes that sharing genomic, epidemiologic, and clinical data is essential to advancing progress for cancer patients. As part of the Cancer MoonshotSM, NCI is developing a National Cancer Data Ecosystem to enable and encourage all participants across the cancer research and care continuum to share, access, combine, and analyze diverse data sets. Elements of this cloud-based ecosystem already in place include the NCI Genomic Data Commons, the Proteomic Data Commons, the Data Commons Framework, and NCI Cloud Resources. To enhance the Cancer Research Data Commons, NCI is also developing the Imaging Data Commons, the Center for Cancer Data Harmonization, and the Cancer Data Aggregator.¹⁹¹

Complementary to these efforts, the goal of NCI's Childhood Cancer Data Initiative (CCDI), launched in FY 2020, is to link clinical care and research data, including genomic data, on pediatric cancers to more rapidly identify potential therapeutic strategies for patients. Specifically, the CCDI aims to gather data from every child, adolescent, and young adult diagnosed with pediatric cancer; create a national strategy of appropriate clinical and molecular characterization to speed diagnosis and inform treatment for all types of pediatric cancer; and develop a platform and tools to bring together clinical care and research data that will improve preventive measures, treatment, quality of life, and survivorship for all pediatric cancers.¹⁹² NCI hopes to eventually apply the CCDI model to other cancer types.

Because of these and similar investments, the U.S. Food and Drug Administration (FDA) has approved a number of therapies in recent years for patients with rare cancer subtypes and related conditions. For example, in May 2021, the FDA granted accelerated approval to sotorasib (Lumakras) for patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with alterations in the *KRAS G12-C* gene, a mutation which is present in only 13.8 percent of NSCLC patients.¹⁹³ Similarly, the FDA approved selumetinib (Koselugo) in 2020 for the rare tumor condition neurofibromatosis type 1, in patients over the age of two, as the first approved treatment for this condition. In 2018, the FDA granted accelerated approval to larotrectinib (Vitrakvi) for adult and pediatric patients with solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion. NTRK gene fusions are prevalent in nearly all cases of certain rare cancer subtypes, including secretory carcinoma of the breast or salivary gland and infantile fibrosarcoma; they have also been observed in some patients with more common types of cancer, such as glioma, melanoma, and carcinomas of the thyroid, lung, and colon.¹⁹⁴ The approval of

¹⁹⁰ www.cancer.gov/rare-brain-spine-tumor/refer-participate/clinical-studies

¹⁹¹ www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative/implementation/data-ecosystem

¹⁹² www.cancer.gov/research/areas/childhood/childhood-cancer-data-initiative

¹⁹³ ascopost.com/news/january-2021/prevalence-of-kras-g12c-somatic-mutations-by-cancer-type-race-and-sex/

¹⁹⁴ www.ncbi.nlm.nih.gov/pmc/articles/PMC6859817/

larotrectinib marked the second time that the FDA granted approval for a therapy based on a molecular driver of cancer, rather than the site in the body that it originates. The first such “tissue agnostic” approval occurred just a year earlier, when the FDA granted accelerated approval to pembrolizumab for adult and pediatric patients with microsatellite instability-high or mismatch repair deficient solid tumors.¹⁹⁵ These approvals are built upon decades of NCI investments in describing the genetic and cellular mechanisms that give rise to cancer.

NIH will continue to support research efforts that reflect the scientific understanding of the many subtypes of cancers, including work that will enable the development of therapies for rare tumor subtypes.

Xenotransplantation

There is an unfortunate and overwhelming shortage of health organs in this country. Statistics show that over 100,000 men, women, and children are currently on the national transplant waiting list. Our traditional cadaveric and living organ donation process has become increasingly inadequate to meet the needs.

Question:

1. What is the NIH doing to develop protocols and research into this area given the shortage of organs readily available for patients in need?

NIH Response:

Xenotransplantation, transplantation between different species, may provide a solution to the shortage of human donor organs and tissues that has limited the benefits of transplantation. The National Institutes of Health (NIH) has long supported research into overcoming the hurdles to safe xenotransplantation. Major challenges include immune responses of the recipient against the donor organ and the potential for transfer of infectious agents from the donor to the recipient. Because their organs are a suitable size for humans, research has focused on the development of pigs that are genetically modified to reduce the chances of rejection by the human recipient and transfer of viruses from the pig organ. Using gene editing technology to inactivate porcine endogenous retroviruses in the pig genome,¹⁹⁶ NIH supported researchers developed pigs that would not transmit those viruses to human recipients. Researchers supported by the National Institute of Allergy and Infectious Disease (NIAID) and at the National Heart, Lung, and Blood Institute (NHLBI) also have developed immune-suppressing drug regimens that have allowed for prolonged survival of pig-to-non-human primate xenotransplants.¹⁹⁷

NIH continues to support research to advance xenotransplantation for many potential clinical applications. NIAID supports the Immunobiology of Xenotransplantation Cooperative Research

¹⁹⁵ www.fda.gov/drugs/resources-information-approved-drugs/fda-grants-accelerated-approval-pembrolizumab-first-tissue-agnostic-indication

¹⁹⁶ www.ncbi.nlm.nih.gov/pmc/articles/PMC5813284/

¹⁹⁷ www.nih.gov/news-events/nih-research-matters/long-lived-pig-primate-heart-transplants

Program,¹⁹⁸ which aims to develop preclinical porcine to nonhuman primate models of xenotransplantation. Current projects are focused on heart, liver, pancreatic islet, and kidney xenotransplantation.

¹⁹⁸ www.niaid.nih.gov/research/immunobiology-xenotransplantation-cooperative-research-program

Submitted by Rep. Herrera Beutler***Physician Scientists Research Funding NIDDK***

Physician-scientists have an important role in the biomedical research enterprise. Their experience allows them to focus on patient-oriented research and improve our understanding of clinical outcomes. This is especially true in pediatric and adult nephrology research supported by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), where physician-scientists traditionally comprised a significant portion of the biomedical research workforce. Despite their contributions to our understanding of chronic kidney disease and end-stage kidney disease, it is our understanding that the number of physician-scientists funded in this area has been declining.

Question:

1. Will NIDDK share the number of physician-scientists funded through the K08 and K23 mechanisms by the Division of Kidney, Urologic, & Hematologic Diseases over the last five years?

NIH Response:

Over the five-year period from Fiscal Year (FY) 2017 through FY 2021, the National Institute of Diabetes and Digestive and Kidney Diseases' (NIDDK) Division of Kidney, Urologic, & Hematologic Diseases supported 77 physician scientists with K08 grants and supported 96 physician scientists via K23 grants. Recognizing that physician-scientists are an essential part of the biomedical workforce, support for physician-scientist training continues to be a priority for the NIDDK. Indeed, the Institute's recent Strategic Plan¹⁹⁹ published in December 2021, affirms a commitment to foster the development of innovative approaches to attract and retain these individuals in NIDDK research mission areas.

2. What steps is the agency taking to reverse the downward trend in physician-scientists being funded if the data demonstrate a downward trend?

NIH Response:

The National Institutes of Health (NIH) is dedicated to strengthening and diversifying the biomedical research workforce, including for physician scientists. As part of this effort, NIH continues to address recommendations described in a 2014 report focused on the physician-scientist workforce from the NIH Advisory Committee to the Director (ACD).²⁰⁰ As the report notes and NIH agrees with, "findings which lead to advances in practice are driven largely by the work of investigators with a variety of degrees, of whom those with clinical training contribute essential knowledge and skills." Investing in research conducted by

¹⁹⁹ <http://www.niddk.nih.gov/about-niddk/strategic-plans-reports/niddk-strategic-plan-for-research>

²⁰⁰ acod.od.nih.gov/documents/reports/PSW_Report_ACD_06042014.pdf

physician-scientists is vital to discovery and innovation; these researchers help transform clinical observations into hypotheses and research findings into medical advances.

Selected examples of steps taken across NIH to address the ACD recommendations include the following:

- Supporting individual F30 fellowship dual-doctoral degree training at institutions with and without NIH funded Medical Scientist Training Programs.^{201,202}
- Evaluating career development (K)-award programs including the K08 Mentored Clinical Scientist Development Award and the K23 Mentored Patient-Oriented Research Career Development Award.^{203,204}
- Reissuing the Pathway to Independence Award (K99/R00) funding opportunity announcement with modifications to emphasize eligibility of physician-scientists.²⁰⁵
- Piloting institutional Research in Residency Programs with potential individual Transition Scholar support during fellowship at same or new institution.
- Releasing a Request for Information titled “RFI Strategies to Enhance Diversity in the Physician-Scientist Workforce”.²⁰⁶
- Leveraging the existing resources of the Clinical and Translational Science Award (CTSA) Program to obtain maximum benefit for training and career development of clinician scientists, including administrative supplements supporting dentists on KL2, new collaborations between CTSA and the National Institute of Biomedical Imaging and Bioengineering (NIBIB) to support biomedical engineers, and collaboration with One Health alliance to support veterinarians.^{207,208,209}
- Increasing the amount of loan repayment (from a maximum award amount of \$35,000/ year to \$50,000/year) to more realistically reflect qualified educational debt burden.
- Continuing to support T35 NRSA Short-Term Institutional Research Training Grant that provides short-term research training for students in health professional schools during the summer in focused, often emerging scientific areas.²¹⁰

Selected examples of programs specifically for physician scientists include:

- Research Experiences to Enhance Clinician-Scientists' Participation in NIDCDs Research (R25).²¹¹

²⁰¹ grants.nih.gov/grants/guide/pa-files/PA-16-305.html

²⁰² grants.nih.gov/grants/guide/pa-files/PA-16-306.html

²⁰³ grants.nih.gov/grants/guide/pa-files/PA-20-203.html

²⁰⁴ grants.nih.gov/grants/guide/pa-files/PA-20-206.html

²⁰⁵ researchtraining.nih.gov/index.php/programs/career-development/K99-R00

²⁰⁶ grants.nih.gov/grants/guide/notice-files/NOT-OD-16-027.html

²⁰⁷ ncats.nih.gov/ctsa/about/training

²⁰⁸ grants.nih.gov/grants/guide/pa-files/PA-18-426.html

²⁰⁹ www.ctsaonehealthalliance.org/resources/call-mentored-opportunities-ctsa-translational-research-fellows

²¹⁰ grants.nih.gov/grants/guide/pa-files/PA-18-404.html

²¹¹ grants.nih.gov/grants/guide/pa-files/PAR-21-188.html

- National Program for the Career Development of Physician Scientists in Diabetes Research (K12).^{212,213}
- The GEMSSTAR grant for early career medical/surgical specialists to transition to aging research (R03).²¹⁴
- The Stimulating Access to Research in Residency (StARR) (R38) and Stimulating Access to Research in Residency Transition Scholar (StARRTS) programs developed to support physicians with in-depth research opportunities during residency and subsequent clinical fellowship or early career faculty appointments.^{215,216}

Cellular Immunity and T-Cells

Congress included language in the FY 2022 appropriations bill encouraging NIAID to conduct additional research around cellular immunity for COVID-19 and requesting an HHS-wide assessment of the department's efforts to incorporate cell-mediated immunity measures.

Questions:

1. What is NIAID doing in response to the FY 2022 language to ensure cell-mediated immunity measures are incorporated into the Institutes' COVID-19 surveillance and research strategy?

NIH Response:

From the earliest days of the pandemic the National Institute of Allergy and Infectious Diseases (NIAID) has conducted and supported research to improve our understanding of the immune response to SARS-CoV-2 infection, including the role of T cells in protection against COVID-19 and COVID-19 disease progression. NIAID supported a collaborative longitudinal study by researchers at Emory University and the Fred Hutchinson Cancer Research Center that demonstrated that SARS-CoV-2-specific T cells were detectable for up to eight months in patients after mild to moderate COVID-19. NIAID also supported two separate studies examining T cell responses in recovered COVID-19 patients and individuals vaccinated against COVID-19. They found robust immune responses to the original strain as well as multiple variants of SARS-CoV-2 in both groups. Additional work by NIAID researchers and grantees showed that most individuals with existing T cell responses against SARS-CoV-2 should generate a T cell response against the Omicron variant, and that SARS-CoV-2 has thus far not evolved extensive T cell escape mutations. Other work from NIAID-supported investigators has shown that vaccine-

²¹² researchtraining.nih.gov/programs/career-development/K12

²¹³ grants.nih.gov/grants/guide/rfa-files/RFA-DK-21-019.html

²¹⁴ grants.nih.gov/grants/guide/rfa-files/RFA-AG-23-031.html

²¹⁵ grants.nih.gov/grants/guide/rfa-files/RFA-HL-18-023.html

²¹⁶ grants.nih.gov/grants/guide/rfa-files/RFA-HL-20-006.html

induced T cell responses recognize the Omicron variant. In another NIH supported study, researchers uncovered features of T cells that distinguish fatal from non-fatal cases of severe COVID-19, which could help harness knowledge of T cells to inform new potential treatments for this disease.

2. Additionally, what is NIAID doing to ensure it advances efforts to incorporate cellular immunity research, including T-cells, into NIH-supported studies related to COVID-19 vaccine schedules, understanding Long COVID, and COVID reinfection?

NIH Response:

T cells are an important component of the immune response to vaccination and infection. Longitudinal assessment of T cell prevalence and function following vaccination, in association with epidemiological data, may help determine the relative strength and longevity of the immune response to vaccination, as well as the role of T cells in protection against reinfection by new or existing variants. Assessment of T cell function after the acute stage of SARS-CoV-2 infection may provide important clues to disease mechanisms, diagnosis, and treatment of post-acute sequelae of SARS-CoV-2 infection (PASC), including Long COVID. In recognition of this, the NIH Researching COVID to Enhance Recovery (RECOVER) Initiative includes studies of the pathobiological mechanisms underlying PASC, including studies characterizing the cellular immune response to SARS-CoV-2. Importantly, RECOVER also includes collection, analysis, and biobanking of serum and peripheral blood mononuclear cells (PBMC), including T cells, from adult and pediatric study participants during the project. A RECOVER Consortium expert committee is monitoring the state of the science regarding immunologic responses to SARS-CoV-2 infection and the best technical approaches for characterizing those responses as well as evaluating optimal approaches for cell-based assays for the RECOVER serum and PBMC samples. RECOVER core immunophenotyping laboratories will conduct the recommended T cell function assays utilizing the biobanked specimens. These analyses will provide a unique resource for correlation of PASC clinical symptoms with deep clinical phenotyping in the RECOVER cohorts as well as for studies by the broader research community. Together, these studies will help us better understand the role of T cells in COVID-19 immunity, as well as help to inform decisions related to vaccine and booster schedules and potential treatments for PASC.

3. How is NIAID making the results of this research available to FDA, CDC, and other federal and state public health agencies that would benefit from integration of T-cell data into when making public health decisions?

NIH Response:

NIAID investigators will continue to integrate T cell data into vaccine and booster

research, including in clinical studies and pre-clinical challenge studies for COVID-19 vaccine candidates. For example, NIAID is supporting a Phase 1 clinical trial in healthy adults to assess the safety and immunogenicity of COVID-19 vaccine candidates developed by Gritstone Oncology, Inc., that utilize a strategy aimed at inducing both neutralizing antibodies and T cell responses to elicit a broad immune response against conserved viral antigens. In addition, the NIAID Vaccine Research Center (VRC) has established the Pandemic Response Repository through Microbial/Immune Surveillance and Epidemiology (PREMISE) program. The program will use data from the measurement of T and B cell immune responses to inform the discovery and development of diagnostic, prophylactic, and therapeutic countermeasures and accelerate the global response to pandemic threats. NIAID anticipates the research conducted by PREMISE will advance our knowledge of immune responses to vaccination and infection and help inform the response to future pandemic threats.

NIAID also is leading a study in fully vaccinated individuals to assess the safety and immune responses (including T cell responses) following boosting with a COVID-19 vaccine different than the one used for the initial vaccination (“heterologous booster dosing”). NIAID released early data from this trial demonstrating that administering the Pfizer, Moderna, or Johnson & Johnson/Janssen COVID-19 vaccines at least 12 weeks after individuals received a different vaccine regimen enhanced the immune response to SARS-CoV-2. The results of this trial were made available to the U.S. Food and Drug Administration (FDA) during FDA’s decision-making process to authorize the use of a single booster dose as a heterologous booster dose in eligible individuals following completion of primary vaccination with a different approved or authorized COVID-19 vaccine for persons 18 years of age and older. NIAID-supported scientists shared results of the “mix and match” study with the FDA Vaccines and Related Biological Products Advisory Committee during its public meeting on October 15, 2021, and with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices during its public meeting on October 21, 2021.

Children and COVID-19

In FY22, the Committee provided a \$7.5 million increase to NICHD to support increased research on the impact of multisystem inflammatory syndrome in children (MIS-C) and other ways in which COVID-19 specifically impacts children.

Questions:

1. How many research projects has NICHD funded to study the impact of COVID-19 on children?
2. What are the key findings of these studies thus far?

NIH Response:

The coronavirus disease 2019 (COVID-19) pandemic has affected millions of children across the United States. The *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) has funded at least 44 research projects in Fiscal Year (FY) 2021 that are focused on COVID-19 in pediatric populations. However, there are many additional such projects funded by other National Institutes of Health (NIH) Institutes, Centers and Offices that are administered by NICHD or have strong scientific involvement from NICHD staff but are not technically reported as NICHD-funded projects.

NICHD is leading studies of diagnostic testing, prevention, and treatment of COVID-19 in children, including Multisystem Inflammatory Syndrome in Children (MIS-C), a rare but severe condition that affects children after initial SARS-CoV-2 infection, and Post-Acute Sequelae of SARS CoV-2 infection (PASC). Scientific advances from NICHD research have identified biomarkers for MIS-C, assessed MIS-C treatment, and described how to reduce transmission in schools through masking, distancing, and test-to-stay strategies.

Moreover, NIH's Collaboration to Assess Risk and Identify loNG-term outcomes for Children with COVID (CARING for Children with COVID) program aims to better understand why symptoms vary among children with COVID-19 disease, and how to identify children at risk for severe illness from SARS-CoV-2 infection, including MIS-C. As part of the program, the NICHD-funded Pediatric Trials Network (PTN) supported research studies focused on the dosing and safety of drugs currently being used to treat children with COVID-19 such as remdesivir. Furthermore, the NICHD-led project—Predicting Viral-Associated Inflammatory Disease Severity in Children with Laboratory Diagnostics and Artificial Intelligence (PreVAIL kIds), which is part of the Rapid Acceleration of Diagnostics (RADx) Radical (RADx-rad) program, —aims to encourage development of cutting-edge approaches to understand the differences between MIS-C, Kawasaki disease, and other febrile illnesses, as well as developing point-of-care diagnostics to predict which children are at risk for developing MIS-C after their initial SARS-CoV-2 infection.

NICHD-supported scientists assessed interventions to prevent and treat COVID-19 in children throughout the pandemic. Beginning in pregnancy, researchers showed that current vaccines to prevent COVID-19 generate high responses in producing antibodies in pregnant people, resulting in more antibodies than what is generated from a natural SARS-CoV-2 virus infection. Moreover, antibodies produced in the mother after vaccination are present in breast milk and travel across the placenta, indicating that vaccination during pregnancy also conferred immunity to newborns. However, early results in one study indicated that women who were not vaccinated and were infected with SARS-CoV-2 may have increased risk of having offspring with neurodevelopmental diagnoses. Studies on the longer-term effects of infection in pregnancy and infancy are ongoing.

NICHD is also managing the Safe Return to School Diagnostic Testing Initiative, a part of the Rapid Acceleration of Diagnostics Underserved Populations (RADx-UP) program. It supports development of diagnostic tools and facilitates testing through clinical studies in real-world

settings, focusing on underserved populations to help administrators, educators, and families and students—including students with disabilities—return to school safely in the context of COVID-19. Findings from this effort showed that COVID-19 diagnostic testing approaches can help safely return children and staff to in-person learning, including in underserved and vulnerable communities. Researchers also showed that similar strategies could be effectively adapted to keep children with disabilities safe and in school.

Researchers also are focused on better understanding the impact of the pandemic among populations already stressed due to other health crises, poverty, and racism. These projects, which focus on children and adolescents from low-income families of color, include COVID-19's effect on substance use among American Indian adolescents; trauma-informed intervention to improve mental health and school success for urban eighth graders; preventive models on parent adjustment, parent-child relational health, and child psychosocial development post COVID-19. Likewise, NICHD funded researchers are examining the mental and emotional impact on children who experience the sudden loss of a parent due to COVID-19 complications. A study found that between 37,300 and 43,000 children have lost a parent to COVID-19. Black children were disproportionately affected, comprising only 14 percent of U.S. children but 20 percent of those who lost a parent to COVID-19.

These are a few examples of the key research findings from NICHD funded research studying the impact of COVID-19 on children.

Perinatal and Youth Marijuana Usage NASEM Study

In FY 22, the Committee included the following language in House Report 117-96:

Underage and Perinatal Marijuana Use. —The Committee includes \$2,000,000 for NIDA to enter into a contract with NASEM to commission a study to determine the scope of the problem of underage and perinatal marijuana use and effective ways of reducing it. Topics explored should include but not be limited to the demographics of underage and perinatal marijuana use; its economic and social costs; adolescent and perinatal decision making and risk and protective factors; and the effectiveness of various prevention programs and approaches, including media campaigns, school-based education, pricing, and access. The NAS will develop a strategy for reducing and preventing underage and perinatal consumption of today's marijuana and THC products, specifically focused on the impacts of THC on the developing brain. To help develop an effective strategy, the NAS shall review existing Federal, State, and non-governmental programs, including media-based programs, that have been shown to be effective with other substances that can be harmful to youth, including any done on marijuana, that are designed to change the attitudes and health behaviors of youth (those under the age of 21). In addition, the NAS shall review existing Federal, State, and non-governmental programs including media-based programs, that have been shown to be effective with other substances that can be harmful to babies of pregnant and breast-feeding women, including with any completed on marijuana, that are designed to change the attitudes and health behaviors of pregnant and breast-feeding women. Based on its reviews, the NAS shall produce a strategy designed to prevent and reduce underage consumption of today's marijuana and THC products in addition to a strategy

designed to prevent and reduce consumption of today's marijuana and THC products by pregnant and breast-feeding women. This shall include but not be limited to: an outline and implementation strategy, message points that will be effective in changing the attitudes and health behaviors of youth concerning underage marijuana consumption and an outline and implementation strategy, message points that will be effective in changing the attitudes and health behaviors of pregnant and breast-feeding women, target audience identification, goals and objectives of both campaigns, and the estimated costs of development and implementation.

Questions:

1. Currently, how many research projects are NIDA and NICHD funding to study youth and perinatal marijuana use – more specifically the impact of THC products on health outcomes for these groups?
2. Why did NIDA decide not to fund the NASEM study requested in House Report 117-96?
3. Would NIDA and NICHD consider co-funding this type of study?

NIH Response:

The National Institute on Drug Abuse (NIDA) decided not to support this NASEM report because at present there is insufficient data on youth and perinatal cannabis use to support an extensive report, and available information on effective strategies for preventing youth cannabis use was recently assembled and released by the Substance Abuse and Mental Health Services Administration (SAMHSA).²¹⁷ Both NIDA and the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) agree that additional research is needed before such a report would be useful to the field and we are committed to building research evidence in this area.

NIDA is currently funding more than 70 studies on cannabis exposure among youth, spanning research to: characterize the impacts of cannabis exposure on perinatal and adolescent brain development and other outcomes; understand the impact of adolescent cannabis use on mental health outcomes; develop and test novel approaches for preventing or reducing cannabis use among pregnant women, adolescents, and young adults; and policy research to understand the impact of the cannabis market and regulations on cannabis use among pregnant women and youth to inform public policy.

In addition, NIDA leads and NICHD contributes to the trans-NIH HEALthy Brain and Child Development (HBCD) Study²¹⁸ and the Adolescent Brain Cognitive Development (ABCD) Study²¹⁹, both of which will be important sources of data on perinatal, child, and adolescent cannabis exposure. The ABCD Study[®] is characterizing brain development in nearly 12,000 children ages 9-10 and following them through adolescence into young adulthood. By integrating neuroimaging with genetics, neuropsychological, behavioral, and other health assessments, this study will shed light on how substance use and other experiences during adolescence affect brain development and later health outcomes such as drug use and addiction.

²¹⁷ store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-01-001.pdf

²¹⁸ heal.nih.gov/research/infants-and-children/healthy-brain

²¹⁹ abcdstudy.org/

To better understand very early brain development and the effects of maternal substance use during pregnancy on child outcomes, the HBCD Study is following a large sample of children from the prenatal period through early childhood, utilizing some of the same types of assessments and imaging technologies as the ABCD Study®. By improving our understanding of what puts a person at risk for or confers resilience to addiction, these studies will contribute in important ways to the development of tailored prevention interventions.

Notably, research on the effects of cannabis products on adolescent health outcomes is hindered by the challenges of conducting research on cannabis overall. Due to regulations stemming from the status of cannabis under the Controlled Substances Act, researchers are not permitted to purchase or analyze cannabis products available in state dispensaries, limiting research on the effects of real-world cannabis products. In addition, NIDA's Drug Supply Program has been the only source of cannabis permitted for use in research, limiting the diversity of products and formulations for researchers to study. Although DEA began the process of approving new cannabis growers in 2020,²²⁰ additional crops are not yet available to researchers. In addition, having additional growers may increase the diversity of products for research use, but this does not address restrictions to research on cannabis products available on the market today.

²²⁰ www.deadiversion.usdoj.gov/drugreg/marihuana.htm

Submitted by Rep. John R. Moolenaar***Gain of Function Research/"Enhanced Potential Pandemic Pathogens" Research***

I'd like to revisit the issue of gain of function research, or what the scientific community calls "enhanced potential pandemic pathogens" research. Last year, in a meeting with Drs. Collin and Fauci, I was told that the NIH doesn't fund gain of function research, or more specifically, not the type was conducted at the Wuhan Institute of Virology that was approved by the NIH.

Questions:**Dr. Fauci:**

6. Now that you've held listening sessions and more information has been made publicly available, do you still believe without any doubt that the origins of the SARS-CoV-2 virus was not due to gain of function research at the Wuhan Institute of Virology? Could you explain?

NIH Response:

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) could not have originated from research at the Wuhan Institute of Virology approved by the National Institutes of Health (NIH). The body of science reported under the EcoHealth Alliance award—including the bat coronavirus sequences published in the scientific literature—showed that the viruses studied at the Wuhan Institute of Virology under the NIH grant were evolutionarily quite distant from SARS-CoV-2 and could not have been the source of SARS-CoV-2. However, NIH cannot rule out the possibility that an institution possesses undisclosed data. A thorough, expert-driven, and objective investigation into the origins of SARS-CoV-2 would provide important insight into the evolution of SARS-CoV-2.

7. One of the points that you and Dr. Collins conceded to me during that meeting was that the Chinese government refused not only to allow international and/or U.S. researchers to verify how and why the virus was first transmitted in Wuhan, but also share any additional information to assist the international scientific community. So, considering the National Institute of Allergy and Infectious Diseases directly vets research grants, what are your thoughts on continuing such collaborations with similar Chinese labs or other international labs in countries where they may be adversarial or malign interest to the U.S.?

NIH Response:

NIH conducts and supports research to gain fundamental knowledge about the nature and behavior of living systems and to apply this knowledge to enhance health, lengthen life, and reduce illness and disability. International collaborations are essential to spur innovation and assure the U.S. biomedical research enterprise remains competitive. In particular, the NIH

collaborates with foreign partners to facilitate disease surveillance and study the factors contributing to the emergence of novel or resurgent infectious diseases with investigators at research institutions in countries around the world, including in China. Scientific exchange is key to our domestic security and global competitiveness in the face of pandemic threats.

All grant applications submitted to NIH for funding undergo a rigorous 2-step peer review process. Applications from foreign or international organizations are evaluated and scored during the initial review process using the standard review criteria, as well as some additional criteria. The Fogarty International Center and the NIH funding Institute or Center determine whether an NIH grant should be submitted to the Department of State for clearance. Grants to foreign and international organizations are subject to the same financial and scientific reporting requirements as domestic grants and are monitored in the same way as domestic grants. NIH does not have the authority to debar a foreign institution from receiving federal funding.

Cancer Research

I represent a largely rural district in Michigan. Cancer does not make geographic distinctions, but one thing we do know is that rural Americans with cancer are underrepresented and underrecruited in cancer clinical trials. One of the goals of the Cancer Moonshot Initiative is to address inequities in care to ensure that every community, including rural communities, has access to cutting-edge cancer diagnostics, therapeutics, and clinical trials.

Question:

Dr. Lowy:

1. Considering the FY23 budget proposal for NCI, how will the agency be making sure that rural communities have the same access to research and clinical trials as urban communities?

NIH Response:

Ensuring equitable access to clinical trials is a top priority for the National Cancer Institute (NCI), and this objective was recently reaffirmed as one of the goals identified in the next phase of the Cancer MoonshotSM. NCI-supported clinical trials networks and NCI-designated Cancer Centers are actively engaged in many longstanding activities to promote clinical trials participation among rural and other traditionally underserved populations. In addition, NCI has recently issued several funding opportunity announcements (FOAs), including through NCI's Center for Reducing Cancer Health Disparities (CRCHD), focused on promoting research in rural communities.

The majority of NCI's clinical trials are supported through several key extramural networks: the National Clinical Trials Network (NCTN), the Experimental Therapeutics Clinical Trials

Network (ETCTN), and the NCI Community Oncology Research Program (NCORP). NCTN conducts later-phase cancer treatment and imaging trials, while ETCTN conducts early phase cancer treatment trials. Research groups within these networks hold annual meeting sessions on topics related to underrepresented populations, and each of these groups has a patient advocate committee to provide input on developing and conducting trials. The ETCTN also recently launched the Create Access to Targeted Cancer Therapy for Underserved Populations (CATCH-UP.2020) program to enhance access via clinical trials to targeted cancer therapy for minority/underserved populations.²²¹ To expand the reach of these networks, and to provide infrastructure for conducting studies on cancer control and prevention, cancer care delivery research, and screening, treatment, and quality of life embedded in treatment trials, NCI also supports NCORP. NCORP includes seven research bases and 46 community sites across the United States, including 14 designated as minority/underserved community sites. There are approximately 1,000 component and subcomponent sites (e.g., hospitals, cancer centers, oncology clinics) through which patients can enroll in NCI-supported clinical trials.

For example, Michigan residents are able to enroll in NCI-supported clinical trials through 58 NCORP sites spread across the state.²²² These sites are component and subcomponent sites of the Michigan Cancer Research Consortium NCORP, the Cancer Research Consortium of West Michigan NCORP, and the Cancer Research of Wisconsin and Northern Michigan Consortium.

NCI also supports clinical trials through the network of NCI-designated Cancer Centers, including the Barbara Ann Karmanos Cancer Institute at Wayne State University School of Medicine and the University of Michigan Rogel Cancer Center. These institutions are expected to utilize their resources to identify the unique needs of their communities and tailor appropriate programs to meet these needs. For example, the University of Utah Huntsman Cancer Institute (HCI) has developed a “Huntsman at Home” program for patients living in three rural-frontier communities in southeastern Utah, a 2-5 hour drive from HCI. The rural program involves a combination of on-ground, remote monitoring, and telehealth services, with evaluation efforts in place to consider the effectiveness of this model.

NCI’s CRCHD has launched a number of programs that aim to increase the participation of rural populations in clinical trials. The National Outreach Network (NON) leverages community health educators to disseminate culturally appropriate information to underserved communities; of the 24 NON sites, eight serve rural populations, and five support the medically underserved. The Partnerships to Advance Cancer Health Equity (PACHE) program, which supports collaborations between Minority-Serving Institutions and NCI-designated Cancer Centers, also funds several projects focused on rural populations.

Recognizing that more research is needed to identify the best strategies for providing care to rural populations, NCI is currently providing funding for projects selected through two targeted FOAs:

²²¹ ctep.cancer.gov/initiatives/Programs/etctn_catch-up2020.htm

²²² ncorp.cancer.gov/findasite/components.php?kw=&state=Michigan

- Improving the Reach and Quality of Care in Rural Populations²²³: This funding opportunity focused on strategies for delivering and improving the quality of cancer care in rural areas among low-income and/or underserved populations. Over the two funding rounds, nine research projects were funded, including research focusing on financial toxicity and navigation, survivorship, telehealth, community-based patient navigation for cancer screening, palliative care, and symptom management.
- Social and Behavioral Intervention Research to Address Modifiable Risk Factors for Cancer in Rural Populations²²⁴: This funding opportunity focused on research to develop, adapt, and test individual-, community- or multilevel interventions to address modifiable risk factors for cancer in rural populations. Three research projects have been funded after the first round, focusing on tobacco control in rural American Indian households, increasing physical activity, and utilizing telehealth options for treatment of obesity.

While being physically remote may factor into an individual's decision to participate in a clinical trial, NCI recognizes that persistent poverty in certain rural communities may also limit a patient's ability to enroll in a study. To identify strategies for overcoming barriers associated with persistent poverty, within the last two years NCI has issued three FOAs focused on expanding cancer research into persistent poverty areas.²²⁵

On May 4, 2022, the White House Cancer Cabinet held a community conversation focused on doubling clinical trials accrual, with an emphasis on equity and inclusion. The expert panelists underscored the importance of concerted efforts to reach traditionally underserved populations; many of their suggestions align with current and planned NCI initiatives. NCI will continue to prioritize increasing access to clinical trials, including among rural populations, as part of its fiscal year (FY) 2023 activities.

Rare Cancers

I remain concerned with the lack of targeted therapies for rare cancer patients. Rare cancers account for 380 of 400 distinct forms of cancer and almost 1/3 of all diagnoses and include all pediatric cancers, yet most of the cancer grant funding is directed to the most common cancers and few targeted treatments exist for rare cancer patients. Plus, much more can be done with data-sharing across agencies among NIH, DoD and the VA and with the use of molecular diagnostics of the patient's cancer tissue at first diagnosis that can advance research, care, and scientific understanding of what drives various forms of cancer. Without increased investment in

²²³ grants.nih.gov/grants/guide/rfa-files/RFA-CA-19-064.html

²²⁴ grants.nih.gov/grants/guide/rfa-files/RFA-CA-20-051.html

²²⁵ grants.nih.gov/grants/guide/notice-files/NOT-CA-21-071.html

grants.nih.gov/grants/guide/rfa-files/RFA-CA-22-015.html

grants.nih.gov/grants/guide/notice-files/NOT-CA-20-035.html

rare cancer research, an end to the data silos, and expanded access to molecular diagnostics, we are leaving one-third of the newly diagnosed cancer patients per year completely neglected.

Question:

Dr. Tabak/Dr. Lowy:

1. Can you please share insights on what NIH, in particular the NCI and NCATS, are doing to address this?

NIH Response:

The National Institutes of Health (NIH) remains committed to supporting research to advance the understanding of all cancers, including rare cancers, and to inform the development of targeted cancer therapies for rare cancers and rare subtypes of cancers, including pediatric cancers (all types and subtypes of pediatric cancers are considered “rare” by definition).

The cancer research community – thanks to NIH-supported developments in understanding the specific genes, proteins, and other unique molecular characteristics driving certain cancer subtypes – continues to recognize that cancer is made up of a collection of hundreds, if not thousands, of subtypes defined by these characteristics. As a result of National Cancer Institute (NCI)-supported efforts and other relevant research, “cancer” is increasingly becoming a collection of rare cancer subtypes.

This evolved understanding of cancer is reflected in NCI’s current clinical trials portfolio and investments in translational and basic research, including several initiatives in the intramural Center for Cancer Research (CCR).

Increasingly, clinical trials are examining targeted therapies based on molecular subtypes. For example, NCI’s National Clinical Trials Network (NCTN) is currently supporting trials assessing therapies to treat gliomas with certain genetic alterations²²⁶ and pancreatic cancers with specific gene alterations.^{227,228} NCI also supports trials that are dedicated to patients with rare tumors, including the NCTN-supported DART (Dual Anti-CTLA-4 and Anti-PD1-Blockade in Rare Tumors) Trial²²⁹ and the Rapid Analysis and Response Evaluation of Combination Anti-Neoplastic Agents in Rare Tumors (RARE CANCER) Trial²³⁰, which is supported by NCI’s Experimental Therapeutics Clinical Trials Network.

To ensure that researchers have a strong pipeline of therapy candidates to consider for use in clinical trials, NCI supports several initiatives to support the preclinical stage of development of therapeutics to treat rare cancers, including the NCI Experimental Therapeutics (NeXT) Program and the Pediatric Preclinical Testing Consortium (PPTC). The mission of NeXT is to advance clinical practice and bring improved therapies to patients with cancer by supporting the most promising new drug discovery and development projects. The PPTC addresses key challenges

²²⁶ www.clinicaltrials.gov/ct2/show/NCT00887146

²²⁷ www.clinicaltrials.gov/ct2/show/NCT04858334

²²⁸ www.clinicaltrials.gov/ct2/show/NCT04548752

²²⁹ www.clinicaltrials.gov/ct2/show/NCT02834013

²³⁰ www.clinicaltrials.gov/ct2/show/NCT04449549

associated with the development of new therapies for children with cancer by developing reliable preclinical testing data for pediatric drug candidates that can be used to inform new agent prioritization decisions.

The first step in identifying new therapeutic targets, however, is elucidating the basic biological mechanisms that give rise to cancers. To further these research efforts, NCI supports the development of resources for broad use across the cancer research community. These resources include cell lines, organoid models, patient-derived xenograft (PDX) models, biospecimens, and other biological samples. NCI makes drug information summaries available on its website, along with extensive cancer treatment summaries. Additional resources include the Developmental Therapeutics Program, the National Clinical Trials Network (NCTN) Navigator, Patient-Derived Xenograft (PDX) Centers, PDX Finder, the NCI Mouse Repository, and the Physician Data Query (PDQ) Database. A more extensive list is available at www.cancer.gov/research/resources/.

Additionally, the Rare Tumor Patient Engagement Network, launched in fiscal year (FY) 2018 and part of NCI's CCR, leverages the resources of the NCI intramural research program and the NIH Clinical Center to bring together investigators, patients, and advocacy groups to study rare tumors. Under the umbrella of this effort, NCI launched the My Pediatric, Adolescent, and Adult Rare Tumor (MyPART) Network, a collaboration of scientists, patients, family members, advocates and healthcare providers to find treatments for rare cancers.²³¹ The MyPART Network collects samples like blood, saliva, and archived biopsy tissue from people with rare solid tumors as part of the Natural History Study of Rare Solid Tumors.²³² The purpose of the study is to engage rare tumor patients and their families in the research process, study how rare tumors grow, track participants' health history over a long period of time, share data with other scientists, build new ways of testing new treatments, and design new clinical trials for rare cancers. MyPART scientists also hold clinics on rare tumors to facilitate collaborations between researchers, patients, and advocacy organizations; to date, MyPART has hosted clinics on chordomas, SDH-deficient gastrointestinal stromal tumors, and medullary thyroid cancer, and more clinics are in the planning stages. Additionally, the NCI Comprehensive Oncology Network Evaluating Rare CNS Tumors (NCI-CONNECT) program aims to advance the understanding of rare adult central nervous system (CNS) cancers by establishing and fostering patient-advocacy-provider partnerships and networks to improve approaches to care and treatment; seven clinical studies and trials are currently open through NCI-CONNECT.²³³

NCI recognizes that sharing genomic, epidemiologic, and clinical data is essential to advancing progress for cancer patients. As part of the Cancer MoonshotSM, NCI is developing a National Cancer Data Ecosystem to enable and encourage all participants across the cancer research and care continuum to share, access, combine, and analyze diverse data sets. Elements of this cloud-based ecosystem already in place include the NCI Genomic Data Commons, the Proteomic Data Commons, the Data Commons Framework, and NCI Cloud Resources. To enhance the Cancer

²³¹ www.cancer.gov/pediatric-adult-rare-tumor/

²³² clinicaltrials.gov/ct2/show/NC10373982/

²³³ www.cancer.gov/rare-brain-spine-tumor/refer-participate/clinical-studies

Research Data Commons, NCI is also developing the Imaging Data Commons, the Center for Cancer Data Harmonization, and the Cancer Data Aggregator.²³⁴

Complementary to these efforts, the goal of NCI's Childhood Cancer Data Initiative (CCDI), launched in FY 2020, is to link clinical care and research data, including genomic data, on pediatric cancers to more rapidly identify potential therapeutic strategies for patients. Specifically, the CCDI aims to gather data from every child, adolescent, and young adult diagnosed with pediatric cancer; create a national strategy of appropriate clinical and molecular characterization to speed diagnosis and inform treatment for all types of pediatric cancer; and develop a platform and tools to bring together clinical care and research data that will improve preventive measures, treatment, quality of life, and survivorship for all pediatric cancers.²³⁵ NCI hopes to eventually apply the CCDI model to other cancer types.

Because of these and similar investments, the U.S. Food and Drug Administration (FDA) has approved a number of therapies in recent years for patients with rare cancer subtypes and related conditions. For example, in May 2021, the FDA granted accelerated approval to sotorasib (Lumakras) for patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with alterations in the *KRAS G12-C* gene, a mutation which is present in only 13.8 percent of NSCLC patients.²³⁶ Similarly, the FDA approved selumetinib (Koselugo) in 2020 for the rare tumor condition neurofibromatosis type 1, in patients over the age of two, as the first approved treatment for this condition. In 2018, the FDA granted accelerated approval to larotrectinib (Vitrakvi) for adult and pediatric patients with solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion. NTRK gene fusions are prevalent in nearly all cases of certain rare cancer subtypes, including secretory carcinoma of the breast or salivary gland and infantile fibrosarcoma; they have also been observed in some patients with more common types of cancer, such as glioma, melanoma, and carcinomas of the thyroid, lung, and colon.²³⁷ The approval of larotrectinib marked the second time that the FDA granted approval for a therapy based on a molecular driver of cancer, rather than the site in the body that it originates. The first such "tissue agnostic" approval occurred just a year earlier, when the FDA granted accelerated approval to pembrolizumab for adult and pediatric patients with microsatellite instability-high or mismatch repair deficient solid tumors.²³⁸ These approvals are built upon decades of NCI investments in describing the genetic and cellular mechanisms that give rise to cancer.

NIH will continue to support research efforts that reflect the scientific understanding of the many subtypes of cancers, including work that will enable the development of therapies for rare tumor subtypes.

²³⁴ www.cancer.gov/research/key-initiatives/moonshot-cancer-initiative/implementation-data-ecosystem

²³⁵ www.cancer.gov/research/arcas/childhood/childhood-cancer-data-initiative

²³⁶ ascopost.com/news/january-2021/prevalence-of-kras-g12c-somatic-mutations-by-cancer-type-race-and-sex/

²³⁷ www.ncbi.nlm.nih.gov/pmc/articles/PMC6859817/

²³⁸ www.fda.gov/drugs/resources-information-approved-drugs/fda-grants-accelerated-approval-pembrolizumab-first-tissuesite-agnostic-indication

THURSDAY, MAY 12, 2022.

**HEALTHY AGING: MAXIMIZING THE INDEPENDENCE,
WELL-BEING, AND HEALTH OF OLDER ADULTS**

WITNESSES

**MARTHA B. PELAEZ, PH.D., BOARD MEMBER, NATIONAL COUNCIL ON
AGING AND EVIDENCE-BASED LEADERSHIP COLLABORATIVE
PATRICIA LYONS, PRESIDENT AND CEO, SENIOR CITIZENS, INC.
KAREN ORSI, DIRECTOR, OKLAHOMA MENTAL HEALTH AND AGING
COALITION
ROBERT B. BLANCATO, NATIONAL COORDINATOR, ELDER JUSTICE
COALITION**

The CHAIR. Good morning. I apologize. We had technical difficulties with getting started here today. So, with that, let me provide some housekeeping efforts here.

And I am going to bang my phone since I don't have a gavel here and to call this hearing to order.

So the hearing is fully virtual. So we need to deal with a few housekeeping matters.

For today's meeting, the chair, or the staff designated by the chair, may mute participants' microphones when they are not under recognition for the purposes of eliminating inadvertent background noise. Members are responsible for muting and unmuting themselves.

If I notice when you are recognized that you have not unmuted yourself, I will ask staff to send you a request to unmute yourself. Please then accept that request so that you are no longer muted.

Finally, House Rules require me to remind you that we have set up an email address to which members can send anything they wish to submit in writing at any of our hearings or markups. That email address has been provided in advance to your staff.

With that, let me just acknowledge and thank Ranking Member Cole and all the members of the subcommittee for joining us for this hearing. I want to just say a thank you to our witnesses for testifying before us today on this important topic, and we welcome you to the subcommittee.

Dr. Martha Pelaez, a board member, National Council on Aging—did I pronounce the name right?

Ms. PELAEZ. Yes, you have.

The CHAIR. Lovely, thank you so much. Board member, National Council on Aging and Evidence-Based Leadership Collaborative; Patty Lyons, President and CEO, Senior Citizens, Inc.; Karen Orsi, Director, Oklahoma Mental Health and Aging Coalition; and Bob Blancato, National Coordinator, Elder Justice Coalition.

We will introduce you all once again before your testimony, but we are so delighted that you could join us this morning to discuss what is an important issue around healthy aging.

I want to specifically recognize our colleague Congresswoman Lois Frankel for her interest in this critical topic. This is a member-driven hearing, would not have been possible without her advocacy. As you well know, the concept of healthy aging encompasses so many things, but its breadth and complexity are exactly why we are here today to be able to talk about it.

This hearing is particularly important today because our country's senior population is growing. According to the Census Bureau, the United States population of individuals over age 60 is projected to increase by 15.7 percent between 2019 and 2025, an increase of nearly 12 million more people.

So we wholeheartedly believe this is something to celebrate. The fact that the percentage of older adults in America is increasing means that people are living longer. That is good. But it simultaneously highlights a need for renewed focus on how we can provide what kind of care and how we provide that care to aging Americans.

Our growing population of older adults simultaneously brings with it a growing population at increased risk for health issues and a need of specialized prevention and treatment services. I am proud to be hosting the hearing today during what is Older Americans Month, which is a time for us to celebrate the contributions that older Americans have had and continue to have on our country. We acknowledge and recognize their unique needs.

This month and the hearing today should serve to recommit the committee to the health and prosperity of our seniors and to our moral and fundamental responsibility to support older adults in the tailored way that they deserve and that they have earned. I am proud that these values are already reflected in the funding that this committee makes to support our seniors and their healthy aging through the Labor, HHS bill and other measures.

Our bill funds the Department of Health and Human Services Administration for Community Living, including the Administration on Aging. And through the ACL, we support and invest in State and local aging networks as they work with national organizations and committed advocates to support and empower older adults.

And little is more essential to supporting the needs of our seniors than ensuring that they don't go hungry. In the recently passed fiscal year 2022, in the omnibus, we included \$967,000,000 for the Senior Nutrition Program, which helps older adults access nutritious meals and vital services to promote their health and well-being.

We included \$900,000,000 for senior nutrition for the American Rescue Plan and the COVID supplementals last year to ensure that low-income seniors received meals during the pandemic. The funds were critical to making sure thousands and thousands of seniors around our country did not go to sleep hungry.

Ms. Lyons, as you mentioned in your written testimony, without continued and sustained funding, more seniors will be at risk of being left hungry and increasingly isolated, which is why I am thankful that you are joining us today in your role as board chair of Meals on Wheels. It is a program that is a lifeline to seniors,

not just delivering a warm meal, but it is about making sure that older Americans live with dignity.

I have gone door-to-door, and I am sure many of my colleagues have gone door-to-door, with the Meals on Wheels program. We know the power of this program in connecting older Americans with essential services, encouraging independence, providing safety checks, and making seniors feel less isolated.

We have to also address preventable injuries to keep seniors safe and healthy. Within ACL, millions of dollars are used for fall prevention programs and grants that have been proven to reduce the number of falls and related injuries that older adults face. And that is the issue that Congresswoman Frankel highlighted when she asked for this hearing.

In addition, the subcommittee funds the Centers for Disease Control and Prevention. CDC programs prevent elder falls and chronic diseases that directly impact the health of our seniors.

Particularly important to the topic of this hearing is the Elder Justice Program, funded again within ACL. Mr. Blancato, as you have mentioned in your testimony, 10 percent of all older adults in this country fall victim to elder abuse. Those most vulnerable, historically underserved experience abuse at disproportionate rates. The funding we invest in the elder justice programs within ACL is used to develop the structure, the systems, and encourage justice for older Americans, and that prevents abuse and provides protection to those who need it most.

Nothing is perhaps more critical to our conversation on healthy aging than the concerns for the specific physical and mental health needs of our seniors. Again, within ACL, the subcommittee funds the NIH's National Institute on Aging.

We held a hearing yesterday on the fiscal 2023 budget with the NIH, and again, as Ms. Frankel asked the question about research on the health of older Americans, the issue of falls, et cetera, we were told that there was promising research to prevent and treat Alzheimer's and other diseases that specifically impact seniors. But I think we have to try to focus and move in the direction of more research as it has to do with cause of falls, the nature about women who fall more than men do apparently and so forth, to get to the heart of what this issue is all about.

And so I am so proud of what this subcommittee has done to fund the Substance Abuse and Mental Health Services Administration, and this is on a bipartisan basis, I might add. In fiscal year 2022, we did \$6,500,000,000 to the agency, including resources that support older adults facing mental and substance use disorders.

Mental health issues plague seniors, which has been a growing concern for years. Social isolation, economic pressure caused by COVID, the pandemic has exacerbated our already existing problems, creating new barriers to reaching seniors when they are most in need. The pandemic highlighted the unique way that mental health issues compound with the physical ones and the needs of older people, not just in moments when they may be experiencing personal struggle, but all of the time.

Because of the unique challenges many seniors have faced over the past 2 years, congressional Democrats and the Biden administration moved quickly to deliver emergency funding that helped

those needs. There was \$1,400,000,000 to implement the Older Americans Act and more through emergency supplemental bills, but it is about ongoing and sustaining support that we need.

Four subject matter today we will talk about with our experts—fall prevention, senior nutrition, mental health, elder justice. The issues, of course, intersect, and the hearing is a crucial step as we try to build on what past successes are and learn more about what to do in each area.

We can't talk about all the issues that are facing older Americans, but we can talk about these as well. And while we can't address everything, I am proud that we are starting a conversation here today.

Looking forward to our witnesses today. Thank you in advance for the visibility that you give these issues and your understanding of how the programs interact and how they support the whole person with aging and the advice that you can give to us on steps that we can take moving forward.

And with that, let me yield and turn to Ranking Member Cole for any opening remarks that he may have.

Mr. COLE. Thank you very much, Madam Chair.

And just for informational purposes, I will be able to stay through the testimony and probably opening round of questions. At that point, we have a conflicting hearing—or I do—on defense, and I am going to need to step away to that. So I regret that, but as the chair knows, we are in a busy time of year with lots of meetings and conflicts.

Good morning again, Madam Chair and members of the subcommittee and our witnesses on the panel. I want to thank you all for being here today and look forward to our discussion on programs, benefits, and challenges for an aging population.

One in six Americans is over the age of 65, and this percentage of the U.S. population is only expected to grow in the coming years. We all share in the goal of ensuring the health and well-being of American seniors. The costs of Medicare represent a real and significant threat to the Nation's fiscal future.

In fiscal year 2020, Medicare represented the second-largest portion of the Federal spending—Federal Government spending, excuse me, spending more than \$775,000,000,000, or 12 percent of the total budget. The largest program was Social Security. Both programs are supported by trust funds with antiquated—or anticipated insolvency. It is clear that the first step to securing the Nation's fiscal footing is addressing the cost of caring for our seniors.

The programs we will be discussing today represent opportunities to lower costs by keeping seniors healthier, happier, and often living at home where they are most comfortable. One program we will highlight today, as the chair mentioned, is falls prevention.

According to the National Institutes of Health, about 30 percent of adults over the age of 65 fall each year. These falls can result in serious injury, even death, and decrease mobility, possibly leading to a loss of independence. Falls are estimated to cost upwards of \$50,000,000,000 in healthcare costs, and that is with just one third of those who fall seeking medical care.

I want to recognize Congresswoman Frankel for highlighting the importance of this issue. Supporting falls prevention programs are

a common sense way to help seniors and reduce unnecessary healthcare costs.

Falls prevention programs help seniors develop strength, balance, and mobility, and they also educate participants on common environmental risk factors that can be avoided or mitigated to avoid a possible fall. The Administration on Community Living has served nearly 150,000 people through their falls prevention programs since 2014.

In addition to falls, mental health is another area where we know it is important for supporting older Americans. The social distancing and isolation taken as a preventive public health measure to address the pandemic impacted seniors disproportionately.

Mental health issues left unaddressed can be a significant factor in suicide, and men aged 85 and older have the highest suicide rate of any group reporting to the CDC. Depression is the most common mental health problem in older adults, and it is correlated with higher rates of emergency room utilization, medication, higher outpatient charges, and longer hospital stays.

Some people assume depression is a part of the aging process, but that is simply not the case. In most cases, depression is treatable, and we need those individuals suffering to feel comfortable discussing this issue with their providers and get the treatment that they need.

Seniors can also be a target for abuse, scams, and discrimination. Elder justice programs help support adult protective services. During the COVID pandemic, numerous scams have been targeting seniors, in some cases using their information to bill Medicare, order tests that were never received, or encourage payment for services that are provided free of charge.

Seniors who have caretakers can also be subject to physical, mental, and emotional abuse by these same caregivers. In many cases, without access to alternatives, individuals are afraid to report abuse if doing so would threaten their ability to live independently.

The Adult Protective Services programs are funded in a patchwork across States with great variability among the States. The subcommittee has led efforts to provide more support at the Federal level to document these challenges across the States.

Surveys show a vast majority of adults prefer to remain in their homes as they age. Fortunately, choosing to remain at home is often more cost effective for both the individual and the cost to Federal health programs. We all have an interest in helping seniors stay healthy and comfortable at home for as long as possible, and a key component of keeping seniors at home is providing meal support.

Senior nutrition programs provide to seniors both in their homes, often through the Meals on Wheels program, and through congregate facilities like senior centers. Those services provide a vital lifeline to seniors through a warm meal and a friendly hello. For many older adults, the person delivering their meals may be the only face they see regularly, and senior centers provide critical connections to services and onsite training.

The chair and I have both spoken ardently in support of these programs. So I won't belabor the point here, just to once again reit-

erate strong support for senior nutrition programs has been a unifying theme of this subcommittee.

Again, I want to thank all our witnesses for coming before us today and sharing their time and expertise. Thank you, Madam Chair, for holding this important hearing.

And with that, I yield back.

The CHAIR. I want to thank the ranking member.

And now just let me introduce our witnesses for their testimony.

Our first witness today is Dr. Martha Pelaez. Your full written testimony will be entered into the record. You are now recognized for 5 minutes for your opening statement.

Ms. PELAEZ. Thank you.

Chair DeLauro, Ranking Member Cole, subcommittee members, thank you for the opportunity to speak to you today about the urgent need to support falls prevention in older persons.

As National Council on Aging board member, I represent the council's national voice for every person's right to age well. NCOA directs the National Falls Prevention Resource Center, which is responsible for educating the public about the risk of falls and how to prevent falls.

As a professional, as an older person, as a daughter of a mother who died due to complications related to a fall, I care deeply about this issue. According to CDC, just like Ranking Member Cole mentioned, falls are about—fall is the number-one cause of injury and death from injury for older persons. Every 11 seconds another person is injured by a fall, and every 19 minutes an older adult dies as a result of a fall.

The annual direct medical costs, as we have heard, is \$50,000,000,000, of which 75 percent is shouldered by Medicare and Medicaid. With the aging of the population, these numbers will continue to increase if we do nothing.

We must recognize that even though all falls cannot be prevented, we want to prevent those that are preventable and in other cases mitigate the impact of a fall, reduce the severity of the fall, and reduce associated healthcare costs, as well as improve the quality of life for those individuals who are at risk of a fall.

To accomplish this goal, we recommend three strategies. First, early detection of fall risk factors with a consistent use of the screening tools during their Welcome to Medicare visit and the annual wellness visit. This is very doable. The CDC National Center for Injury Prevention developed the Stopping Elderly Accidents, Deaths, and Injuries, known as the STEADI initiative. This has become the gold standard for falls risk assessment.

Every 5,000 healthcare providers who adopt STEADI produce a savings of \$3,500,000 in direct medical costs over a 5-year period. So STEADI must become the universal tool used for fall risk screening, and reimbursement for its use must be incentivized.

An essential component or companion to early detection is education and support of older persons as partners in the work of falls prevention. We have a number of evidence-based education programs that have been shown to not only reduce falls and falls risk factors, but also healthcare cost. Just as, too, A Matter of Balance is associated with a decrease of \$938 in total medical costs per participant.

Another program is a formal education program known as CAPABLE. With an investment of \$3,000 per participant, that program has yielded more than \$30,000 in savings in medical costs per participant.

So the second strategy is to establish coordinated cross-agency Federal effort to address falls. There are already a number of Federal agencies engaging in falls prevention, but there is no coordinated and comprehensive strategy under the purview of any one single agency.

So the healthcare system spends \$50,000,000,000 on older persons falls. However, the Federal Government appropriates less than 1 percent of this amount in falls prevention. And most of that funding has remained stagnant over the years.

So a federally coordinated cost prevention national strategy would increase opportunities to leverage resources across disparate agencies and contribute to the sharing of valuable information.

Strategy three is to promote Federal leadership in research, demonstration, and evaluation. The lack of an integrated and cohesive system of research result in inefficiencies, missed opportunities, and an absence of critical data in Federal aging research. This data is needed to calculate the impact and outcome of services.

In conclusion, to achieve this vision, expanded Federal investments are crucial. So on behalf of NCOA, I applaud the leadership of Representatives Frankel and Morelle in laying the groundwork with their Government-wide fiscal 2023 request. I thank you for the opportunity to share recommendations, and I am happy to answer any questions the committee may have.

The CHAIR. Thank you so much, Dr. Pelaez. The statistics you quote are really pretty extraordinary. Thank you.

And again, we say thank you to Congresswoman Frankel for bringing this to light.

Our next witness is Patty Lyons. Your full testimony, Ms. Lyons, will be included in the record, and so you are now recognized for 5 minutes.

Thank you.

Ms. LYONS. Thank you.

Chair DeLauro, Ranking Member Cole, and distinguished members of the subcommittee, thank you for this opportunity. It is such an honor to be able to share my firsthand experience about the impacts of nutrition and the clear intersection that exists between all the topics the panel will address today.

Regardless of age, nutrition is a critical part of the health, development, and overall quality of life. But it is simply fundamental to healthy aging. Despite the wide recognition of this, millions of seniors were struggling to meet these basic human needs prior to the pandemic, and these issues have only intensified since.

We know in 2020, one in eight older adults were threatened by hunger, and it is estimated that almost half of all older adults are already malnourished or at the risk of becoming so. With the rising spending on healthcare, it is imperative that we invest more significantly in cost-effective programs that will allow folks to age with better health.

The good news is that there are already simple and impactful solutions. Service providers such as mine seek to holistically meet the

needs of older adults in their communities by providing a combination of nutrition, safety, socialization, and community connection supports.

A study from 2015 found that older adults receiving home-delivered meals and the social connection that it provides experience statistically significant improvements in their health as compared to their counterparts who do not receive the service. Those who received meals were more likely to have improved physical and mental health, including reduced feelings of anxiety and loneliness, fewer hospital admissions and readmissions, and fewer falls. All ultimately reducing our Nation's healthcare costs.

By being invited to cross the threshold into the homes, there is the ability to observe, assist, and provide that sense of security. Last week, one of my clients fell in his home during the night. It was our volunteer who called us to give us an alert, and we contacted his sister, and together, we entered his home.

He smiled at us when we came in, and he said to his sister, "I wasn't scared at all because I knew they were coming to bring my meal." This story is not unusual, unfortunately, but it exemplifies the true strength of these programs.

The power and the importance of the OAA nutrition program was never more evident than during the COVID-19 pandemic. Overnight, thousands of programs like mine quickly adapted to continue safely offering to our clients the critical person-centered supports that go well beyond the meal itself.

Even prior to the pandemic, Federal funding for aging services was not keeping pace with increasing demand, rising cost, and inflation. Last year, a survey of our Meals on Wheels America members found that 97 percent of us already know that there are older adults in the community who need our services, but we are not able to provide it. Sixty percent of the programs reported that the major limitation to this is funding.

Eight in 10 of our programs are still serving more meals and more clients than we were before COVID-19, and many of us are poised to have to take drastic steps such as discontinuing or cutting back those services in order to sustain our program due to this funding challenge.

I want to thank the leaders of the subcommittee in particular. The ACL receiving that emergency funding necessary so that we could address the significant needs presented by the pandemic. But we are at a crossroads. Pandemic-level funding for these programs has to remain because we cannot go backwards. After all, we all now know what it is like to be a homebound, isolated older adult.

This past weekend, my next-door neighbor, a young man of 5 whose name is Griffin, came over to visit, and he asked me in all earnestness if I was afraid to be 100. I laughed, but I have to confess that I thought, golly, how bad do I look today? But I simply replied that, no, it is a little ways off for me.

But I share this story because, as I thought more about it, I realized that I really am not afraid to turn 100, and it is because I know that the organization I work with will be here to help me, as we already help many 100-plus-year-olds.

Organizations like Senior Citizens, Inc., are able to do this because of the funding that we receive through the Older Americans

Act. I understand that you have got a lot of difficult decision that you are facing, and I know I have thrown a lot of statistics at you. But it really comes down to this.

We can provide a year's worth of nutritional lifesaving support for less money than one night in a hospital or 10 days in a nursing home. So as you are developing the appropriations bill, I urge you to include an investment of \$1,934,000,000 into the OAA nutrition program so that we can ensure the health, safety, and social connectiveness that our seniors deserve and so that the Griffins of the world will have organizations like us here when they turn 100.

So thank you for your leadership and your consideration.

The CHAIR. Thank you. Thank you.

Our next witness is Karen Orsi. Your full testimony will be included in the record, and you are now recognized for 5 minutes.

Ms. ORSI. Thank you. I virtually thank this committee for your focus on helping seniors and the opportunity to speak on mental health issues [inaudible].

My name is Karen Orsi. I am with the Oklahoma Health and Aging Coalition in Oklahoma City, a Certified Community Behavioral Health Clinic, and I also serve on the executive committee of the National Coalition on Mental Health and Aging. I am not a clinician or a policymaker, but I am in the trenches, where I recognize the need for policy to support healthy aging.

The model of my coalition's recovery has no age limit. Aging is the one thing we have in common. So my presentation is not about "them." It is about "us," as we age. They don't need culturally sensitive and age appropriate services. We will need specialized services.

To remain independent and flourish, we need access to a spectrum of services that support continued health and independence. Without resources, healthy aging is elusive.

Achieving wellness requires balance in all of the elements of wellness. Mental health and physical health happen in the same body, and my written testimony describes the mind-body connection in much more detail.

Now all of today's focus areas are interconnected. For example, for nutrition, consider the time, planning, delivering, and funding of home-delivered meals. But if the person is depressed, that meal may go uneaten. Uneaten meals negatively impact weight, muscle, exercise, and the absorption of medications. Or if the person is financially stressed, the meal may be shared with a pet.

And falls. The fear of falling may prevent a person from leaving home and contribute to loneliness, which, in turn, may increase physical and mental health problems. Loneliness can cause depressive symptoms, and in an attempt to dull emotions, self-medicating with alcohol and medications can increase instability and actually cause a fall.

In social justice, aging does not provide immunity from abuse or neglect. And any resulting trauma impacts both physical and mental health and will probably require treatment.

So it is natural to focus on the physical as we age, but it is usually from the neck down—blood pressure, heart disease, arthritis, diabetes. When we talk about brain health, it is usually associated with dementia or Alzheimer's. Depression or anxiety are often con-

sidered to be just another symptom of aging, not a medical condition requiring treatment.

Now as we age, we experience an increased risk for developing behavioral health disorders because our aging bodies develop chronic diseases, and those diseases increase the risk, as do the medications to treat those diseases. Unaddressed trauma, loneliness, social isolation, numerous life and role changes also increase the risk.

And mental health disorders, trauma, and loneliness negatively impact your physical health. So those symptoms of mental health distress often overlap with symptoms with physical illness.

Mental disorders complicate the treatment of medical conditions and increase the use of healthcare services and cost. Even a mild depression can have a serious impact on sleep, nutrition, exercise, disease self-management, muscle loss, balance, falls, memory, and increase risk of developing heart disease, stroke, and diabetes.

Hearing loss, vision impairment, and incontinence can occur, and each can trigger depressive symptoms. These examples underline the importance of screenings at the time of any diagnosis and follow-up.

A workforce shortage exists, but the level of care required by Medicare actually limits access to care, and not all providers accept Medicare. And of those who do, very few have training in geriatric issues.

Older adults deserve behavioral health services that are culturally sensitive and age appropriate. Now isolation means being physically alone, while loneliness is defined by the satisfaction with your relationships. Loneliness has health risks similar to obesity and smoking. It can lead to depression, sleep issues, cognitive decline, poor cardiovascular function, and impaired immunity.

And I can't talk about aging without challenging ageism. Societal norms that marginalize people, make them feel disrespected, unwelcome, incompetent, and invisible. Ageism is not just black balloons on your 40th birthday. Ageism impedes and impairs treatment of both physical and mental health issues.

Through the ageism lens, aging is heeded as a disease itself, with the inevitability of decline, cognitive impairment, disease, disability, grief, sadness, loneliness, a decreased quality of life rather than as a process of development. Ageism, together with a lack of training in gerontology and geriatric issues, is dangerous to healthy aging.

And now I need to address the antithesis to healthy aging, suicide. Older adults have one of the highest rates of suicide of all age groups, and the top circumstances are depressed mood, physical health problems and mental health problems. Early identification and treatment of disorders can result in positive outcomes at all levels.

In closing, I want to bring hope. Not the eyes closed tight, fingers crossed hope, but the science and power of hope. Identifying and reducing hopelessness in life can improve the quality of life and functioning and be a preventive factor in suicide. My hope is for the implementation of a hope initiative for healthy aging that includes the integration of mental and physical health and the development of resources to support all of the elements of wellness.

Thank you for your interest in mental health and its impact on healthy aging.

The CHAIR. I did it. I unmuted. Anyway, sorry.

Thank you. Thank you very, very much. Very powerful testimony.

And I want to now hear from—we all want to hear from Bob Blancato, and Mr. Blancato, your written testimony will be included in the record, and you are now recognized for 5 minutes.

Mr. BLANCATO. Thank you, Chair DeLauro, Ranking Member Cole. Thank you for this hearing and inviting me to testify.

Your focus on healthy aging is timely in the middle of Older Americans Month and the start of the Decade of Healthy Aging, as declared by the World Health Organization.

Healthy aging is for more than one generation. It supports the well-being of American society overall. Healthy aging remains elusive for many older adults, especially the 1 in 10 over the age of 60 who are victims of elder abuse. The triple evils of abuse, neglect, and financial exploitation pose a direct threat to healthy aging.

Healthy aging includes physical, mental, and emotional well-being, but a 2018 NIJ report said elder abuse victims reported considerably higher rates of first-year depression, general anxiety disorder, and poor self-reported health compared to nonvictims.

Financial security is necessary for healthy aging. The FBI reports that people over 60 make up the majority of cybercrime victims, with average victims losing \$10,000. Romance schemes, preying on isolated and lonely older adults, had its victims lose \$139,000,000 according to the FTC.

The pandemic had led to more older adults being isolated. Another FBI report stated the elder fraud jumped by 30 percent in 2020, and older adults lost more than \$100,000,000 just to COVID-19 related scams.

I come as the national coordinator of the Elder Justice Coalition and a repeat witness to this subcommittee, which was the first to provide dedicated money for elder justice. Prevention is the key to healthy aging. Elder Justice, at its core, through its services and interventions works to reduce and ultimately prevent elder abuse and mistreatment.

So, today, I urge the subcommittee to make continued investments in elder justice. First, maintain the emergency funding provided to the Elder Justice Act in the last two pandemic bills. Specifically, we call for \$188,000,000 in funding for the elder justice Adult Protective Services, for continued APS formula grants. The President's fiscal year 2023 budget level of \$58,000,000 is insufficient to meet current and future needs.

We support the President's request for \$36,800,000 for the Long-Term Care Ombudsman Program in the Older Americans Act and ask for an additional appropriation of \$52,000,000 under the Elder Justice Act to allow them to expand their work in assisted living facilities.

How are these emergency funds used by APS and Ombudsman? In Connecticut, funds were used by the Ombudsman Program to pay overtime to extend work hours and cover weekends, enhance virtual work, and purchase a Zoom account to support a statewide family council.

In Oklahoma, funds were used to hire an intake specialist for both APS and Ombudsman and hold a safe reentry ombudsman volunteer conference later this month.

Other uses, supporting tribal APS programs, providing emergency housing and shelter to victims. In rural areas, purchasing and replacing vehicles for APS victims.

But what critical service or program ends if this funding is not continued? As the pandemic eases its grip, people in the field expect an increase in reported elder abuse. Staff capacity to respond is critical. And with the ombudsmen, as they regain access, their workload investigating quality of life issues will also increase.

We also recommend increased funding for Title VII of the Older Americans Act for public awareness programs, multidisciplinary elder abuse teams, and elder abuse hotlines; additional funding to ACL to expand elder abuse prevention training for all staff and volunteers in the Older Americans Act; and approving education materials for older adult participants. This would be especially necessary in the National Family Caregiver Support Program.

Funding grants to Area Agencies on Aging and other community-based groups to address social isolation, as included in the House-passed Build Back Better bill. A vital program in promoting health aging is the social services block grant. The primary source of funding for APS in some States, but also it funds home-delivered meals, case management, and home care. Its funding has been frozen for years. It deserves an increase.

Increased funding for nutrition and senior center programs in the Older Americans Act. They are part of elder justice, as congregate sites provides socialization to reduce isolation which helps to combat elder abuse.

On the equity front, we ask the subcommittee to instruct ACL and its data collection system to do more to ascertain elder abuse prevalence in communities of color and LGBT communities. Let us coordinate all federally funded information and referral programs to help people find out where and how to report elder abuse. Let us have more funding for research and practice into self-neglect, the most frequent category of elder abuse reported to Adult Protective Services.

And finally, where it falls in your jurisdiction, support for the President's recent nursing home reform proposals. Federal health and social service programs must expand their focus on prevention. Programs that promote the independence and dignity of older adults contribute to healthy aging. Keep investing in elder justice. It can address the related consequences of abuse including isolation, falls, malnutrition, and mental health.

The most vulnerable older adults, including those with disabilities, are often the most susceptible to elder abuse. They deserve priority in how prevention services are accessed and provided. Healthy aging is a most admirable goal, but let us direct our resources to those who still lack it.

A victim of elder abuse is never the same. If your support of elder justice prevents more victimization and promotes more healthy aging, it is a most worthwhile investment.

Thank you.

The CHAIR. Let me just say a thank you to all of you. This has really been quite extraordinary testimony this morning.

We spend time—we provide resources. We spend time speaking about the plight and difficulties of older Americans, of seniors, and et cetera. But what you all have laid out is the staggering statistics, which should give us even more strength, if you will, in making the determination of where our resources are going and for what purposes.

We do have programs and policy initiatives in place, but I think we have to think about whether or not they are meeting the moment that you all are laying out to us, and are we doing enough to provide for the physical and mental health of our senior population, older Americans?

And once again, I want to just say a thank you to Congresswoman Frankel for her initiation of this effort, but it has really been very, very powerful testimony. I thank all of you.

And with that, I am going to ask my questions, and then I will yield to Ranking Member Cole. And then what I will do because I am going to have to just head into a—just pop into another hearing and then I will come back, and ask Congresswoman Lee to take the chair as I do that.

So with regard to my questions, Ms. Orsi, you referred to a culture of bootstrap strength, stoicism, and self-reliance. That is something many of us admire about this older generation. I know I did with my mother. My mother passed away at age 103, you know? And my God, didn't complain. Never complained.

But as I say it is something we admire, but it also seems to be an impediment to recognizing and addressing all of the unique needs. So what can we do to overcome the stigmatism—the stigma, not stigmatism—that is in your eye. The stigma of mental health services in the aging community and make sure mental health is just as important to address as older adults' physical health?

Ms. ORSI. Well, thank you for the question.

The CHAIR. We are having trouble hearing you, Karen.

Ms. ORSI. Let us see, if I can turn this up.

The CHAIR. There you go. Much better, much better.

Ms. ORSI. Okay. Yes, several layers to answer your question. The first thing is that you will find stigma across the board. However, there was pretty much a silver lining with COVID, as hard as that is to imagine, because now there is interest on mental health issues across the board and especially for older adults. It used to be a flashlight. Now there is a big spotlight on mental health issues.

When I talk about older adults, I put—I kind of break off the category because what we are talking about is four to five decades of experience, depending on what your chronological ages are [inaudible] start at 50 and go to over 100. That is a lot of years. So when I am talking about older adults, I talk about boomers and then talk about advanced age.

And the advanced age that you referred to, the people in the 80s, 90s, and 100s, they do not have a culture of asking for help because of that bootstrap. They do not have a culture of accepting behavioral health services. So that is an additional challenge.

They do go to primary care for everything. So that is an opportunity if we would have our streams in primary care, it would get them more help. But it is a very high hill to climb for our advanced age population because of their culture, because of their experience. They don't know about treatment. They don't know about recovery. They don't believe in treatment. They don't believe in recovery.

And as such, that is one of the battles that we are—besides the whole stigma of mental illness, getting our advanced age population to believe in treatment and recovery, and that is—you know, why my mom, it was so important, I think. Recovery has no age limit.

And the research shows that older people recover even better sometimes than our younger folks do for things like depression and anxiety.

The CHAIR. Thank you.

I want to ask Mr. Blancato a question. You talk about older adults lost more than \$100,000,000 to COVID-19 related fraud in 2020. And disturbing that elder fraud jumped about 30 percent nationally in 2020. What should have been done differently, Mr. Blancato? And what actions do we need to take to prevent elder abuse and fraud?

Mr. BLANCATO. Thank you, Chair.

A lot of things, I think. I mean, first of all, it is—and Ranking Member Cole referenced the COVID scams alone, which were atrocious. The fact that they occurred as quickly as they did at the time, things like vaccines became available and so on. I think it is a recognition that elder abuse is a crime, and we need to put the full resources of those entities of the Federal Government that are responsible for crime prevention to work.

Now this has been done really effectively. The Justice Department has done good work, and the FBI has done good work in terms of rounding up scam artists, and the FTC and other entities as well.

But as you know, in the Elder Justice Act in a program that is under your jurisdiction, the Elder Justice Coordinating Council has 14 different Federal agencies that work together using their resources that exist in fighting elder abuse. What they need to do is concentrate more of those resources on the scam issue and on the scam because, again, it is the loss of resources that promotes the loss of independence, which contributes to unhealthy aging for many older adults.

The CHAIR. Thank you. I am going to try to get in an additional question here, and that is to Ms. Lyons.

About senior nutrition, so evident during COVID. Impressed with the programs like your space and the challenges and how you nimbly responded to reaching seniors, what changes did you have to make in your meals program at Senior Citizens, Inc., during COVID that you believe should be here to stay?

Ms. LYONS. Well, we learned an awful lot about what is critical. We learned that what we always knew, which is it is more than a meal. You have to provide that social element. That just drop shipping frozen meals is not what is critical. It is that social connection, which is what makes Meals on Wheels so powerful.

I think one of the greatest things that this committee helped do was to provide the flexibility between transferring money between Title III(c)(1) and (c)(2), and we would love to see that remain. Because what happens is somebody goes to a senior center. They have to leave to go have surgery, something like that. We have to discharge them, then readmit them to (c)(2), where during COVID, we were able to shift those monies and were able to build almost like money follows the person, build that customized way to make sure that they keep their nutrition.

The CHAIR. Thank you. I went over my time. So let me now yield to the ranking member, Mr. Cole.

Mr. COLE. Madam Chair, you never go over your time. You are the chair.

Let me ask, actually, the same question to all of you. We have had a number of hearings on a variety of topics, all of which have shown us that COVID has a very long tail. In other words, we had to get through the pandemic, but there are a lot of consequences, whether it is drug addiction, mental health challenges, you name it, that various populations face.

So I am curious as to your impressions and thoughts about what is the tail for senior Americans with COVID? What do you see in your respective areas, problems that are going to continue even as the pandemic hopefully fades?

And let me start, if I may, Ms. Lyons, with you because you sort of handle a panoply of different things.

Ms. LYONS. I think we are seeing that the congregate sites are very slow to come back, which is why that flexibility is important. They are afraid to be around each other, but it is a critical element.

My biggest concern is what will happen when the COVID relief money stops. I don't want to take a lot of time, but I will share with you a story. We started serving a client—and we provide pet food for our clients in home as well so they don't share their meal. And one day, our volunteer came to his door, and he gave her two cases of cat food. And she said, "I am sorry your cat passed."

And he said, "Oh, no. I have been eating this, but now that Meals on Wheels is a part of my life, I don't need to do this anymore." And he is somebody that was added during COVID, and I can't imagine what it is going to be like to tell these people that we can't keep serving them.

Mr. COLE. A very good point. Mr. Blacato, how about you? What do you see in terms of any aftermath from COVID?

Mr. BLANCATO. Congressman Cole, as I mentioned in my testimony, the concern we have and what we are hearing from the field is that as the pandemic eases and more people begin to report elder abuse, those cases are going to skyrocket, both in number and complexity.

Because it may be that they have been unable to report for months at a time, and the abuse may have gotten considerably worse. So it is critically important, and that is why the emergency COVID funding to provide direct formula grants for Adult Protective Services, we have to recognize that they are the front lines providing help to both prevent elder abuse, but serve the victims who are confronted.

But there is a real concern in the field about what we are going to find as things loosen up and as things go forward, and that is why a continuation of the emergency funding is critical.

Mr. COLE. Thank you.

Ms. Orsi, again, same question. What do you see as the lingering effects that are going to cause problems or exacerbate existing problems from COVID?

Ms. ORSI. Well—

Mr. COLE. Again, we are having a hard time with your audio. I don't know what the problem is, but—

Ms. ORSI. It is probably my unstable Internet.

Mr. COLE. When you lean forward, we get a better sound.

Ms. ORSI. I will get closer. It has an impact [inaudible] COVID. I know this is blasphemous, but there has been some positive outcomes from COVID, and the one is which globally older adults have reported that they have handled COVID better than younger people, which just points to the resilience of older Oklahomans, older Americans, and that is what we can use in terms of helping people and providing assistance.

Now the verdict is still out. Down the line, we are going to probably be seeing a lot more effects. Plus, we don't know—we know that COVID has impacted the brains of healthy people that have never had mental health disease, but we really don't know what the outcome is going to be there.

So I mean it is for all age groups that it has really been impacted. We are concerned for our older people because many times they have a poverty of resources, so when they are suffering, we don't have the ability to provide them the help that they need.

Mr. COLE. Okay. And Ms. Pelaez, how about you? What are the things that give you pause as you look forward that are an aftermath of COVID? I think you are muted.

Ms. PELAEZ. Sorry. The important thing about falls, about the COVID period with relationship to falls is that not only the older adults, and we know that they were overrepresented in those who actually suffered and died from COVID. But even those who never had COVID had an increase in social isolation, an increase in just simply inactivity because of their own protection, self-protection from COVID.

So that physical inactivity and that lack of conditioning, their mobility will affect their risk for falls. So we will see an increase in falls-related injuries just simply because of the fact of the social isolation and the inactivity that was actually produced by the pandemic.

Mr. COLE. Thank you very much.

My time has run out. So, Madam Acting Chair Lee, I will yield back to you.

Ms. LEE [presiding]. Thank you very much.

First, let me just thank all of you, our witnesses, for being here today. It is such an important discussion, and of course, I have to thank Congresswoman Frankel also because she knows how personal this is for myself, but how important it is for us to really know how to help our constituents. And what you have given to us already today has been an eye-opener, and so I want to thank you very much.

I have a 101-year-old aunt, and I am her primary caregiver on the weekends. She lives in assisted living. My other aunt, who passed away a few years ago, was 100, and my mother passed away at 90. So I have learned a lot through experience, and what I have learned has not been that hopeful for myself, and I am going to give you an example. And I guess this speaks to mental health issues because I really hadn't thought about this as staff training and not knowing how to approach seniors from a mental health framework or perspective.

My 101-year-old auntie, perfect cognitive skills, and she will just say, "Oh, I don't want to eat today," or "Oh, forget it, I am not going to drink my water." And the staff will say, "Well, she says she is not going to do it. We can't make her do it." So what can I say? She gets dehydrated, then she has to go to the hospital. You know, the whole 9 yards.

Yet when she was rehab, I know the staff would say, "Oh, you have got to drink your water today. You don't want to end up in the hospital." Or, "You have got to eat. This food is great." They encouraged her because they understood kind of how to do that. And so I just—so she did.

When I am there, "Oh, I don't want to do this," you know? I say, "But Auntie Lois, you have got to for these reasons. Now, come on." And then she will do it.

So, and I know that I hadn't thought about that in terms of mental health until today, and I am wondering, Karen, or anyone who can answer this, how are staff trained in terms of identifying how they talk to people, seniors, at that age and understanding this is a mental health issue really, and there is a way to approach seniors to help with their mental and physical health. Because if they don't get seniors to drink water, they get dehydrating, end up in the hospital.

And that is a strategy that mental health—I am clinical social worker by profession. So that is a strategy I know that needs to be taught to caregivers.

Karen, unmute, can you? Okay. Get a little closer to your—

Ms. ORSI. This is one of the big areas [inaudible].

Ms. LEE. Can you get a little bit closer? You are breaking up a little bit.

Ms. ORSI. Okay.

Ms. LEE. Okay, that is a little better.

Ms. ORSI. I will keep trying. We have a lack of trained professionals to [inaudible]. So there is a huge issue, and it is not only the training for social workers, but workers in nursing homes and assisted living centers, et cetera, et cetera. And there are some definite methods that we are looking at, things like the four aims, things that matter—healthy aging societies, age-friendly societies.

But we need to provide training to everyone that works with older adults. I mean, if you work at Subway, you get training on how to make sandwiches and how to work the cash register. But if you work with older adults, many times the workforce is so slim that if you apply, you are accepted.

Mr. BLANCATO. And Congresswoman Lee, I would add to that, if I may? It is a shortage issue, okay? The absolute shortage reduces the amount of time that they can spend communicating with an

older adult. And if they are not properly trained, that communication will go to waste.

But we really have to address the staffing issue, particularly in nursing homes, assisted living facilities. Training is critical, but so is having incentives to have the right number of people on the ground in the facilities to address the many needs that are in there.

Ms. LYONS. And if I could add, that is exactly—they nailed it exactly. It is the shortage. It is this constant turning of aides. But it should be part of the certification to become a CNA. It should be required that they have annual training on how to do that. We do this in our program, but it is not required, and it should be.

Ms. LEE. So that would be part of the State certification process as a State-by-State process? Okay.

Ms. LYONS. Yes.

Ms. LEE. That is very helpful because—and I have noticed the staff turnover, staff shortage. But that could be deadly because of not encouraging and using mental health skills to get a senior to eat or to drink water or to do their rehab or to take their—help with a shower.

So very helpful, and I want to thank you very much for that. And I will come back later if we have a second round.

Now I will yield the rest of my time to Mr. Harris. Dr. Harris.

Mr. HARRIS. Thank you very much.

And thanks for all of your interest in taking care of our seniors.

Let me ask, because several of you have mentioned nutrition. One concern of mine is that we don't promote proper nutrition enough, I think, in the Federal Government.

So, for instance, if a senior citizen is on the SNAP program, they can go to a store, and they can buy salty potato chips, and they might have hypertension. They can buy foods that probably aren't good for them, that aren't—might not be providing optimum nutrition.

Now we have the Women, Infant, and Children Program, where we say, okay, we are going to put guardrails on what you can buy because we think it needs to be nutritious. Could we envision having that kind of program for our seniors as well? Because their nutritional needs are different from other age groups. And again, anyone on the panel who would be interested in commenting on that.

Mr. BLANCATO. If I may, Dr. Harris, I will start, and I know Patty has some thoughts, too, on this. It is a very good point.

And I think the Government Accountability Office put out a report in 2019 making that exact point, urging that there be a better focus on the varied nutrition needs of older adults. The dietary guidelines, the next round of them in 2025 and 2030, are supposed to be done by HHS with a focus on the very point you raised about dealing with nutritious food.

I think the other issue to point out is it still there is a price factor going into this. It is cheaper and easier to get bad food than it is to get good food, and we have got to address that. We have got to find ways to make that happen because we have a growing problem, malnutrition with older adults. One out of every two older adults is malnourished.

I would also point out that in the fiscal year 2022 bill that was just adopted, there will be a White House conference on food, nutrition, hunger, and health in September. And I know these issues. We are going to—Meals on Wheels America and ourselves are going to work hard to have these older adults issues put into that conference so that we come out with some real recommendations with some teeth.

Ms. LYONS. And Bob is exactly right. It is time that we do put some guardrails around that. But I will also say like in our State prior to the COVID relief funds, our seniors got \$20 a month in SNAP, and for many of them, it is not worth going through that process. So, with \$20, there isn't a whole lot you can buy, and so you are going to get that comfort food that you want, like a potato chip or baloney, if you happen to be my family.

But it is a big issue, and I think it is one of the reasons there are such strict USDA guidelines for home-delivered meals and congregate meals, and I think you should address it.

Mr. HARRIS. Do you think—do you think those guidelines are adequate?

Ms. LYONS. I do. We have to provide a lot of nutritional education as well, and I think just like you do with the WIC program, there should be some guidelines on how you can spend your SNAP dollars.

Mr. HARRIS. Okay, thank you.

Ms. PELAEZ. I also would like to add to that that sometimes we forget about the fact that older adults themselves need to have good, evidence-based nutrition education and support for their own self-management. In other words, we sometimes don't just become bad eaters when we turn 80. We have had habits that are long building, and we now have multiple chronic conditions, and we really need to learn how do we actually change our habits. How do we actually begin to eat healthier? How do we seek opportunities to have better nutrition?

We need to build that self-confidence as older adults. There are evidence-based programs that actually do that. So please don't forget the need to have the older adult as a partner in this process of healthier nutrition.

And yes, regulations are good. Staff training is great. But we also need to build in some support to teach older adults to become better nutrition—have better nutrition that makes better decisions and change habits, which is not always easy.

Mr. HARRIS. That is a good point. And I think that we should probably put those guardrails on a little earlier in life so that by the time someone reaches senior age, they have actually gotten the message that there are good foods, and there are not good foods, and I am afraid our SNAP program doesn't do it. Our WIC program does, to a pretty good extent, but our SNAP program doesn't.

Anyway, thank you very much. I yield back.

Ms. LEE. Thank you. I will yield now to Mr. Pocan.

[Audio malfunction.]

Ms. LEE. Something is wrong with your audio, Mr. Pocan. I think there is a technical issue.

Okay. Shall I yield to Ms. Clark and then—okay, Ms. Clark, and then we will come back after Ms. Herrera to you.

Ms. CLARK. Thank you, Madam Chairwoman.

And I really want to thank all my panelists for being here for the incredible work you are doing, and a special shout-out to Congresswoman Frankel for inspiring this hearing and continuing to focus on this really important topic.

I want to go back to senior nutrition, and according to Federal definitions, we put all adults 60 years and older in one guideline, where, compared to children, by the time a child reaches 18, they are up to 5 different age categories of dietary guidance. So my question is for you, Ms. Lyons.

How can we do better, and are we really meeting the dietary guidance needs of older adults, and how can we use extensive nutritional research to maximize food assistance programs?

Ms. LYONS. That is a great question.

I think if you asked our programs, we would say we are very constricted by the guidelines. It would be nice to have the flexibility to change the menus based on people's health needs. We do provide choice, most of our programs do, both home and in the congregate setting. But it is very, very defined.

If we could have the flexibility to not provide greens to people who are on coumadin or some type of medication. We really are prohibited from doing a lot of customization. And I think—I think we should look as the medical industry and as nutritional industry where are those points? That the food desires of somebody who is 90 years old are a lot different from the person who is 65.

Ms. CLARK. Yes.

Ms. LYONS. And you know, if we could have that kind of flexibility, if we had had that kind of information. There has just not been a lot of study on older adults because, frankly, not a lot of people are living to be 100, and so it does need to be addressed.

Ms. CLARK. Yes, which brings me exactly to my next point. I am very proud to have Tufts University and their incredible research into nutrition in my district, and they have identified eating patterns that help older adults slow the progression of conditions that we consider age-related, like cognitive decline. So are we putting enough Federal resources into research on nutritional needs of older adults?

Ms. LYONS. I am sure there is a lot of money going into research. The disconnect is having that research then become part of that day-to-day process of providing it. I think there is usually a lag between what we have learned and how it gets implemented, and I think that is where we should probably invest a little bit of time of how do we make it part of that day-to-day meal-delivery process?

Ms. CLARK. Yes. Another concern I have is about malnutrition screening tests. They are very basic, but they are not routinely utilized. And one of the barriers to adoption is the lack of programs to address nutritional problems if identified, which you alluded to.

We also lack consensus on the definition of malnutrition in older adults. So how can we bring providers and nutrition experts together to develop an effective screening program to identify at-risk older adults and begin to implement those policies to address malnutrition?

Ms. LYONS. I think anytime you can bring everybody to the table, you are going to walk away with a much better product. And I

think that includes involving not only experts, but people who are providers like us so that we can talk about the issues of the mass production and getting it out.

And then also the people that are the end-users. Asking the seniors what is it that you want? What do you need? How do you define malnutrition? And then giving us the flexibility to provide more than just what is prescribed with an Older Americans Act.

Most of us do that. Most of us use outside private money to get Ensure, to get all those other products that help support nutritional health. And you know, that is why programs like the OAA nutrition programs are so vital. But I think if we could bring everybody together and have a discussion on how do we do this on a nationwide level, it would make profound changes.

Ms. CLARK. Well, thank you. I see my time has expired, but I look forward to continuing this work together in a partnership.

Thank you.

Ms. LYONS. Thank you.

The CHAIR [presiding]. Thank you. And let me now recognize Congresswoman Herrera Beutler.

Ms. HERRERA BEUTLER. All right. Thank you so much.

And this has been incredibly informative. One of the things I wanted to ask about that I hear about nonstop from older Americans of my district, honestly from friends, parents, from my own parents, I hear a lot about inflation.

In April, inflation was 8.3 percent, and the cost of food, housing, gas, energy, all of it is at record levels. And obviously, older Americans, specifically those on fixed incomes are worried about affording their prescription drugs, which I heard a little bit in what we talked about.

Ms. Orsi, in your testimony, you highlight the eight elements of wellness, and then the mental and the physical stressors that seniors encounter at age. I was hoping maybe you could speak a little bit to the impact that inflation might have and how we might be able to address some of those things to better support vulnerable seniors?

Or does it not? Am I just inferring this based on information I am getting from—kind of anecdotally?

Ms. ORSI. There have been [inaudible] buying their prescription medications, not taking them, skipping tests, skipping doctor's appointments due to COVID. Now we compound that with inflation. So it is going to have a drastic impact. In order to really focus on healthy aging, my statement about the elements of wellness, it is this can't be just piecemeal.

I am an aging advocate that has realized after years of working in the aging network I can't just promote mental health. I have also got to promote financial support and nutrition and fall prevention and social—social connectedness and resilience support and all of those issues.

So in order to address inflation, what we are going to do again is to address the property of resources that we have, have those connections where with an older adult seeking mental health treatment, if we know they are financially strapped, we can immediately connect them to resources. But now what are those resources?

That is another big issue, another webinar that we need to have is what are the resources that are available. It is easy to make a referral, but where does that referral lead? Does somebody answer the phone when you make a referral?

Ms. HERRERA BEUTLER. Thank you.

Ms. ORSI. And especially can that person deal with older adult issues?

Ms. HERRERA BEUTLER. Thank you for that. And if anybody else wants to chime in there briefly, I have one more question. But if Ms. Lyons or Ms. Pelaez has any comments, you are welcome to?

[No response.]

Ms. HERRERA BEUTLER. All right. Well, otherwise, robocalls. I got data from my—just from Washington State. As of March of 2022, we received 50.9 million robocalls in one month. And obviously, we are all vulnerable to scammers. People who are at home maybe who are more isolated could be even more extremely vulnerable to scammers who may want to take advantage of robbing them of their life savings. We have all heard these stories.

Mr. Blancato, actually, how can the committee target resources to protect seniors in this area, and how can we best educate them about the risks of these types of scams and help them avoid them?

Mr. BLANCATO. Thank you for the question. And yes, I am sure that even while we have been having this hearing, we probably got some robocalls. That is how fast they come.

Outside your jurisdiction, let me just point out that the Federal Communication Commission is doing a lot of good work in this space. They are penalizing companies that don't provide coverage and protection from these calls.

But from the standpoint of elder justice, I think supporting the work of APS, Adult Protective Services, are a lot of things. Okay, they can intervene. Part of their prevention strategy is education. Okay, warning people what to avoid, how to—giving out tips. It becomes very important to have the tips available early in the process before you become victim.

Because the answer is you don't even—the minute you say “hello” you are in trouble, okay, on these kind of calls. And if you think about it, the average victim of elder abuse in this country is an older woman living alone between 75 and 80, okay? And now 46 percent of older women live alone over 75 and older.

So the question is they are home all day long. The phone rings. It is a scammer on the other end. They need to know before that phone rings what to avoid. And older adults, the older American nutrition programs provide education in their facilities as well. We need to embark on more funding for prevention and education in this space.

Ms. HERRERA BEUTLER. Okay, wonderful. Thank you all.

I have more, but I don't think it is short enough to fit in 27 seconds. So, with that, I yield back.

Thank you, Madam Chair.

The CHAIR. Thank you. Thank you very much.

I might also add as an addendum, one of the things that if we do not immediately put together a COVID supplemental package, we are going to put everyone, and seniors and people who are uninsured, the people who have been told that there is free testing. But

if there isn't any money to cover that, when they go and they find out that they will have to pay, they will turn around and go home.

And that is necessary. So the imperative of passing a COVID supplemental bill is important obviously for the humanitarian reasons, but for testing, for therapeutics, for vaccines, et cetera, and what that means for people who are with regard to their insurance coverage, but also getting their costs covered. But that package is equally as important.

Let me now recognize Congressman Pocan.

Mr. POCAN. Thank you, Madam Chair. I think this should be working. I switched computers. I apologized before. My official computer doesn't work so good. My personal one works just fine. Go figure.

I want to go back to nutrition and specifically the Meals on Wheels program. I have done a lot of delivering of meals through various communities' Meals on Wheels, and I grew up in a lower middle class family. So my mother didn't have a lot of money when she retired and just recently passed at 93 years old. So she was getting Meals on Wheels for quite a while when she was in some senior housing.

One of the things, though, that I have noticed, as much as that social connection is so very important and checking in on seniors, all those are extremely important. But in a number of the programs in my district, in order to save money on food, they have switched to contractors that are doing the jail food.

And jail food is not the same as food that is made for seniors. And in one particular program, they dropped to a third of participation because the food was bad. And as I delivered food, I heard it from a number of the seniors.

Do we need better guidelines? I know Representative Harris kind of asked that. But I am concerned that if this is a trend in order to save money—because we do offer I think pathetically small amounts in things like SNAP, et cetera, to feed people—I am worried that this program also will not be the great program for many other reasons besides nutrition that it is.

Ms. Lyons and anyone else, can you address that?

Ms. LYONS. It is a huge problem. I have been asked to provide food for—I live in Savannah, Georgia. So right across the river from us, and there is a jail that is doing the food.

And they approached me, and they said people get sick. We have had people get food poisoning. We want you to do this program. But when I tell them how much it costs, they are like, "Oh, no, we can't do that." So it really comes down to then the demand versus what it really costs to provide a really good meal.

I do wish the OAA had got—they do have guidelines, but nobody gets really penalized for not providing the grade of food that they should, for not providing—we are expected to keep these standards, but there is not a penalty. And so when States get desperate to serve rural areas or to save money because they have got so much, they are resorting to things like drop shipping of five frozen meals and not having that daily wellness check. Not having those minimum guidelines. Using day-old food.

So you understand that because it is a matter of money and trying to meet a need. But you are absolutely right. There should be

a minimum standard that is held to that by the Older Americans Act—I mean by the triple As, the Area Agencies on Aging. And in some instances, it would be better not to have food than to have bad food.

Mr. POCAN. I will tell you that is exactly what happened at the last program I was at. I mean, privately, the people who worked there wanted to take me aside and explain that they drop off. They have had it, and I saw it when I talked to folks.

In addition to that, I know that Social Security payments—we tie increases to Social Security to the CPI. Right now, CPI is great because, unfortunately, with the COVID inflation.

Ms. LYONS. Yes.

Mr. POCAN. But I know there is another CPI out there that is the CPI-E that takes into consideration more expenses that seniors have, like around medication, rather than others. Do you find that is also something that I know it is not directly in your area, but that we should be providing more to people who get Social Security because as small as that amount is, it is extremely helpful. But that increase hasn't really kept up with what people need for real expenses.

Ms. LYONS. True. One of the things that the OAA provides is that we don't have a strict income guideline because there is a recognition that when you are an older adult, there is a different cost of living. And you have got medical expenses, you have got caregiver expenses. You have got things that a younger person doesn't have.

And it would be really nice if you could apply that same kind of recognition to Social Security, to SNAP, to things like that. But I know it all comes down to money, which is great that this committee is looking at how to keep people healthy because that is the investment that keeps that big sack of money at the end.

Mr. BLANCATO. And if I could add one thing, Congressman, which is the Older American Act does target its services to the elderly in the greatest economic or social need, with particular attention to low income, rural, limited English speaking. So there is an effort to make sure that there is more reaching those individuals in the services that are provided.

Mr. POCAN. One of my most rural areas I just came back from, this happened, and they are down to a third of the people because of the changeover of food. And I just feel like it may not be addressed enough, but I really appreciate it.

Thank you for your time, and I yield back, Madam Chair.

The CHAIR. I now recognize Congressman Cline.

Mr. CLINE. Can you hear me, Madam Chair?

The CHAIR. Yes, we can.

Mr. CLINE. All right. Thank you. Sorry about that.

We are dealing with some technical difficulties of our own.

I want to ask all of our witnesses. I am a district that is very diverse. It has rural areas and urban areas. And so, to Dr. Pelaez, when talking about falls specifically, I know that older adults falls are becoming more prevalent and a growing issue of concern, and they are very costly. And the direct medical cost of fall injuries is \$50,000,000,000, up from \$38,000,000,000 a decade ago, of which 75 percent is shouldered by Medicare and Medicaid.

Can you tell me, do you see a statistical difference in cases of injury due to falling in rural areas versus urban areas, the frequency or the severity?

Ms. PELAEZ. That is a great question, and I don't know that we have very good data to answer your question. That is one of the reasons why we really need to have better screening, better data collected, in a systematic and coordinated fashion.

For instance, we know that fire departments, both in rural and urban areas, do a lot of the lift and assist. When someone falls alone, they call the fire department for help. They come, they lift that person, and that is what we call "lift and assist."

If the person is not badly injured, so they don't have to go to the hospital, that is a statistic that never gets really recorded in anywhere except in the fire department. So having a coordinated system of better reporting, having more systematic screening. We know that older adults do not talk about falls. There is a stigma related to falls.

If I have fallen, that means that I am getting weaker, and maybe my children are going to think that I am due to the nursing home. So I don't really talk about falls.

So to answer your question, we really need to invest more in data, but I will check on—and there are some centers that really have good statistics on rural aging. So I will check and promise you that I will get back to you with any more information we get on that issue.

But it does pinpoint the fact that we need better data collection and better screening, better reporting.

Mr. CLINE. Okay. I have such limited time. Ms. Orsi, can you talk about mental health, rural versus urban? Is there a difference in the type of need and the services available obviously, but can you speak a little bit to the rural-urban divide?

Ms. ORSI. There is a great urban-rural divide, and our resources across the board are not as available to many people. And I am sure that if you are involved with any kind of rural situation you understand we have had some patient issues. We have a lack of service providers. It has been helpful to have the telehealth. That has been very helpful for people, but still it is not enough because not everybody has broadband.

I mean, I have got good connections, and I am having issues today. But if you are in the rural area, there are a lot of issues that just are such challenges to try to get the help they need, and then not much help is available.

Mr. CLINE. Ms. Lyons, can you also speak to this? Meals on Wheels is a great program. I have participated in it many times in some of our more urban areas. But talk about the challenges in rural areas, specifically with the rising price of gas.

Ms. LYONS. Yes, the rural areas are much more expensive to serve just simply because of the delivery piece of it. Volunteers with inflation are saying they can't afford to do these routes that are 30 miles going to one house. But that doesn't diminish the need by any means, and having the flexibility to charge a slight different price for rural versus urban helps a lot.

But yes, it is—it is a challenge, and it even makes it more important that you have that socialization that comes with the meal because they are so isolated, as Ms. Orsi was saying.

Mr. CLINE. Thank you. I appreciate all the work that all of you do.

I yield back, Madam Chair.

The CHAIR. And now I am really so pleased to introduce the initiator, instigator, the source of this—the reason for this hearing and, again, to properly say thank you to you, Congresswoman Frankel. This is an extraordinary amount of information that I think we have to digest, and I appreciate your efforts to bring it to everyone's attention.

Congresswoman Lois Frankel.

Ms. FRANKEL. Thank you, Madam Chair, for bringing this to us today.

And Mr. Cole, I know was here. I know he has got a deep interest in this, too.

And thank you to the panel.

Madam Chair, it is always something, usually it is something personal that usually brings something to people's attention, and in this case, it was very personal. I have probably there is 350,000 seniors who just live in my county that I represent, and one of them is very special to me. It is my 96-year-old mother, who I just want to tell you is, she is physically in good shape now. But she had a number of falls, and finally, the fourth one, she broke her leg. And I have seen how it dramatically has changed her life.

She had superb medical care, but she was someone who was living independently before. She is very clear of mind. She is still of clear mind. She is now afraid to live by herself, uses a walker. And when I saw the medical expenses, I was shocked. Of course, she is on Medicare, but she also had some personal expenses, which is not really as relevant.

But this is why I started looking into this because, all of a sudden, my friends tell me, well, their parents all fell. And then my mother said, oh, all my friends have fallen. And then one of my friends fell, and she broke her jaw. And then I fell, and I broke my finger. I mean, I am going like "Is everybody falling?"

And the answer is when you get to a certain age, yeah, a lot of people are falling. And I just want to say the \$50,000,000,000 figure is the tip of the iceberg, folks, right? It is the tip of the iceberg because it doesn't even include what Medicaid, for example, is going to spend if someone goes into a nursing home or into assisted living facility.

And there are so many other things. It doesn't even deal with what it affects the family and how you become a caretaker that you weren't a caretaker before. And we love our parents and so forth. I would do anything for my mother, but I want to tell you, it is like she can't really do anything on her own. And getting the walker in and out of the car, I mean, it changes everybody's life in a lot of ways.

And I saw someone who is very clear mind now who, we talk about nutrition and isolation and so forth, who how just having—she is in an assisted living facility—how that affects her, just her well-being and how she feel everyday about herself.

So, and then multiply this out. Thirty-three million with falls reported. Hello? What would you say? A lot more falls than are actually reported.

And Madam Chair, I wanted to just let you know that I have made a request—actually, myself and a number of members—because this is an appropriations committee, a number of requests to the committee to take a look at some of the falling shortfalls, and I wanted to discuss this with our guests.

The Interagency Coordinating Committee on Health and Aging and Age-Friendly Communities has been authorized, but never funded. Could somebody—also the Research, Demonstration, and Evaluation Center for the Aging Network, also authorized but never funded. Could any of you please speak to the value of funding these programs?

Ms. PELAEZ. So, Representative Frankel, yes, the problem is that what you are referring to is occurring at all levels. ACL falls prevention competitive grants have provided important seed money for local and State organizations to reach out to a variety of partners and develop their own falls coalition, but those are not funded. So the sustainability and the effectiveness becomes extremely limited.

We have seen that the authorizing of coalitions that actually have the funding to bring Federal agencies that all have relevant resources and responsibility for falls would leverage the amount of funding that is available and would actually create the sustainability of cost-effective measures that can be happening at the local and regional levels.

So what I am saying is that these coordinating councils, these interagency groups are effective. We have seen them in the Elder Justice Coalition. We have seen it in other areas. But they need to be funded, and that is basically the bottom line.

Ms. FRANKEL. Madam Chair, I think I have run out of time, but if we have another round, I will continue with my questions on this area.

Thank you, Madam Chair. I yield back.

The CHAIR. Congressman Harder.

Mr. HARDER. Thank you so much. And thank you, Chair DeLauro, for hosting today's hearing.

And thanks to all our panelists for being here.

We are in the middle of an urgent and growing crisis of affordability amongst our seniors, at least in my community. With inflation on the rise, the skyrocketing cost of prescription drugs, and the shrinking supply of affordable housing, seniors in my community are really finding it harder and harder to get by.

Every year, I hear from more seniors who are unable to afford their housing, their food, their medications. Our housing prices have gone up by 20 percent in the last year alone, and that could be the difference between living down the road from your grandkids or being forced to move out of your community.

And ultimately, I think this is a big problem for a lot of seniors that have to choose between a roof over their heads, lifesaving medications, or a meal. And frankly, it seems to be getting worse.

Ms. Orsi, given your expertise on wellness for older Americans, are you seeing those financial challenges impact the quality of life of our seniors, and what are you hearing?

Ms. ORSI. [Inaudible.] They are wellness issues. In order for a person to be healthy, we have to look at the whole picture. So we have to find ways that we can better support people in terms of their financial along with their mental health.

In terms of answer, I don't have one. I wish I did. But I am sure, together, we can come up with some good answers.

Mr. HARDER. Thank you. What about affordable housing in particular? I think every community has its own set of unique challenges, but our community is growing very quickly, and a lot of our seniors are feeling forced out of their homes, or at least forced to live far away from the families that they love.

What do you think the Federal Government can do to support seniors who are going through some of these challenges on affordable housing or other financial burdens and upheavals? I will open that up to your or any other panelists that may have other ideas or suggestions on that topic.

Ms. ORSI. So I am not a financial [inaudible] many times an older person will not have choices, and they are forced to live somewhere that is maybe you and I might consider a little undesirable. But it is either that or the streets. So what are the choices?

At the same time, we know that a large number of our homeless population are older adults. So, again, in terms of housing, it is all ages are suffering from the housing situation right now, but particularly our older adults. But older adults, a lot of times, are the invisible population. Despite our numbers, we are still pretty invisible.

We are still always talking about investing in children, which we should do. But we need to invest in the old adult population that got us here.

Mr. HARDER. Yep. And what about that cross between prescription drugs—oh, sorry. Patty?

Ms. LYONS. No, sorry.

Mr. HARDER. What about that intersection between prescription drugs and other healthcare needs? How acutely felt do you feel like those financial strains are for older Americans?

Ms. ORSI. Well, they are extremely felt [inaudible] We didn't talk today too much about medication prescription at all. But medication, older adults receive one third of all the medications that are prescribed in this country. And we have they are in pain. They get a lot of opioids. We have an opioid problem. So the prescription drug price is really important, but another piece that we really need to look at is the number of meds that people take.

Now granted, when you have got a lot of chronic conditions, you need to take medications, but a lot of those create adverse events, increase hospitals and falls and all that other stuff. And I have got a friend who is a geriatric pharmacist that does training with me, and he says that the amount of drugs that are prescribed to older adults are America's other drug problem.

So besides mere cost, I think we really need to be focusing on what is the amount of prescription drugs that people are taking.

Ms. PELAEZ. So that also requires a great deal of investment in educating our medical community. The primary care providers are the ones that are the front door for the medical system to older

adults. And most of them have never taken one course in geriatrics, let alone geriatric pharmacy.

So how do you really invest in medical education and educating the health systems on how to provide better care for older adults? That, in itself, will begin reducing falls because medications are one of the many factors that need to be reviewed in order to prevent falls.

Mr. HARDER. Well, thank you so much. I see my time is up. So I yield back to the chair.

Thank you.

The CHAIR. Well, we have completed a first round of questions. I would like to do a second round. And let me just—because this is a all virtual, let me just check to see who of the members are still remaining.

I believe Ms. Lee, Ms. Frankel, myself. Are there any other members on the Democratic side of the aisle who are still here?

[No response.]

The CHAIR. And I am not sure who is still on the phone on the Republican side of the aisle.

Dr. Harris, Congresswoman Herrera-Beutler.

[Pause.]

The CHAIR. Okay. Well, it would look like this. Myself, Ms. Frankel, and Ms. Lee, who are still on. And so, with that, I am just going to say—oh, is Congressman Harris on?

Mr. HARRIS. I am here, but I have no further questions.

The CHAIR. Okay, lovely. Thank you so much.

Then move to the three of us for 5 minutes, 5 minutes each, and then, Andy, will you be doing—Congressman Harris, will you be doing closing for Congressman Cole or—

Mr. HARRIS. I can do that. It will be brief.

The CHAIR. Okay, and I will just move then to close after that. But let me just ask, if I can, I would like to get in two or three questions at a clip here.

I was interested in what you said, Dr. Pelaez, about just primary care and the need for primary care. But also as you attach to that the training of a workforce, if you will, a geriatric workforce. So we need a nursing and a medical community that is trained to recognize elder abuse and the mental health needs, the trauma, the identity, falls-related injuries.

U.S. Census Bureau says America is graying starting in 2030, when all boomers will be older than 65, older Americans will make up 21 percent of the population, up from 15 percent today.

And so let me just ask Ms. Orsi, is—and others can chime in. Is today's geriatric workforce robust enough, is it diverse enough to adequately serve the growing population of older adults and all of their unique needs?

Ms. ORSI. No. No, we don't. We do not have training ability.

The CHAIR. So let me ask others, if you want to chime in?

Mr. BLANCATO. Yes. Absolutely, Madam Chair. It has been a longstanding problem. The reimbursement rate under Medicare for geriatric physicians has been declining for years, providing no incentive for people to come into the field.

And when you talk about even on the training side, too many older adults go to emergency rooms with a bruise, and they assume

it was a fall, but it could have been elder abuse because you don't have forensic centers that can identify that. That is one of the recommendations I made in our testimony. We consider funding through grants, forensic centers specific for elder abuse like we have for child abuse. But we need to do more in the geriatric care space, for sure.

Ms. PELAEZ. Actually, when you really think about families with children, they would never think of taking a child to a primary doctor that was not a pediatrician. But we have 80, 90, 100 years old that are being taken care of by primary care physicians who really have learned to care for older people in a very strange way.

I have had doctors who say, "Oh, I am expert in taking care of older people because that is all I do." But when you really try to find out where is their science-based training, and there wasn't any.

So we really need to improve the medical education of people who take care of older adults. We need to demand that they have minimum criteria to do what they do. Otherwise, it is not fair. We are really compounding the problem by allowing a medical system that continues to ignore the needs of geriatrics, and that is very important.

That would be important at all levels—for mental health, for nutrition, for elder abuse, for falls, for everything. But particularly with falls, my mother was 94 years old when—she was chronic heart failure, but she really was falling a lot.

And I took her to the doctor. The nurse practitioner wanted to do all sorts of tests, but I said no. But she is falling. What can you do for her? And eventually, she said, "Well, don't—Mrs. Pelaez, don't fall again."

And I said to her—and I said to her, "What about physical therapy? What about an occupational therapy? What—." She said, "Oh, what a great idea."

So this is what we are encountering day in and day out in our communities. That is what we can [inaudible].

The CHAIR. Well, I will just make a note on that, and I do have another question. I told you my mom passed away at 103 years old. And I am an only child. So I was back and forth from New Haven, Connecticut, to Washington, and so forth. But I was not there during the week.

So at one time, we had seven caregivers for my mother so that she would have around-the-clock. But it is wonderful, and I will trade—and they were mostly women. They were all women. The women were just extraordinary with her. But the medical training, they did not have, which it was of concern to me.

I mean, they were good. They ministered. They got her to a doctor, or they took care of giving her the pills that were laid out. But it is interesting in terms of the profession, and quite frankly, we need to think about people that need to be paid more than a minimum wage. They need to be paid what they—and then we really need to take a whole look at and provide—help to provide the training because these are good jobs for people.

And that is something that we need to think about is what we are doing here in terms of training and making sure that people—and I know Congresswoman Lee will talk about her mom, et cetera.

We all have this issue, and we want to make sure that we have the best. You feel an obligation to have the very, very best treatment for your loved one at this stage.

So, and we should take a look at what we need to do in this area of training and providing this kind of training. Let me just ask at the same time, I am going to just try to get both of these in. This is about nutrition, and this is about falls.

It is about preventing those emergency room visits, and when you are looking at a falls prevention program, it is how do we prevent—you have got good ideas, and I thank you for them. How do we prevent the injuries, and whether it is with regard to nutrition or whether or not it is a fall, et cetera, on the prevention side rather than dealing with it after the fact?

Ms. PELAEZ. Right. We need to invest in public health and aging. Prevention, public health, they are the experts in prevention. We need to really have a robust public health approach to preventing falls.

There are many programs that have been proven to show that if they are done correctly, they are evidence-based, they help build muscle mass. They help create better balance. They help modify your environment.

There is a need for a person-environment fit. As you grow older, your environment has to be more supportive of whatever deficits in function you have. We have to approach falls from a public health perspective, from a community perspective, in addition to look at it as also related to medical conditions.

That is why we are emphasizing the STEADI screening tool. Because we cannot fix what we don't know. So if we don't really do proper risk assessments in our wellness visits, we don't know what we need to fix within that environment. But we also have to create a community-based health, public health approaches that actually help older adults improve balance, maintain physical activity, maintain good nutrition, but also modify their environment so the environment continues to be supportive of people's needs.

Technology is great. We have demonstration programs that need to be funded so we actually identify what are the best ways to deal with prevention. Investment in prevention is key.

The CHAIR. Thank you. Thank you.

With that, Congresswoman—go ahead, Bob. And then I have got to go—yes, I am well over my time.

Mr. BLANCATO. All right. Quick point.

On the Welcome to Medicare exam, they are needing more focus on falls prevention and education. In nutrition education, we should blend nutrition education and falls prevention, and we should also increase the reimbursement for DEXA screening.

The CHAIR. Okay, thank you. Congresswoman Lee?

Ms. LEE. Thank you very much.

You know, this is so important I am beginning to feel like this is like a group support session or a group therapy session. I wish we would have had this meeting like 10 years ago or 15 years ago. Then I can see so many similarities and commonalities on the issues that all of us have.

Chair DeLauro mentioned my mother who lived to be 90, and I tell you, same situation. Caregivers, great people, but not trained. They needed better pay, better training.

I learned so much about this because I was the one from afar who had to constantly manage her care. And so fast forward to now, my aunt, 101, I know a heck of a lot more than what I did then. So I am still managing her care, but there is still a lot of the same issues. Ten years later, my mother—well, 7 years later, my mother passed away 7 years.

So it is just so important that we really have as a priority, care, treatment, the needs of our seniors because they deserve the best care in the world. Just like our children deserve the best teachers in the world, our seniors deserve the best care in the world at that point in their lives.

So let me ask you, because I have always wanted to ask this question, and I don't—and given we have such experts here, I want to know about this, if it is true or not and what criteria factors into this. Okay? And maybe we are in denial about this as we age.

Fifty is the new 30, right? Sixty is the new 40, right? Seventy is the new 50. Eighty is the new 60. Ninety is the new 70. Okay. Now, are there any—is that scientific, or is that something we are just saying to keep us hopeful that we can stay 50 years old as we age?

Ms. PELAEZ. What we know is true is that we are living longer, and we are also—but we look forward to live longer and fewer years, those added years to our lives, without frailty and disability. That is our goal. So that is where it comes that now 80s are 60s, or whatever. We want to compress the amount of years that we actually live with disabling conditions.

And again, we are succeeding to a certain extent. But because we are growing, our population is becoming not only older, but the older people are living longer. So that we are increasing the octogenarian and nonagenarian and centenarians in our communities. Those are the people we need to focus on and see how we can actually ensure that the longer years that they have earned are really healthier years.

And to do that, we need to really invest in prevention with a geriatric focus lens with actually understanding how do we do that. Communities, community support is going to be the key and—because healthy aging is more than medical, biological treatments. We know how to cure some medical conditions, but we still are learning how do we maintain older people robust, active, and healthier to enjoy the number of years that we have gained in terms of longevity.

Ms. LYONS. And I would add, if you don't mind, I am an only child, and my mom lived with me the last 5 years of her life. And she passed at 95. One of the things that we haven't talked about, and I know I am supposed to be focused on nutrition, but we also run an adult daycare program, which is a perfect alternative for people who are living with family members.

So they are taken care of at night, but while we are working, my mom went to our adult daycare center. There were CNAs there. There is an RN there. They can help her with toileting. They can

help her with those things that she just needed. She wasn't ready for a nursing home, but she just needed a little bit of support.

So I just throw that out there. As you are looking at all this and talking about healthy aging, that is a good middle piece that doesn't receive a lot of funding.

Medicare and Medicaid will pay for a nursing home, but they don't pay for adult daycare, and that is a good middle piece. And it keeps them safe. It keeps them from being scammed by personal care homes that say they are going to take care of them, but they don't. I mean, it just filters all the way through.

Ms. LEE. Thank you very much. I yield the balance of my time.

Thank you. So I guess, really, 60 is the new 40. We can psych ourselves up to believe it, but that is basically, though, because of all of the what you said, Martha, about all of the other factors that have increased life spans.

The CHAIR. Congresswoman Frankel.

Ms. FRANKEL. Again, thank you. Thank you all.

I recently talked with folks from CDC, and they described what they thought were the four pillars on fall prevention. Clinical care, make sure there's a fall prevention routine as part of clinical care. Increase awareness among older adults and their caregivers. Engage emergency responders. And address specific populations because they have different needs. I think one of my colleagues brought that up before.

So I want to do, see how I can get through this. But the clinical care, for example, you talked about a program called STEADI evaluation, if you could tell me a little bit more about that. And do doctors get paid for this assessment?

Ms. PELAEZ. Not right now. There is not much incentive to really—we know that in the wellness visit, it is required to do a depression screening. But there is no requirement to really do a fall test.

They ask have you fallen? But there is not a risk assessment of falls. That would be a huge step in the right direction.

Ms. FRANKEL. Yeah, I agree with you on that. I am just thinking of my own mother's journey because before she had her really bad fall, she had had another fall before where she had a wound. I mean, so she was with a doctor, a primary care doctor, wound care. She had paramedics, all these touches, and I kept asking, like you, what can we do? And there was really no response, other than, well, she is old, I guess, you know.

So is there any payment or any training for first responders in terms of other than, okay, we have a patient here. Do they have to report? Do they have contacts? I mean, what—is there any program? I know there are some fire departments that do have programs for that. Is there any kind of a national effort?

Ms. PELAEZ. Yes. Actually, Pinellas County—Pinellas, our county, is doing a great job. And that actually came from the fact that it is very costly for fire departments to do those calls that are not reimbursed. So they decided that they were answering more falls calls almost than fire calls. So the fire and falls became actually a dual issue for them.

They are exemplary in terms of the education they give to the first responders, the resources they invest in community education,

the partnerships they have formed with the local falls coalition. And it is an excellent example of how resources from different sectors can come together and actually address a problem that affects everyone. So, yes, I think that Pinellas County—the Pinellas, our county is a great example that could be replicated.

Going back to the demonstration research of funds, I think one of the missing links is that we really don't have or don't invest enough resources in evaluating those efforts of those models of innovations. This country has been building innovation, but when we innovate, we need to evaluate and say is investment in this innovation going to actually be better in terms of cost-effectiveness, in terms of quality?

We are not at the point that we can actually do this demonstration nationwide and have everyone learn from it. So that is one of the reasons that we call so much not only for the interagency coordinating body, but also the funding of demonstration projects that help us learn from those experiences.

Ms. FRANKEL. And let me just emphasize that those are both authorized programs not yet funded, if I understand that correctly.

Ms. PELAEZ. Yes.

Ms. FRANKEL. And the other point, well, I see I am running out of time, but I would just say that educating older people gets difficult, especially as they may lose some of their ability to understand. Do you want to quickly comment on that?

Ms. PELAEZ. Yes. There are really two sets of people, maybe three. But primarily, those who are mentally able, but they really have to make—to understand how their bodies have changed, how their environment is changing. They need to understand how they can prevent falls.

And the program A Matter of Balance, the CAPABLE program. There is tai chi. There are a number of programs that do that very, very well. They are evidence-based. They are proven to be effective.

But then there are programs for people with dementia or people who really are unable themselves to learn how to avoid falls. Those programs are really targeting the caregivers, the family, the environment. Technology is helping, actually, a lot to help families create better caregiving for people with dementia with a focus on avoiding falls.

And we really need to learn from those and scale them. Scale them and make them really nationwide movements.

Ms. FRANKEL. Thank you so much. Thank you.

I yield back, Madam Chair.

The CHAIR. Thank you. Thank you.

I see that Congresswoman Roybal-Allard has joined us. So let me yield time Congresswoman Roybal-Allard.

Ms. ROYBAL-ALLARD. Thank you so much, Madam Chair. And I apologize for being late, but I was chairing another hearing. But I did want to attend whatever I could of this hearing because it is such an important hearing.

I have one question that I just want to pose to anyone on the panel. Today, people are living longer than ever before, but they are not necessarily living healthier. In fact, 58 percent of adults over the age of 65 have two or more chronic conditions.

I have read recently about the field of general science which aims to better understand the aging process and how it drives the entire range of age-related diseases and conditions. The hope is that we can delay or prevent multiple aging conditions at once and rather than tracking them one at a time.

Can any of you talk about how research on the aging process could help address the many health problems that older people face?

Ms. PELAEZ. I will be glad to start the conversation. I think the point is extremely important, but I also want to say that you can live very healthily even with multiple chronic conditions.

I have at least four chronic conditions that I am dealing with, and I consider myself a great, very healthy human being because they are managed, because I am able to control their symptoms and deal with them, and they really do not affect my function in any way. So we have to do both. We have to really continue to learn how investing in the biomedical research that will help us understand better the aging process and what can be done about it along the life course, and we also have to really invest on this concept of wellness.

And wellness is different from disease in many ways. Diseases can be managed. Chronic conditions can be managed, and you can be very healthy living with chronic conditions if you have, actually, the proper support to do that.

Both are super important, and we really—because whatever we are going to learn by investing in bio research is going to be a long-term investment, and it is not going to happen overnight. So we need to be doing both.

I hope I answered your question.

Mr. BLANCATO. I would like—oh, go ahead, Karen.

Ms. ORSI. I will just make a quick comment. Granted, that is a very important topic, but I think also we are all aging advocates on this call. But I think in order to be an aging advocate, we always have to go back to ground zero. Many of our older adults are aging into Medicare. There is a lot of chronic diseases because they did not have access to healthcare when they were younger.

So we have to focus on from the beginning. To be an aging advocate, I have also got to be an adolescent advocate. People need to have healthcare and access to it. And if they get that proper care, then we wouldn't have such a chronic condition-centered older population.

Mr. BLANCATO. Congresswoman, I remember when I worked for the House Committee on Aging, when your father chaired the committee years ago, and we would talk about research back then and the need to coordinate it.

I think right now, you are at a point where there is a lot of research going on, but the question is how do you do an inventory in such a way to determine the most important that should be continued to go from research to practice? And I think what you are talking about is very important, and I think this hearing also from the standpoint of investing in prevention as an element and showing how research into prevention can show results, good results, I think is important, too.

So, hopefully, we can analyze that a little more deeply. Because there is a lot of good research going on in the National Institute on Aging and the National Institutes of Health and places like that.

Ms. ROYBAL-ALLARD. And I just want to point out not just prevention, which is absolutely key, but also the fact that when someone does have a chronic disease, as was mentioned, they have to have affordable access to the right kind of healthcare. And something that the chairwoman has been pushing for some time and has mentioned several times in our hearings, they also have to be able to afford the medication that is needed, which is something right now that is not necessarily true.

So I just want to commend the chairwoman for her consistent advocacy and efforts to make sure that prescription drugs that are needed for maintaining someone's health will be affordable.

And I yield back, Madam Chair.

The CHAIR. Thank you. Thank you very much for those kind words.

And just as a moment, couldn't get to your event last night, but congratulations on your award from the Coast Guard. Just unbelievable. There was 5-minute voting—and you have to talk to Dr. Harris about that—22 votes, 5-minute votes each. So it was a little tough to get back and forth. Anyway, so—but congratulations.

Ms. ROYBAL-ALLARD. Thank you. It was a lovely evening.

The CHAIR. Okay. Congressman Harris, let me ask you to make a closing comment, and then I will as well.

Thank you.

Mr. HARRIS. Yes, thank you very much. Thank you very much, Madam Chair, for having the hearing.

Look, I think most people don't realize that we have about 45 million people over age 65 right now, and by 2060, that is going to be 90 million. I mean, we are not anywhere near the plateau phase of the aging demographic in the United States. We are nowhere near it. And the sooner we start to plan for the problems that are going to be associated with that, the better.

One topic that was brought up is Medicare. The fact of the matter is, Madam Chair, you know we are going to have to deal with Medicare. The Part A trust fund goes broke in 3 years. Part B expenses are projected to double in the next 20 years. And yet our providers are facing a 9 to 10 percent payment cut, not keeping up with inflation, payment cut.

And the elderly tend to retire in rural, more rural areas where it is already difficult to find providers. This is going to be—if we don't pay attention to this, we are going to be left with our seniors who can't get access to the needed medical care because, as has been mentioned many times, there are usually many comorbidities in our elderly population.

It requires specialists. The need for geriatricians has already been brought up. But when you are dealing in a specialty that is compensated for by Medicare with decreasing payments every year, it is not a way to attract our youngest and our brightest into the field. So we have so many complex problems associated with the changing demographic. The sooner we deal with it and begin seriously thinking about this, the better.

So I want to thank—I want to thank everyone on the panel, and I yield back to you, Madam Chair.

The CHAIR. Thank you so much.

And again, I want to, you know, a shout-out to Congresswoman Frankel, who initiated this effort. But I have been struck not only in your personal testimony at the outset, but in the course of the hearing that the rich data and information is stunning. And I just don't say that and say, "Oh, my God, isn't that wonderful?" But we are—become liable if we have got all the studies. And Bob, you pointed that out. I mean, well, we have got a lot of data. We have got a lot of research. We need to do some specific research in some of the medical areas, and that we can try to do it.

But we have enough data for us to be able to look at some of the mechanisms that we currently have and how they need to be extended or plussed up or provided more revenue in the area. There are some areas where we are—we have to focus on. We talked about workforce. We talked about training. We talked about an infrastructure, if you will, around this. We talked about training.

You have been all wonderful in your testimony to not only lay out the problem, but to help us to think through, you have laid out some of the solutions. And we need to and I believe we will try to take up these efforts as we move forward with the appropriations bills.

And it has also been stunning to me that everyone on this call has these concerns. Barbara Lee pointed that out. My mom would say to me, "Rosa, these are supposed to be the golden years, but they are the lead years."

Because we are all excited that my mother lived to 103 years old. It is unbelievable living longer, but I dealt with the feeling all the time of the quality of her life and what was the quality of her life?

And that is what you were focusing on. That is where you are guiding us. And I think that we need to be very cognizant of, again, the agencies that are tasked with this effort, whether it is nutrition, whether it is mental health, whether it is the propensity for falling, and understanding that better.

We are going to go to the NIH, and again, most—it is women. Most of these falls occur with women. Why? Why is that? What is it that—we have Dr. Harris here, but what is the medical difference, the gender differences that provide that? What are we doing with the Older Americans Act?

And I will just say this. We focus on Social Security. Yes, I think you are right about Medicare and what we need to do. But I don't think we spend enough time reflecting on the things that you all have focused us about today and how we can translate that into assistance for older Americans.

We do not have to write an omnibus healthcare bill, but we do need to know where in the system we can plus-up and make a difference.

So I will just say to you I am hopeful. I feel that you will say yes to this, but I know your resources. But as we go down and looking at the appropriations bills and we are putting them together, that we can call on you to be resources and to check in with you about if we are following the right path.

So, thank you. Thank you very, very, very much for the work that you do and for your testimony.

And with that, I am going to call this hearing to a close. Thank you very, very much.

TUESDAY, MAY 17, 2022.

DEPARTMENT OF LABOR

WITNESS

HON. MARTY WALSH, SECRETARY, DEPARTMENT OF LABOR

OPENING REMARKS BY CHAIRWOMAN ROSA DELAURO

The CHAIR. I would like to call to order the hearing on the fiscal year 2023 budget request for the Department of Labor.

This is a hybrid hearing, so we need to address a few house-keeping matters.

For the members joining virtually, once you start speaking, there is a slight delay before you are displayed on the main screen. Speaking into the microphone activates the camera, displaying the speaker on the main screen. Do not stop your remarks if you do not immediately see the screen switch. If the screen does not change after several seconds, please make sure you are not muted.

To minimize background noise and ensure the correct speaker is being displayed, we ask that you remain on mute unless you have sought recognition. The chair, or an individual designated by the chair, may mute participants' microphones when they are not under recognition to eliminate inadvertent background noise. Members who are virtual are responsible for muting and unmuting themselves.

Finally, House Rules require me to remind you that we have set up an email address to which members can send anything they wish to submit in writing at any of our hearings. That email address has been provided in advance to your staff.

With that, I would like to acknowledge Ranking Member Tom Cole and all of the members of the subcommittee who are joining today's hearing, both in person and virtually.

And I want to say a thank you to all the members and our witness for your flexibility as we start this hearing earlier than expected to welcome the Prime Minister of Greece later this morning.

I would very much like to welcome you, Secretary Walsh, first in-person hearing of this subcommittee as Secretary of the Department of Labor. You joined virtually last year and happy that it is in person today.

I want to first thank you for how hard you have fought this past year, throughout your entire career, for American workers and for working families. These last 2 years have been difficult for so many, especially for working families. Far too many people lost their jobs. Small businesses and restaurants were forced to close. Schools were shut down. Our childcare infrastructure collapsed.

PANDEMIC AND INFLATION IMPACTS

And the pandemic exacerbated what we have known for a long time, that pay has not kept up with the costs of living. Too many Americans were already struggling, and the pandemic took a massive toll that left so many reeling.

Workers are living paycheck to paycheck. They are struggling to pay taxes that are too high. Big corporations with monopoly prices are pushing—or monopoly profits are pushing up the prices. And now we are facing a war abroad that has spiked inflation and created an energy and a cost of living crisis as well.

And economic opportunity remains hard to reach for millions in underserved communities. The employment rate for black and Hispanic workers remains considerably higher than that of the overall population. Workers without a college degree face more barriers to employment than college graduates do.

Far too many women have been pushed out of the workforce or forced to consider new employment over the last 2 years as sectors that employ predominantly women continue to suffer, and access to childcare and workplace flexibility make returning to the workforce that much harder for mothers.

We need to be doing even better for the communities that need us the most. That is really why we were all elected. Franklin Roosevelt's Secretary of Labor Frances Perkins, the first woman appointed to a presidential Cabinet, said—and I quote—"I came to Washington to work for God, FDR, and the millions of forgotten, plain, common working men," and I would add women.

Working for the forgotten and for our workers should be the reason every single one of us is in Washington, and we know, Mr. Secretary, that that is why you are here. We have a responsibility to protect and lift up our workers. So thank you for joining us today to discuss the Department of Labor's budget. We appreciate all you have done and will continue to do to protect workers and support their families.

WORKFORCE AND EMPLOYMENT INVESTMENT

Just the important work of rebuilding our economy began last year. I am proud that the Congress passed the first fiscal year 2022 Government funding omnibus in March, including a \$653,000,000 increase for DOL programs. With \$550,000,000 more for employment training programs, we help workers reenter the workforce, earn better wages, improve their families' economic stability.

We increased funding for registered apprenticeships to help Americans develop into new high-skill trades. We strengthened State grants and job training programs that help ex-offenders return to the workforce, supporting those with significant barriers to employment find good-paying jobs, helping employers hire and retained skilled workers.

With \$50,000,000 for Strengthening Community Colleges Training Grants Program, we are meeting the demand for skilled workers by providing training at community colleges. I am proud that this committee was instrumental in creating this program in 2020 and the Apprenticeship Grants Program in 2016, both of which are

growing our economy from the bottom up and lifting people into the middle class.

A priority of mine for years has been to strengthen worker protection agencies at DOL, and we worked closely, proud to work closely with DOL to bolster the Wage and Hour Division, the Occupational Safety and Health Administration, and the Employee Benefits Security Administration. We provided a total of \$1,800,000,000. These critical agencies protect against wage theft and worker misclassification, enhance the health and safety of American workers at a time when potential workplace hazards threaten millions of us.

To support working conditions abroad, we increased the International Labor Affairs Bureau, ILAB, capacity for high-impact international assistance that combats some of the world's most abusive labor practices, including the use of child labor and forced labor. And with funds from the U.S.-Mexico-Canada Agreement, the USMCA, ILAB is making huge strides to enforce the labor provisions of our trade agreements while helping workers and employers in Mexico make their workplaces safer.

Protecting workers must always include protecting those who find themselves unemployed. We are addressing longstanding problems in the unemployment compensation system that disproportionately harm workers of color, service industry workers, blue collar workers by modernizing technology and expanding reemployment services for job seekers.

We included district-specific community project funding to support workers in our home districts and try to meet the needs, including funding for job training, workforce development, apprenticeship programs. And the America COMPETES Act strengthens our workforce while keeping our economy competitive.

FY 2023 BUDGET PROPOSAL

As we begin fiscal year 2023, we need to build on these investments. The budget request proposes \$14,900,000,000 for DOL programs, a 13 percent increase over 2022.

There is a plan to look at workers and their families and how they can access opportunities they need and deserve. To support workforce development, the request would increase investments in State grants for workforce training, Apprenticeship Grants, and other job training programs, double funding for Strengthening Community Colleges Training Grants to reach students when they need it most.

The budget request also continues our efforts to rebuild the unemployment compensation system to help unemployed workers make ends meet while they look to quickly reenter the workforce. And supporting our workers means maintaining a strong commitment to worker protections. Pleased to see the request of an increase of \$355,000,000 for worker protection agencies to rebuild this critical, important mission that has gone underfunded for decades.

WORKER UNIONIZATION

We must do even more to support our workers, the people who keep our Nation running. I am proud that we were able to support

the people who keep this body running, congressional staffers, with a bill paving the way for staffers to unionize. This example should reverberate across our Nation. More needs to be done not only in this building, but everywhere. Workers deserve a fair shot at a good-paying job.

I want to lend my voice and my support to the millions of American workers joining together and unionizing to fight for higher wages and better working conditions. We have seen successes at Amazon, Starbucks, and other corporations, and that there is no better way to strengthen the middle class than to ensure that workers have a seat at the table, which is why I strongly support the PRO Act, strengthening workers' bargaining rights and their ability to freely choose to join a union as they fight for a better future for themselves and their families.

Mr. Secretary, the work that you and the rest of the Department do to provide safety and opportunity for our workers makes our country better, pushes our economy forward. We have made progress over the past year, but as you know, there is so much more to do. People need to have Government look out for them, and those who are working and the vulnerable who work hard.

This budget request and our support for our workers will ensure that we live up to these ideals, and I look forward to working with you over the next year and to today's discussion.

And with that, let me recognize Ranking Member Cole for his opening remarks.

OPENING REMARKS BY RANKING MEMBER COLE

Mr. COLE. Thank you very much, Madam Chair.

Mr. Secretary, it is wonderful to have you here.

Before I get into my prepared remarks, I want to make three quick observations. This is a big day for our committee. You are going to name this hearing room after our former chair of the whole committee and longtime chair of this subcommittee, Mr. Obey. So that will be a happy moment, and I thank you and congratulate you for doing that.

Second, God thank the person who got us new chairs up here on this podium.

The CHAIR. That is right.

Mr. COLE. If you haven't noticed, we can all move and get in and out. I don't know who the staffer is that who did it under your brilliant leadership, but please give that person a raise.

The CHAIR. A raise, right.

Mr. COLE. That was wonderful.

And finally, just as a housekeeping matter, I am going to have to leave at about 9:45 a.m. because Rules is meeting to redo our structure. So I apologize to you, Mr. Secretary, and certainly to you, Madam Chair, and my colleagues for having to depart early. That is not the normal pattern for me.

INVESTMENTS IN DEFENSE INDUSTRY WORKFORCE

But I am particularly pleased, Mr. Secretary, to have you here in person in this year's hearing and welcome you to our subcommittee. And I want to start by thanking the Secretary for trav-

eling to my district recently, which he was kind enough to do at my request, to visit Tinker Air Force Base, which is America's largest defense aircraft maintenance depot and keeps—it is actually the world's largest—keeps many of our Nation's most important national security aircraft in safe operational order long after their normal life span.

As I have raised before in this subcommittee and Defense Subcommittee, our aircraft depots and, in fact, all of DOD and the economy at large have serious shortages of qualified high-skilled workers. The Secretary was very helpful in helping us think through that problem and helping us come up with ways to begin to address it. So we appreciate that.

We have got a particular need for advanced software developers, computer engineers, and other cyber professionals. And I suspect we are not alone in needing that particular set of skills.

The Secretary took the time to meet with key base leadership, the union leadership, and several workers onsite to investigate the issue. I will ask a question on that topic later, if time permits. But I look forward to working with you, Mr. Secretary, and your team in the coming months to pursue cooperative solutions along with the Air Force.

FY 2023 BUDGET PROPOSAL

Now turning to the President's budget request for the coming year, I must reiterate several concerns. Last year, President Biden signed the American Rescue Plan into law without a single Republican vote. This legislation pumped nearly \$2,000,000,000,000 of new spending into our economy, much of it unneeded and poorly targeted. I firmly believe that the law has been a direct cause of the 40-year high inflation we are currently experiencing.

Gas prices are averaging well over \$4 a gallon, and prices in the grocery stores are up in double digits. History has taught us we cannot spend our way out of inflation, yet this year's budget seems to think we can do just that. I respectfully disagree.

The spending levels requested in this budget double down on those same levels resoundingly rejected by Congress from the last budget. To enact such an increase in this environment would irresponsibly add to the national debt and further push our economy into possible recession.

In fact, some believe we are already on the course of seeing a recession within the next year, a fact I find incredibly unfortunate. I believe the worst effects of the President's economic policies could have been avoided if such a sharp partisan approach to spending had not been pursued early in the administration.

The fiscal year 2022 appropriations represents a compromise. It did not include the more than 17 percent increase for non-defense agencies requested by the administration. Instead, we came together and funded joint priorities in a bipartisan manner at reasonable levels, and I certainly hope we can do that again for fiscal year 2023.

My second concern centers around the lack of support we are showing for employers. Unemployment is at an all-time low of 3.6 percent. That is a good thing. In my State of Oklahoma, we are significantly below the national average at 2.6 percent.

Businesses are struggling to find workers, and a worker shortage is exacerbating the inflationary pressures, further pushing our economy into a downward spiral. Yet I do not see a workforce policy from the administration reflecting the realities of many businesses. Recent proposals to “modernize” the Davis-Bacon standard for a prevailing wage return us back to a definition that has not been used for nearly 40 years.

The budget requests a more than 20 percent increase for the Wage and Hour Division, a more than 35 percent increase for the Office of Federal Contract Compliance Programs, a 15 percent increase for the Occupational Safety and Health Administration, and nearly 200 additional staff for labor enrollment in the Department.

Specifically in your budget materials, you cite the need for greater enforcement of those participating in the sharing economy. With unemployment at record lows, we do not need excessive executive overreach, stifling innovation and flexibility for both workers and employers.

Innovative solutions like those found in the sharing economy have enabled millions to find work when they want it and help those find workers when other options were not available. We should be supporting these new forms of employment, not smothering them with overly aggressive rules, regulations, and enforcement.

APPRENTICESHIP PROGRAMS

I do want to commend your support for the apprenticeship programs. We have seen these programs flourish in recent years under multiple administrations. I think apprenticeships represent an opportunity and a pathway to high-paying jobs, many of which do not require a college degree.

However, I am disappointed by the lack of support to alternatives to registered apprenticeships. I hear from businesses regularly about the limiting structure and cumbersome model of registered apprenticeships. The model was not built for the economy and the opportunities of today, and it is not doing enough to support today’s worker.

It is underutilized by many industries, notably the growing sector of information technology, cybersecurity, and supply chain logistics. I think the administration should do more to support intermediaries in these areas and alternatives to registered apprenticeships to bring opportunities to these aggressively growing businesses and to American workers.

These are just some of the policy differences that I am sure we will discuss today. I am hopeful that we will work through this shortened budget year, and will be able to once again find the middle ground.

I have said before, and I will say it again. The chair and I have worked together for the past 7 years to find a spending level we can both support in the final appropriation, and we have been able to do that seven times in a row.

So I certainly hope to do so again, and I would certainly not like to see our 7-year streak broken, and I don’t believe it will be. I think we will be able to find common ground and get this bill down

to you and give you a budget within a reasonable period of time so you can go about your important job.

I know the chair doesn't want to drag this into next year, and I don't want to drag this into next year. We both want to get our work done on time.

So I want to thank you again, Mr. Secretary, for appearing before us today. I want to thank you in particular for taking the time to come to my district. That was a very generous act on your part, and I look forward to your testimony and our continued work on our shared priorities.

With that, Madam Chair, I yield back.

The CHAIR. I thank the gentleman.

And Mr. Secretary, your full written testimony is going to be entered into the record, and with that, you are recognized for 5 minutes for your opening statement.

OPENING REMARKS BY SECRETARY WALSH

Secretary WALSH. Thank you very much, Madam Chair. It is an honor to be here today. And Ranking Member Cole as well and members of the subcommittee. It is great to be in person. Last year was my first—

The CHAIR. Your mike?

Secretary WALSH. Oh, sorry. Can you hear me?

The CHAIR. Yes.

Secretary WALSH. It is on, yes. Last year was my first hearing when I did Zoom, and it was hard to, quite honestly, get into a rhythm here. So it is great to be here today.

I am pleased to outline President Biden and Vice President Harris and the administration priorities for the Department of Labor's fiscal—2023 fiscal year. My mission, as Secretary of Labor, is to empower all workers morning, noon, and night.

The frontline workers who have carried us through the pandemic and the worst days of the pandemic, the marginalized workers who face barriers to employment opportunities, the veterans who serve our Nation, the rural workers who serve through targeted workforce training programs, the Department of Labor stands with all workers in every community to build a stronger, more resilient, and more inclusive economy.

DEPARTMENT OF LABOR'S RULE IN THE AMERICAN RESCUE PLAN

I am proud of the Department of Labor and what we have accomplished this past year. We have successfully implemented the key provisions in the President's American Rescue Plan. That plan was very important to opening up our economy, supporting healthcare workers, supporting pensions, supporting Unemployment Insurance in our country, protecting workers from COVID-19 and heat exposure, strengthening retirement security and access to mental health services that we need to do more of in this country.

We expanded career training programs to connect more Americans to more opportunities and connect more industries to skilled workers. We implemented the President's \$15 an hour minimum wage for Federal contractors. We had people in this country that

were earning \$7 an hour, trying to raise a family on. That is impossible.

We had legislation—we worked on legislation to stop surprise billing, medical billing, and protections for tipped workers that Chair DeLauro and Chair Murray advanced in 2018.

We advanced Government-wide initiatives to support workers' organizing rights, climate action, and infrastructure implementation. In all our work, we are committed to equity for the most vulnerable workers in all of our communities across America.

ECONOMIC RECOVERY

We have in this moment a unique opportunity to help workers truly thrive. The President's plan has produced a historic job-driven recovery, and Congress has made transformative investments in workers through the Bipartisan Infrastructure Law and other actions that Congress has—that you have taken.

GOOD JOBS INITIATIVE

In the Department of Labor, the Good Jobs Initiative, we are partnering across Government to make sure these investments create good jobs and access for all people. I am committed to supporting congressional efforts to invest in the workforce training, childcare, education, healthcare that working families need and depend on in this country, in every single community and our neighborhoods in our country.

FY 2023 BUDGET SUBMISSION

This 2023 budget submission builds on these investments and renews our pledge to serve workers, job seekers, and retirees in America. The workforce development budget requests \$303,000,000 to expand registered apprenticeship programs, proven programs that work to help people get better jobs and get into a good industry; \$100,000,000 for community college partnerships with employers. And I have been to about 10 community colleges in the last few months to go around and talk about the importance of investments in every community.

One hundred million dollars for career training in growing industry sectors, such as Tinker Air Force Base when I was there last week with you, Mr. Leader, and we talked about the challenge that the Air Force has with competing with the private sector and getting good-paying jobs into those areas. These are powerful tools for connecting diverse workers to skilled opportunities, and they meet critical supply chain needs in our economy.

For example, the administration is working urgently to ensure that infant formula is safe and available for families all across our country. While this work is led by the FDA, our work is to increase the number of qualified truck drivers on the road to address the issues that many others have not over the long term, and we are going to continue to do that. And it is critical to providing good careers of workers for people of color, women in rural America, and veterans opportunities to get into those good-paying jobs.

The budget increases funding for our veterans through our Veterans Employment and Training Service Agency. It increases fund-

ing for our Women's Bureau to expand access for women to careers where they are underrepresented.

WORKER PROTECTION AGENCIES

The budget invests \$2,200,000,000 in the Department's worker protection agencies. This work is more essential now than ever as we rebuild the staffing levels. That includes OSHA's efforts to double down on the number of inspectors by the end of the President's first term.

It will restore MSHA's capacity for enforcement in mine plan equipment reviews. It would restore staffing on Employee Benefits Security Administration to protect workers' health, retirement, and disability benefits. It would increase funding for our Wage and Hour Division to safeguard the wages of vulnerable workers. It would offer our Office of Federal Contract Compliance Programs to ensure Federal contracting advances America's promise of fairness to all workers in this country.

The budget increases funding to the Office of the Labor Solicitor, rebuilding the entire Department's capacity to enforce the laws. We are also requesting resources for the Bureau of International Labor Affairs. ILAB ensures our training partners uphold their labor commitments—our trading partners, excuse me, uphold their labor commitments so American workers can compete on a level playing field.

STATE UNEMPLOYMENT INSURANCE FUNDING FORMULA

This budget fully funds and updates the State funding formula for Unemployment Insurance. This would be the first comprehensive update in decades. It allows States to serve claimants more efficiently, and our request includes \$150,000,000 to strengthen the integrity of the system. Every single one of your States has had a problem over the last 2 years with Unemployment Insurance.

Finally, the budget requests nearly \$4,000,000 to support Good Jobs Initiative. This enables us to advance the President's priority of good jobs with the free and fair choice to join a union.

As Labor Secretary, I have traveled across this Nation to meet with workers and employers and better understand the needs of people and communities in this country. Despite all they have been through, workers are showing up each and every day to move our communities forward. In return, we must do all we can to ensure their well-being and empower them with opportunity.

I want to thank you all once again for the opportunity to testify to you in person today. I look forward to discussing our budget request with the committee, and any questions that I can't answer, we will work with your teams to make sure we get the answers for you by the end of today, hopefully. Depending on how early we get out. [Laughter.]

The CHAIR. Thank you very, very much, Mr. Secretary.

I was really interested in—because we have been discussing the issue of infant formula for the legislation, et cetera—but the tie-in with the truck drivers. I really hadn't thought about that and if we can move product where we have a greater supply, and that is what the head of FDA had said to me yesterday, that we have some places that have supply. But if we can move that quickly,

then we can get the product back on the shelf so parents are not at risk.

So, thank you.

ENFORCEMENT OF WAGE THEFT PROTECTIONS

Mr. Secretary, last week, along with my colleagues, we introduced the Wage Theft Prevention and Wage Recovery Act. It is legislation to put hard-earned wages back in workers' pockets, crack down on employers who unfairly withhold wages from their employees.

Every day, employers do cheat their employees out of legally owed wages. They violate employees' overtime, minimum wage, and tipped work rights. Wage theft disproportionately harms low-wage workers, amplifying poverty and making the enforcement work at the Department's Wage and Hour Division all more critical.

Mr. Secretary, how can the Department proactively stop bad actors from withholding hard-earned wages from workers? How is the Wage and Hour Division prioritizing meaningful enforcement efforts to ensure that corporations are not stealing wages from our most valuable workers?

Secretary WALSH. Thank you, Madam Chair, and I look forward to certainly partnering with you to ensure that this bill moves through Congress that is being moved through.

The Wage Theft and Wage Recovery Act would strengthen the fundamental protections that would allow workers the full compensation that they have earned, and it will crack down on corporations that subject workers to abuses, quite honestly. I mean, we have to do everything we can in our power to take the steps that people aren't losing their wages, their hard-earned wages. That is the bottom line here, I think.

And certainly, at the Department of Labor and my past roles as working in the building trades or working on a construction site, when somebody does their job, they expect to get the wages. I have spent a lot of time going around this country and been in a lot of church basements talking to workers that, quite honestly, have been taken advantage of because they feel they have no power to support themselves on fighting back for their back wages that they are owed.

Anyone in this country, in the United States of America, that goes to work any day, every day, should be paid for every single minute that they work. That is the bottom line. And this bill will help us ensure that illegal practices that are disproportionately hurting low-income workers are overturned. And we have to make sure we protect all workers in this country as we continue to move forward, and I think that that is something that is really important.

We also have to continue to support 35 percent of our workers that are tipped workers, and we have to make sure that our tipped workers as well aren't taken advantage of. Those are the folks that serve us the food, that serve us the coffee, that clean our tables, that bring us the food when we go out to restaurants, and it is appalling to think that in 2022, we have people in this country that are being taken advantage of. And again, mostly low-income workers, workers of color, women.

That, quite honestly, should not be the case. So I look forward to working with you and Congress, this committee and Congress, to pass that law, and I hope it is a bipartisan effort because the wage theft is happening on both sides of the aisle.

The CHAIR. Thank you. Thank you for your efforts in that area.

ROLES OF ILAB IN USMCA

Let me just ask a question about ILAB and USMCA. Since the passage of the USMCA, the implementation act included \$210,000,000 from this committee for ILAB, and so there has been great progress made in this area as noted. ILAB, in your testimony, you have talked about integral to supporting the first independent union elections at General Motors at the plant in Silao, Mexico, and the Tridonex auto parts facility in Matamoros.

So, in April, the Department announced \$28,000,000 in investments to combat forced labor and human trafficking and support workers' capacity for negotiating these collective bargaining agreements that would raise wages and improve conditions in Mexico. How will you support ILAB's critical monitoring, enforcement, and capacity-building roles in the USMCA? As we continue to make progress in Mexico, what other areas of the world can we focus on to support workers and, as a result, American businesses?

Secretary WALSH. Well, thank you very much.

Last month, Deputy Secretary Julie Su traveled to Mexico. She met with their Labor Minister in Mexico to talk about what is happening on the ground. She came back and reported to me that she felt really good. We have hired four labor attaches—there is a fifth one coming—in Mexico to look at the trade agreement.

She felt positive when she was talking to the Labor Secretary—Minister, I should say, and their commitment to enforcing labor laws in Mexico. And certainly, I support ILAB in all of their efforts to make sure that wherever we are in the world, whatever work we are doing in the world, that we are doing it collectively together.

We are also working, which you didn't ask me the question now, but I just want to quickly say also looking at child labor and how that impacts—how that impacts labor negotiations and how it impacts labor all across the world. We saw last year—and I will stop. I know my time is over.

Last year, we saw the first time in 20 years an increase in child labor abuses in this world. So we are focused on working to—partly due to the pandemic and partly due to a whole bunch of different reasons, but we can't be standing by as a country and watching those happen.

The CHAIR. I would hope that you will just keep in touch on that issue. I think that we really ought to be leading in the effort in eliminating child and forced labor that exists. And we may not eliminate it, but we should do all that we can as the U.S. to curtail it.

So, thank you. And with that, let me recognize our ranking member, Mr. Cole.

Mr. COLE. Thank you very much, Madam Chair.

INCREASING REGISTERED APPRENTICESHIPS

Mr. Secretary, in my opening remarks, I mentioned the bipartisan agreement on apprenticeships and how important they are, and this committee has increased funding for those under administrations of both parties. But we have only had a modest increase in the number of folks that are actively registered apprentices.

What are the sorts of things we can do to increase those numbers? We all know this is a good pathway to a great job and the skill sets that our economy really needs. So what is the Department thinking about that we could attract more people into these opportunities?

Secretary WALSH. Yes, I think that, first and foremost, we have to let people know that these opportunities exist. And I think that what we are doing at the Department of Labor is we are looking at other industries where we can expand registered apprenticeship programs similar to the building trade model, which is the gold standard, looking at in other areas how do we do that.

We were able to, with the trucking challenge, with the supply chain challenges we had, were able to in a matter of 48 hours turn around an application. We have over 100 companies right now that are working on—that have an apprenticeship program in the trucking industry. We have 400 that have signed up. We are able to turn that around in 48 hours and move that forward.

Not to keep bringing it up, but at Tinker Air Force Base the other day when we were there, I started thinking about opportunities for apprenticeships working with community colleges. Just for the members of the committee, there is a need over the next year at Tinker for 3,000 engineers.

They have about 1,500 engineers from the local colleges in Oklahoma. There is about 1,500 other opportunities that are needed there, and they are competing with the private sector. So they can't compete fiscally with the private sector because of the cost.

So you think about a program like that, creating an apprenticeship program that allows Tinker to hire people to come in as apprenticeships, get on the job training, working with schools, working with universities. And over a very short period of time, a couple years, you can scale those workers up where they already have an understanding of how the base works.

That is how I envision these programs working. Not just in engineering, but in high tech, biotech, anything, any industry we want to think about we could create a program. But we are going to have to need—the companies, the private sector is going to have to work with us. And the public sector, to some degree, investments. But I really think it has to be a private sector really investment because that is the best way it is going to be.

The last thing I will say, we signed an MOU with the country of Austria a month ago to talk about what—Austria and Switzerland have a really robust apprenticeship program. And when they do it, I mean, it is embedded in their philosophy.

We are not there yet as a country, and we have to get there slowly because I think a lot of people, as you mentioned in your opening remarks, are resistant to it. And they have to understand this is not a program we are creating just for the sake of creating a pro-

gram. It is actually a process, a program we are creating for advancement for educating people to go to work and get good jobs.

Mr. COLE. Just for the record, you can mention Tinker as much as you would like. Go right ahead. [Laughter.]

UNEMPLOYMENT INSURANCE FRAUD PROTECTION

Mr. COLE. You mentioned in your remarks some of the modernization efforts on Unemployment Insurance programs. And look, I recognize we are coming out of an extraordinarily difficult period, where we had systems that were strained well beyond what their capacity was ever meant to be or anybody could envision. I mean, when you are going through a pandemic and you make decisions that we are going to have slowdowns or shutdowns, and you got to give people an alternative, and these systems simply weren't set up to handle that volume well. So I am glad you are, number one, looking at that.

We have had quite a few reports about fraud. Again, when you put this much money through the system, that is going to happen and particularly when the system can't handle it. So I am interested in going forward, if you could detail a little bit more about what are the specific things you are going to try and help State uninsurance funds do? What are the protections in terms of fraud going forward that you would highlight?

Secretary WALSH. Yes, when Congress made the appropriation last year, I wasn't quite sure how many States and territories would be involved and want to be interested in doing something with Unemployment Insurance. We have 49 States that are very engaged in this process. We have put together tiger teams that have gone in to identify challenges in different States and identifying, working with them and making investments through grant programs to make sure we fix the challenges that these States have had.

I think that the unemployment system ultimately is going to need an investment both on a State and a Federal level to bring their systems up to 21st century standards. Many of their systems are working on systems that were built in the 1980s and 1990s, and the infrastructure is just not there. But what we are doing with the Unemployment Insurance office is working to make sure that where making this \$2,000,000,000 investment, we need to make sure that every single penny of this \$2,000,000,000 goes toward modernizing and fixing the challenges that we experienced through the pandemic.

Pre-pandemic, the fraud numbers were very low. Post pandemic, the fraud numbers were high because of the pandemic and the amount of money that went through the system, and I am expecting those numbers to come back down. But I am not expecting the problems to go away if we don't fully address it.

So we are working with States right now. Some States are making their own investments. We are taking that \$2,000,000,000 that Congress gave us, and we are investing it. Our team is working really hard on it. They are strong, but powerful, but mighty team. They are the same team, quite honestly, that was able to distribute the money from the CARES package and the American Rescue Plan that Congress supported over the last couple years.

Mr. COLE. Thank you very much. My time has run out.

And unfortunately, as I mentioned earlier, I am going to have to leave. So I regret that. But again, thank you for visiting my district, and thank you for the job you do. It is much appreciated.

Secretary WALSH. Thank you, Mr. Ranking Member.

Mr. COLE. Yield back.

The CHAIR. Congresswoman Roybal-Allard.

CHILD WORKFORCE SAFETY

Ms. ROYBAL-ALLARD. Mr. Secretary, welcome. Before I ask my question, the chairwoman mentioned the international child abuse of children in the workforce, and I just want to point out that in our own country, we are also guilty of child abuse in the workforce. And I am talking particularly about children that work in agriculture, who are the children—are the only children in agriculture are not protected under our labor, child labor laws. And as a result, children that work in agriculture die at much higher rates than children in any other industry, not to mention the impact it has on their education and also on injuries.

And I do want to thank your office for helping me put together, providing me with information, and I am introducing a bill, H.R.—or I have introduced, it is 7345, the Children’s Act for Responsible Employment and Farm Safety of 2022, which is intended to address this issue to protect children in agriculture. And it has all kinds of exemptions, of course, for family farms, and we have tried to address every concern that has been raised. So I just wanted to bring that up to this subcommittee because it is a little—a dirty little secret that we have in this country about these children.

OSHA RULEMAKING DELAYS FOR HEALTHCARE WORKERS

Mr. Secretary, I am a co-chair of the Nursing Caucus, and I am very concerned that nurses and other healthcare workers have experienced high rates of infection and death from COVID-19 and increasing rates of workplace violence during the COVID-19 pandemic. This is due to the fact that there is a failure of healthcare employers to have in place any kind of workplace violence prevention plans.

But more importantly, it is also largely due to OSHA’s failure to act. OSHA has, for many years, said that they were in the process of writing a proposed rule on workplace violence in healthcare settings. Given OSHA’s lack of action, Congress, this House has tried to correct that and has passed a couple of bills to make that happen.

It seems inexcusable to me that OSHA has yet to finalize a rule to protect these healthcare workers. Can you please explain why OSHA has been unable to put together a rule to protect these healthcare workers, and hopefully, can we expect something this year?

Secretary WALSH. Thank you, Congresswoman. Thank you for raising this important issue. And I certainly look forward to working with you on the legislation, and your office.

I don’t know if I would describe OSHA as failing. I know that there has been, in the last year and a half, OSHA has been full

out working hard on temporary standards dealing with COVID. Workplace violence is also one of those issues we have to work on.

In the last 4 years, OSHA has lost significant amounts of money, have been significantly understaffed, and there are some concerns there. So we are staffing up OSHA. I will promise you right now I will make this a priority. We have had conversations. We have done more than conversations.

I actually had a group of nurses in my office. Last week was Nurses Week in the United States of America. I had a group of nurses in my office from around the country. One of the issues they brought up was workplace violence and particularly not just during COVID, but pre-COVID.

And workplace violence isn't just around nursing. It is about other professionals well. So I give you my commitment that I will work with your office on this.

Ms. ROYBAL-ALLARD. Okay. I appreciate that. And I see my time is almost up. So I yield back.

The CHAIR. Congressman Harris.

Mr. HARRIS. Thank you very much.

H-2B VISA ABUSE PROTECTIONS

Very good to see you, Mr. Secretary, and again, thanks for the visit back in March. The first thing I would like to talk about a little bit is the H-2B visas, which we talked extensively in our office about.

At that time, you indicated that there may have been—you were going to look into whether or not adequate protections exist against abuse in the system. Were you satisfied? I mean, are there ways we can improve it to make sure that we get the workers, but the employers don't abuse the system?

Secretary WALSH. Yes, thank you for that.

There is always ways we can strengthen protections for workers when it comes to H-2B visas. We are in the process still of looking at that, but I am satisfied where we are today. We were able to get the allotment of 35,000 out.

Thank you for meeting with me. I know it is important to your district and is important to a lot of people's districts on this podium and in this Congress. So we are going to continue to strengthen that.

The system of H-2B visa changed in 2014. Congress used to allot—as you told me, Congress used to allot. We didn't have to do this additional every single year or every single twice a year. I think, for me personally, that was a better system than having to do this.

But I want to make sure that as we do the H-2B visas, as we do an allotment, whether it is 20,000 or 35,000 or whatever the number is, I want to make sure the workers that are being brought into this country to work in tough industries that work really hard have the protections that they deserve. So as of right now, I feel confident. But we are looking longer term to make sure that workers have good protections.

Mr. HARRIS. No, thank you very much.

And please, if you find areas where we can tighten it up, again, to protect the workers. Because the employers I work with, they

need the workers. They are willing to follow the rules. Just tell them what the rules are.

And those who aren't willing to follow the rules shouldn't be getting the workers. It is that simple.

Secretary WALSH. Right.

Mr. HARRIS. So, but thanks for your help on that. Hopefully, we can get back to the old system, maybe returning workers or something, so you are not involved twice a year because I am sure you have better things on your mind.

B-1 VISA PROGRAM

The other issue I did want to bring up, and you probably will have to get back to me about it, is the issue of how we are constructing offshore wind because there is going to be a push for it. It is interesting that there is also a visa system involved. It is called the B-1 visas, which are outer continental shelf visas, which we give to ships that are going to do the construction, and they bring in the labor.

Now, normally, it is not American labor doing this. I mean, I was a little surprised. I thought we were going to construct these offshore wind mills. We are not.

There are lot of ships, Nordic country ships. And then they hire workers from non-Nordic countries because Nordic countries obviously would be competitive in salary with our salaries. They hire other, Eastern Europeans, things like that, where they pay much less. So we are losing American jobs because I think of the way that visa system works.

So if you could look into how the B-1 visa system works, and let us know if there are ways that we can get some of those jobs to be done by Americans. Those are good jobs, those construction jobs, and I think the system, for instance, by allowing these countries, these Nordic countries to apply, get the visas, but then hire other countries' workers at a low cost I think just undercuts our abilities.

Do you have any knowledge about that? Because this is one of the growing industries.

Secretary WALSH. Yes, the issue there is the work that is on the shore, our workers can do that. When you get to the rigging out in the harbor, out on the sea, the companies will often say that our workers aren't trained and aren't able to do the work.

But I think that we will be able to scale up our workers pretty quickly, our tradespeople, to be able to do this work. I know that this is an ongoing conversation. I am not as familiar with the visa that you just brought up, and I will look into that. But I think what we really have to do is make sure that we have good training programs.

Our workers can do that work. It is just a matter of some new technology that has come into the United States of America, and for the most part, it is a brand-new industry, offshore wind. That means we have talked about it for a long time, but now we are starting to see actually the fruits of construction there.

And I think after a short period of time, meaning get one of these up, we should be able to have the workforce that is trained. Our workforce in America, our building trades can build anything.

Mr. HARRIS. Yes, I agree.

Secretary WALSH. There is no reason why we can't be building offshore wind.

Mr. HARRIS. And again, if you could look into that?

Secretary WALSH. I will.

Mr. HARRIS. If there is a loophole they are exploiting or something.

MINIMUM WAGE FOR TIPPED WAGE WORKERS

And finally, the last thing is one of the industries hardest hit by COVID was the restaurant industry. They still have concern over a minimum wage that would include tipped wage workers. I mean, they—and you understand the issue. I mean, the fact of the matter is that a tipped wage worker whose wage is less from the employer has to earn the minimum wage when you add tips in.

So any efforts to expand the minimum wage that doesn't take into account a tipped wage I think would hurt our restaurants. And these, as you know, a lot of them, small businesses, at least especially in my district. If you come out and visit, we will bring you to a place, a mom-and-pop place that barely survived COVID that has real concerns.

So they want their employees to earn a fair wage, but as you understand, if you bring that tipped wage up to the minimum, it prices them out of the market. So, again, just to raise the concern.

Secretary WALSH. Yes, one of the things—and we can talk more about it. One of the things that we have seen in the restaurant hospitality industry is 11.2 percent increase in wages, and most of the restaurants that I have spoken to haven't necessarily complained about it to me. And some of them are small restaurants. But I will get back to you on that, and I look forward to getting to your district and having some crabs.

Mr. HARRIS. Thank you very much.

I yield back, Madam Chair.

The CHAIR. I recognize Congresswoman Clark and say a thank you to Congressman Pocan for having Ms. Clark jump the line here.

So, Congresswoman Clark.

Ms. CLARK. Thank you so much. Thank you, Madam Chair.

Mr. Secretary, always good to see you, and thank you for your incredible work since you have been in your position.

WOMEN IN THE WORKFORCE AND CHILDCARE INITIATIVES

And I especially want to thank you for your focus on women in the workplace. We know that at the height of the pandemic, 2.5 million women left the workforce, and 1 million fewer women in the workforce today than in February of 2020.

And we know who these women are. They are low income. They are essential workers. They care for our children and for our parents, our seniors, our disabled family members. They are primarily black, brown, indigenous, and rural women. And they are moms, because we know there is a price to be paid in this country for being a mom.

So your Secretariat finds itself at the intersection of another crisis that we are having for women in this country, and that is that we are about to see *Roe v. Wade* overturned and moving in many

States to mandated pregnancies, Government-mandated pregnancies. So as we are looking at who is most impacted by this post pandemic economy and, frankly, who was most impacted going into the pandemic, but the pandemic shown a light on these women and their economic forces, these are the exact same women, low-income moms, who are most likely to seek abortion care.

So in this new world that we are entering, this new crisis for women, some of the work that you have done is around childcare, which is absolutely necessary. A recent GAO report that I requested found that only 11 percent of all workers have access to employer-provided childcare, and we know the United States is way behind other developed countries in supporting this.

Can you tell me a little bit about the impact that you will see in being able to have women have jobs that can provide for their families if we do not do something about childcare?

Secretary WALSH. Thank you, Madam Chair. And certainly, this is an issue that both of us worked on back in our days in Massachusetts.

If we don't do something as a country about childcare, we are going to do severe damage to our economy. If we don't get women back into the workforce at a big level—and we are seeing women come back into the workforce, but we see high levels of unemployment—it will impact our economy, number one. Number two, it will impact our family structure in America, number two.

I know that in legislation, a couple of pieces of legislation the President has filed that is in front of Congress now. But this is an issue—again, this is not a partisan issue. This is a bipartisan issue of childcare in America, about the cost of childcare, the availability of childcare, and not just childcare, high-quality childcare.

The cost of paying folks that work in that industry also are predominantly women and women of color that are underpaid, making minimum wage in that industry. If you look at the numbers, across the board what the pandemic has taught us is that we have deficits in different parts of our economy. One of our deficits are certainly in job training that we saw, people quitting jobs at high rates, and the biggest glaring spotlight is on women in our economy.

And it is not just childcare. It is paid family leave as well. Women, 51 percent of the women in this country are the leads in the family. Yet we don't respect them for that.

So, I mean, I am certainly working across agencies with Secretary Cardona, Secretary Raimondo, working on how do we strengthen our childcare system. It is time for us as a country to make a major investment in childcare. That is the best I can say right now.

DEPARTMENT OF LABOR SURVEY DATA UPDATES

Ms. CLARK. And speaking of childcare and moms, the data that came out of the Department of Labor, the most recent that we can find is 2018, showed that 1 out of 4 moms had to return to work within 10 days of giving birth. We are the only wealthy country that doesn't have national paid leave, which is a disgrace.

But can you tell me, are you considering updating that information and surveys to give us new insight?

Secretary WALSH. Let me just get my quick cheat sheet here. The latest data that we have is the 2020. But let me just say this to you. I will work with the Women's Bureau and your office to get updated numbers. We need to have numbers from 2022, not from 2020, not from 2018, not from 2016. That was yesterday.

I will do everything I can to get some updated numbers with you so we can actually see up close and personal what the real issues are.

Ms. CLARK. Thank you so much.

Thank you, Madam Chair and Congressman Pocan, for your indulgence.

The CHAIR. Congressman Fleischmann.

Mr. FLEISCHMANN. Thank you, Madam Chairwoman.

Mr. Secretary, good morning, sir.

Secretary WALSH. How are you?

Mr. FLEISCHMANN. Good, good. Congratulations to your Boston Celtics, first and foremost, for making the Eastern Conference finals. The Secretary and I have different views on a lot of things, including sport teams, but I always appreciate great winning. So I wish you well, sir.

Secretary WALSH. Thank you.

Mr. FLEISCHMANN. I also appreciate the fact that you have taken the time to come back. Let us face it. This administration and our side have some fundamental strong differences in ideology and on policy, but I think we both want the best for the American worker, just different paths to get there. So thank you for your willingness to sit down and talk through some of the difficult issues. I appreciate that, sir.

EEOICP OMBUDSMAN POSITION

Mr. Secretary, I first wanted to commend the Department for opening the Ombudsman position to oversee the Energy Employees Occupational Illness Compensation Program. This is an issue, albeit a little bit parochial, it is of particular importance to my issue and my constituents in the Oak Ridge area. Many employees, contractors, subcontractors, and their vendors were exposed to radiation, beryllium, and other highly toxic substances that have left them with chronic illnesses, sir.

My first question is what is the administration's timeline for reviewing applications and filling the Ombudsman's position, and what plan of action do you hope to see from the new Ombudsman, Mr. Secretary?

Secretary WALSH. Yes. Thank you very much for the question, Congressman.

First and foremost, we are in the process of hiring right now, and we are looking at a timeline—I just got whispered in my ear—about 6 months we should have that position ready to go. And I look forward to, obviously, working with you in this area to make sure that people are getting the proper attention they deserve.

EEOICP TRAINEE POSITION PROTECTIONS

Mr. FLEISCHMANN. Yes, sir. Mr. Secretary, we are receiving a lot of calls from constituents who have been exposed to these particular substances over the years, and many of these people were

actually trainees at the time. A little bit of a specific question, is the administration open to expanding the EEOIC program to include trainees as a covered class, sir?

Secretary WALSH. Let me have a conversation with my office and get back to you on that. I am not prepared to answer that question at this particular second.

Mr. FLEISCHMANN. Understood. And getting that background, as I say, it covers a specific class of worker, but as trainees, these people were, of course, workers and exposed in that capacity. But understanding—

Secretary WALSH. I don't see the challenge—I don't see the obstacles there. Let me just—again, before I commit to anything, I just want to have a conversation with the office.

Mr. FLEISCHMANN. Agreed. Understood.

CONTRACTOR PROCUREMENT PROCESS TIMELINE

Finally, sir, the Advisory Board on Toxic Substances and Worker Health officially requested a support contractor 3 years ago, sir. It is my understanding that the contract is still in the procurement process and has not yet been sent out for bids. Mr. Secretary, is this a normal timeline for the procurement process? When do you expect the process to be completed, sir?

Secretary WALSH. It doesn't sound right, certainly, the timeline for 3 years on this. Again, I have to go back and check and do little bit more research on this. I wasn't prepared to answer, per se, this question today. So I will get back to you and your office right after this hearing.

Mr. FLEISCHMANN. Understood, sir. I know we have got some other hearings and issues coming up. So, Mr. Secretary, I will just say thank you.

And Madam Chair, I will yield back.

Secretary WALSH. Thank you.

The CHAIR. Thank you. Congresswoman Lee.

Ms. LEE. Thank you very much, Madam Chair and Ranking Member Cole, for this hearing.

And thank you, Mr. Secretary, for being here. Good to see you.

RACIAL EQUITY IN UNEMPLOYMENT AND HIRING FOR AFRICAN AMERICAN WOMEN IN THE WORKFORCE

And thank you in your testimony for being straight up, pretty blunt and authentic in much of what you talked, wrote about especially in your testimony as it relates to black women. And we know that black women—and you laid this out in your testimony—right now, the unemployment rate is at 5 percent, and it is the highest of women by race and ethnicity. I think it was 6.6 percent a month ago. So it is heading in the right direction, but it is very concerning.

And so I know that black women have been disproportionately impacted during COVID, but what in the world are you able to do to address this? What are you doing to address it?

And then, secondly, with regard to your commitment to racial equity, thank you again for being very clear in your testimony about what the issue are around racial equity. And in fact, you mentioned that oftentimes black women, the intersection of racism and sexism

means that black women are experiencing a different and more difficult recovery, but also how they are treated differently within these jobs.

And so in terms of the executive order, how does that 13985 calling for equity throughout the Federal Government, how do you address equity as it relates to African-American women and the unemployment rate? And then, secondly, you talk about we must embed equity into how we recruit and hire and what have you. But how are you doing that? How do you embed it?

Because, I mean, I understand how structural racism works. So there are systems you have to dismantle before you can do anything to move forward to develop equity strategies. So I am curious as to how you are doing that and what you see in terms of black women and strategies to make sure they are treated properly, first of all, and that their unemployment rate comes down?

Secretary WALSH. Well, thank you, Congresswoman. Let me just start by saying you talk about it, and you don't run away from it.

It is no surprise to me that the black unemployment rate in this country is 5 percent, and we can't say—unfortunately, we can't say because of the pandemic it is 5 percent. Pre-pandemic, there was a challenge with black women and employment in this country, and the black community as a whole in this country.

We have had usually the black unemployment rate is double that of the white unemployment rate in this country. It has been historic, forever. I think some of the things that we can do is when we think about the Bipartisan Infrastructure Law and we think about opportunities and challenges that come from that law, I think we have an obligation to make sure—and part of the Good Jobs Initiative—is making sure that we have an equitable recovery, making sure that those investments from the Bipartisan Infrastructure Law, whether it is on a construction site or the jobs that are going to come off it, that people of color, particularly black people and Latino, have an opportunity to get access to those good-paying jobs.

The investment in the Davis-Bacon prevailing wage, when we think about raising wages, in many parts of this country people work on Davis-Bacon prevailing wage projects. They are being paid lower rates. We haven't looked at Davis-Bacon in the last 40 years. That is an opportunity to lift wages up for people.

We passed the \$15 an hour minimum wage, Federal contracting minimum wage. We had many people, particularly communities of colors, that were working on those projects that were underpaid and paid \$7 and \$8 an hour by Federal contracts and Federal contracting. We were able to lift that wage up to \$15 an hour.

The executive order that the President signed that you referenced, 13985, is across the Government. The President has asked all of us to look to make sure that equity is embedded in everything that we do as a department and how do we continue to move forward.

My Women's Bureau—if you want to be more kind of granular, my Women's Bureau is really focused on creating opportunities and pathways as well. So you know, this isn't words I am saying to you. This is the action that we are taking in the Department of Labor, and we certainly have a long way to go, but—and we also have to

measure the data. Data tells the truth. If you don't have the data and you don't look at the data, it doesn't tell the truth.

Ms. LEE. It is too bad we don't have the data after—

Secretary WALSH. No, no. What I am saying is measure the data to make sure that the investments we are making now, that we see in a very short period of time that the data is actually speaking a different story is what I meant by that.

FEDERAL INFRASTRUCTURE PROJECT CONTRACTING STANDARDS

Ms. LEE. Apprenticeship programs and work on the infrastructure project. In my district, for example, in the Golden State of California, historically—well, California eliminated affirmative action. The only type of programs that you can apply racial equity and gender equity to are federally funded programs.

So you look around in my district, and you don't see any black and brown people working on these big infrastructure projects in the past. So how do you make sure—and you are going to make sure the black and brown people are on the infrastructure projects and what kind of a stick do you have for contractors to make sure they do that?

Secretary WALSH. Well, I think the stick is you work with—I am working with the building trades now to make sure that we are creating career apprentice programs into the building trades. I have done it in the past. As head of the building trades in Boston, I have created a couple different programs that have created pathways in there for people of color and women to get into the building trades. They were successful programs. They are proven programs that work, building pathways.

I know how to do it. You don't need a stick. What you need to do is have conversations about equitable. And I know that you talked about some of the affirmative action programs that have gone in our country. We are way beyond, in my opinion, affirmative action programs. We should be doing this as the nature of business in this country.

Ms. LEE. We should.

Secretary WALSH. So, again, I feel confident in the conversation I have had with the building trades and the conversation I have had around this infrastructure law. And not just the infrastructure law, but private construction as well, to get more opportunities and more pathways into the trades.

And not just the trades. I think when we talked with Chairman Cole, when we talked a little bit about apprentice programs, we need to make sure that all of these apprentice programs, when we create them—whether it is trucking or in other industries—we need to make sure that they are diversified as well going in the beginning of them.

Ms. LEE. Thank you very much. Thank you, Mr. Secretary.

The CHAIR. Ms. Herrera Beutler.

Ms. HERRERA BEUTLER. Thank you, Mr. Secretary. It has been helpful to just sit here and listen to your approach. I commend you. You obviously worked these issues. Not all Secretaries do, to be honest. You obviously work them, and I appreciate that, your willingness to work them with all of us up here because it is true that

the American worker is pretty forefront on our minds, especially right now.

RECOVERY OF UNEMPLOYMENT INSURANCE FRAUD

And I wanted to ask, Ranking Member Cole talked a little bit about the unemployment fraud that took place during the pandemic. I just wanted to make sure you are aware 2 weeks ago, Department of Justice issued a press release that a Nigerian citizen pled guilty to COVID-19 unemployment fraud in Washington State and 17 other States. That individual was able to submit more than \$2,000,000 in unemployment claims.

And so I know that since then, OIG found \$163,000,000,000 in pandemic unemployment benefits could have been paid improperly. And I was watching our Secretary of Labor at the time, and she was not doing a very good job, and there were a lot of warnings. She has since moved on, thankfully. Although now she is at a Federal level, which is not a good idea. But I digress.

I wanted to ask how much has DOL, have you all been able to recover of that fraud?

Secretary WALSH. I don't have the exact number. I will get it to you. But I will tell you I meet monthly with my IG, and our IG is going after any fraudulent cases \$250,000 or above. So I will get you a number.

A lot of these cases are in court. So it is going through the court process. We are talking now about a year since they are identified. We work very closely with the Justice Department, but anything over \$250,000, the Department of Labor's IG is going after. So I will get you the money that was recovered, and I will also get you the money that is on the hook that we are in court on.

Ms. HERRERA BEUTLER. Great.

Secretary WALSH. So you have kind of two numbers right there.

Ms. HERRERA BEUTLER. That would be great.

CHILDCARE INDUSTRY AND WORKFORCE SHORTAGE

Representative Clark also spoke a little bit about childcare workforce shortages, and I think—so this has been an issue I have been working with a number of folks on the panel for a while.

Childcare continues to be a top issue for folks in southwest Washington. Twenty-five percent of our region's childcare capacity completely disappeared during the pandemic, and it was already an issue before the pandemic, already a childcare workforce shortage.

And I just wanted just a commitment from you, and I think you will give it pretty readily, that the Department is going to commit to helping us build this pipeline for childcare workers, quality childcare workers, as we try and address the shortages to free up opportunities for moms and others in this country.

Secretary WALSH. No, you have my commitment on that. And not only that, I would love to talk to anyone that has ideas on it because it is a very challenging career. Because what happens in a lot of childcare facilities is that somebody will start in the childcare industry. They will work. They are getting paid low wages. And then, ultimately, a lot of them go into teaching, and they get into an opportunity—

Ms. HERRERA BEUTLER. Yes, they get pulled right out.

Secretary WALSH [continuing]. And we lose that—we lose that infrastructure. And then—so I would love any ideas you have on that.

Ms. HERRERA BEUTLER. There are a couple of bills, and we will make sure to pass them your way, bipartisan bills. Some are bicameral. Because there is a few different things you have to do. Some of it is training. Some of it is making sure that there is physical brick and mortar places. Some of it is making sure that the families can afford it. So we have a few different bills that we will be happy to get your way. Again, bipartisan and bicameral.

Secretary WALSH. Our childcare industry got destroyed during COVID. A lot of them, States, they were able to fund them for the first 6 months of COVID. And then, after the 6 months, they went back to the old structure. But people didn't go back to work—

Ms. HERRERA BEUTLER. People went home.

Secretary WALSH [continuing]. So they didn't get—or they weren't getting the money from the parents, from the families, or whatever, the vouchers to do it. So they went out of business. So that whole industry is in desperate need.

Ms. HERRERA BEUTLER. We have some ideas for you.

Secretary WALSH. I would love to hear.

IMPACT OF PROJECT LABOR AGREEMENTS

Ms. HERRERA BEUTLER. On another topic, project labor agreements. And I suspect we won't see eye-to-eye on this. But I think it is important—

Secretary WALSH. You never know.

Ms. HERRERA BEUTLER. I think it is important that you understand. You mentioned that the PLAs are welcome news for all workers, but that is not what I am hearing from the 87 percent of non-union workers in construction. This administration's recent—their executive order on PLAs, mandating them, I think my challenge is, is that they limit the pool of qualified bidders primarily to one stream of bidders. And that can have impacts not just for taxpayers, but for people who are working, and they won't have the chance at a job that is a good job.

In Washington State, the unionization rate is actually relatively high, at 18 percent. And Washington State is not exactly a red State, right? I am in no way anti-union. I have family members who work in the trades who are part of unions. That is not my issue.

But I am pro worker and, I think, pro competition. And what I am concerned about is that the PLAs are going to really kind of disenfranchise 80 percent of non-union contractors, smaller, mom-and-pop industries—again, I have family who are in this side of the business—in Washington—and they just want a fair shot at competing for projects funded by the Federal Government.

My opinion is this mandate is going to increase the cost of Federal construction projects, and it is going to curb competition. What are your thoughts?

Secretary WALSH. First and foremost, the project labor agreements of the President's executive order is \$35,000,000 or above, so the 87 percent of contractors that can't apply for it wouldn't apply for it in the beginning because we are talking about large construc-

tion projects that the bidding pool is small. That doesn't prohibit non-union, non-signatory contractors from bidding on that work.

And actually, project labor agreements prove that it actually saves taxpayers money because there are guarantees in the project labor agreement that job done on time, on budget, doesn't have work stoppages in it, and the project labor agreements that I have been involved with as the building trades or in my time in my other roles I had in my career, oftentimes, those projects come in underbid, under budget, and on time.

I mean, that is the reality of the situation. There is no question about it. And it doesn't prohibit—

Ms. HERRERA BEUTLER. I have to stop you there just because I am way, way over time.

Secretary WALSH. I am, too. [Laughter.]

Ms. HERRERA BEUTLER. I am way over time, and there is a question about it. I have to submit that for the record. We differ on that one.

Secretary WALSH. Okay.

Ms. HERRERA BEUTLER. But thank you so much.

Secretary WALSH. Thank you.

Ms. HERRERA BEUTLER. Yield back.

The CHAIR. Congressman Pocan.

Mr. POCAN. Great. Thank you, Madam Chair.

And thank you, Mr. Secretary. I really want to thank you and your staff. I think you have done a great job in the role, as has your staff, and I think your knowledge and your passion for workers is very much appreciated.

I would like to try to get to three subjects. So let me start with the first one.

WORKER ORGANIZING AND EMPOWERMENT TASK FORCE

You served alongside Vice President Harris as the vice chair of the White House Task Force on Worker Organizing and Empowerment, which earlier released a report that had 70 recommendations for actions the administration should take to empower workers' voices in their workplaces. Many of those recommendations call for coordinated efforts by the Department of Labor and other agencies such as the NLRB, which has been flat-funded for a decade.

What resources do you and other agencies like the NLRB and the Office of Solicitor require to fully implement those recommendations from the task force?

Secretary WALSH. Yes. I actually have a meeting later today to talk about the task force. It is our first kind of follow-up since the report came out. I don't have the exact number what we will need, but any resources you want to allocate our way, I will gladly take them. And that is not a snide comment. It is the reality of the situation.

But let me have my meeting today, and after I get a chance to understand exactly what departments, what areas we need, I think I would love to come back to you.

Mr. POCAN. Yes. I mean, we are in the middle of doing the next year's budget, so please do that.

Secretary WALSH. Yes. Good timing.

PERSUADER RULE UPDATES

Mr. POCAN. Also I found it very exciting the new wave of organizing that we are seeing. I think you and I coming with a labor background have seen a lot of traditional labor organizing in the past, but now we are seeing it at Starbucks and Target and Trader Joe's and Amazon and in the video game industry and a lot of other industries that haven't seen it before.

One campaign I am watching particularly closely is the quality assurance workers at Raven Software, a company in my district, which has faced captive audience meetings and other types of classic union-busting tactics. I know one of the recommendations in that task force report was for the Department of Labor to update its rules for persuader activity reporting.

Can you explain how an update to the persuader rule will help protect and empower workers, and what resources do you need from this committee to make that update?

Secretary WALSH. Yes, thank you for that.

I can't get too much into it because we are in the rulemaking process right now. But certainly, I have spent enough time as well talking to workers in this country that are disgruntled, quite honestly, and we are seeing an increase in involvement in union organizing. We are seeing workers rising up. We are seeing last month I think 4.7 million people quit their jobs because they weren't happy in the job they had.

So I actually think a lot of what we talked about today—just a little off topic—the job training, workforce development investments, the apprenticeship—I think we have to do that for our economy. Because we can't continue an economy where people are quitting at the rate they are quitting every month because they just really want to earn more money. We actually have to create pathways for them into better-paying jobs.

And that is why we are seeing a lot of this—or I think that is why we are seeing a lot of this organizing conversation going on. People saying, wait a second, union workers over there seem to have a better situation, better benefits, more money, and I want part of that.

So I think, as a society, as an economy, as the Department of Labor, I think we have to work closely with Commerce as well on how do we create better pathways into better-paying jobs, whether they are union or not.

Mr. POCAN. Sure. And as you look at that rule, I mean, part of that additional organizing, though, has got the additional pushback. And we have seen it time after time, whether it be Amazon, whether it be Starbucks, or in the video game industry, like Raven Software. So do appreciate anything you can do in that area.

BLS TRACKING OF STRIKES AND WORK STOPPAGES

Many of these campaigns also involve smaller bargaining units, and like let us take Starbucks, for example. I am interested whether this new way of organizing requires a shift in how we track this type of activity at the Federal level. The Bureau of Labor Statistics only tracks strikes and other work stoppages involving over 1,000 workers.

Do we need to change the way the BLS tracks this kind of activity in light of these trends, and if so, are you going to need additional resources, or what can we do to get to that point?

Secretary WALSH. Yes. I think I haven't thought of it that way until you just brought it up. I would have to talk to BLS, but I am assuming if we don't track it, they will need additional resources to track that information.

I will have to get back to you on that. I honestly—that is a good point. I haven't thought of that.

Mr. POCAN. Great. No, I appreciate it.

And Madam Chair, I will yield back my 40 seconds.

The CHAIR. Congressman Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair.

LOWERING INFLATION

And good morning, Secretary. Just wanted to raise some issues that I am hearing as I travel throughout my district. The number-one issue I hear is inflation and the concerns of people's paychecks not going as far as they used to.

I am wondering what ideas you have at lowering inflation because I do have concerns. Ms. Herrera Beutler talked about project labor agreements. It kind of defies logic to me that by discriminating against certain people working on projects, that somehow that would be a cost savings. It seems like competition would actually encourage more, but that is a different topic.

But I am just wondering if you could tell me what your plans are to help lower inflation?

Secretary WALSH. Yes. That is obviously a great question. I think inflation that the country is dealing with right now, we saw a little dip in it last week in inflation. It went down 0.2 or 0.3 of a percentage point, but it is still high. One of the biggest things that we can do, I can do as Secretary of Labor, is continue to work on the supply chain issues.

Supply chain has caused part of the problem in creating getting goods and services to our shelves and our stores and into our—into people's homes. We have worked—I have worked really hard over the last 8 months, along with Secretary Buttigieg, to really think about making sure that we are doing everything we can to get the ships offshore onto land and the product into the stores.

Also monitoring very closely the negotiation right now in the L.A. ports to make sure that we are not seeing any disruption. There is negotiation between the carriers and the ILWU, ILA—the longshoremen—making sure that we don't see any shortages there that, again, could add to inflation further down the road. I feel pretty comfortable where we are in that situation today.

I was out in L.A. about a week ago, week and a half ago. I sat down with the company. We had a conversation about the ports. We had about 27 ships offshore to be coming in to be unloaded. I was there a previous month before that, where I was actually in Seattle, and we had 67 ships. So we are seeing that alleviation of the burden.

My concern is that right now in China, many manufacturing facilities are closed down. So we have about 100 ships, to my knowledge, offshore in China, waiting to be loaded and be brought to the

United States. We have to make sure we have a system in place that moves those goods and products across the ocean.

OSHA VACCINATION AND COVID TESTING POLICY

Mr. MOOLENAAR. I appreciate the update on the ports and the ships. I think that is a big concern. I think the trucker shortages also seem to be a concern. As I talk to people, there is just a real need for more truck drivers.

I wonder, the OSHA policy, the vaccine mandate that your administration pursued, the court chose not to implement that. Are you continuing to pursue that? Because I do think, between truckers trying to go in Canada across national lines, there was a big concern about that.

I do feel that some of these administration policies are contributing to an environment where people are having to choose between getting a vaccine or doing their job, and I think it is discouraging people in the workplace. I wonder if you—

Secretary WALSH. Thank you.

Mr. MOOLENAAR. Are you rethinking that, or are you still pursuing that?

Secretary WALSH. Well, first and foremost, the policy that came out of the Department of Labor was not a mandate. It was an “either/or.” It was a vaccine or testing. That is the policy I had. It is in black and white what we did.

And for the most part, trucking was not going to be part of that because truckers drive in their truck by themselves, and they were covered by it to some degree, but it wasn’t a mandate. And it hasn’t discouraged one person from driving a truck.

I think where we have a problem in this country with trucking is we haven’t made investments in trucking in a long time, and we have people—I met with the independent trucking agency that was talking about how those drivers that are independent drivers, that own their own rigs and drive their own trucks, that they are undercut all the way along the way, and that is where the disgruntledness comes from.

So I think in the trucking industry, the biggest thing that we are being able to do at the Department of Labor is working to shorten the time to get into a registered apprenticeship to 48 hours. So we have over 100 companies right now that have signed up with the Department of Labor that actually have apprenticeships that we are able to limit that to 48 hours.

They have truck drivers—I think there are thousands of truck drivers in the system now. We have worked with big companies, small companies, union companies, non-union companies, independent companies. So we are working with everybody who is interested.

And I think bringing some faith back into the trucking industry. Trucking is a good career. Trucking is a good middle class career that gives people the opportunity to earn a good living. And for some way over the time, we have lost a little bit of that, but I feel confident as we move forward that we are going to meet those challenges.

Also we have 70,000 over the last 5 years, 70,000 CDL veterans that have come out of the service that we have an opportunity to

get them a pathway into trucking, and we are working on that now as well.

Mr. MOOLENAAR. Great. Thank you, Mr. Secretary.

Secretary WALSH. Thank you.

Mr. MOOLENAAR. Thank you, Madam Chair.

The CHAIR. Ms. Frankel.

Ms. FRANKEL. Thank you, Mr. Secretary. Hello, good morning. Thanks for being here and for your work.

First, I just want to pick up on something that Ms. Clark talked about, and I know you are sincere about an equitable economy. So I will just do a little ranting, which is this.

If we ban abortions across this country, which it looks like we are about to in 26 States, there is not going to be an equitable economy for women if they are not allowed to make their own decisions about their bodies, their lives, and their futures.

All right. You don't have to comment on that. I had to say that.

FLORIDA STATE UNEMPLOYMENT INSURANCE PROGRAM

All right. So, first, I want to talk to you about Florida. Florida, when COVID hit and there was unemployment assistance, our State I think was the worst, if not one of the worst, in getting that money out. You have asked for an increase for unemployment assistance. Is there any way we are going to be able to help States like Florida?

I don't know if we can force them to make the system better. I mean, our system was designed in the way so people could not get unemployment because one of the Governors—I think it was Rick Scott—did not believe in unemployment. Okay, are you getting the answer from the—

Secretary WALSH. No, no. I am asking about Florida just specifically so I can answer some questions you have.

Ms. FRANKEL. Yes. No, just I don't know if there is a way to get our State government to help people when it is necessary.

Secretary WALSH. Well, the question I asked them, we did have a tiger team in Florida. We have been able to assess and working on assessing the system in Florida.

Florida is one of the States that has worked with the Department of Labor. I believe they have received a grant as well to help them implement some changes in Florida. So, to my knowledge, the relationship between the Department of Labor and Florida's unemployment office has been strong, been good, and we are working there.

Now I can't promise in that particular case, as you know, we don't have the ability to increase benefits and the timing of getting the benefits out and how they institute a program. But what we can do is work to fix some of the shortfalls and make recommendations to Florida, you know, in some cases.

I just finished a book on Frances Perkins, and there was a real move at one point to make the Social Security Administration a Federal program where we would set the benefit across the board. But they decided back then to make it a State program. We administer it, and they do it.

So I think I have gone back and forth on, being in the legislature in Massachusetts and being able to push for higher benefits and

being the Secretary of Labor. I think at this particular moment, I wish it was a Federal program so we could actually do some real improvement there.

Ms. FRANKEL. Thank you.

IMMIGRATION REFORM

I know you have lots of ideas on creating good-paying jobs. We know unemployment is very, very low in this country now. What is the relationship between immigration and getting us—fixing this? It is the labor shortage. The labor shortage—

Secretary WALSH. Yes.

Ms. FRANKEL [continuing]. We want to create more good jobs. Does that mean there is going to more labor shortage?

Secretary WALSH. No. Thank you very much.

I mean, I am glad you opened the door for me, and I don't know if I am going to get myself in trouble on this. But the reality of the situation is we need immigration reform in the United States of America.

I have talked to every business, and the Republicans and Democrats on this committee, go talk to businesses in your communities privately and ask them what they want. Every single company is going to say we need immigration reform. Big companies need it. Small companies need it. People need it. We need more workers in this country.

We are a country that constantly depends on immigrant workers. We always have. My parents were two of those workers that came to this country.

We are a country that if we want to continue to move forward as a country, we need to figure out some immigration laws and get some reform. Not H-2B visas, H-2A visas. Not those visas. That is not immigration. We need real immigration reform in this country for a pathway to citizenship because those are some of the challenges.

Now I know I am speaking to Congress, and we could do something about it. I know nothing is going to happen about it, I will be completely honest with you. And I think it is really unfortunate. But talk to your employers, talk to your employers in your districts and the big employers in this country—

Ms. FRANKEL. Okay. We can do that. I have got to get one more question right in here.

Secretary WALSH. Yes. I am not filibustering. I apologize.

CAUSES OF INFLATION

Ms. FRANKEL. No. Okay, listen, we have been talking about inflation. In my opinion and many, the President is being unfairly blamed for inflation. I would say that COVID is the biggest factor.

But one of the analysis I heard had to do with supply and demand and versus demand for products versus supply for services, or demand for services. Would you comment on that?

Secretary WALSH. Yes, I mean, the President is taking it for inflation, and he is the President. So, obviously, he has big broad shoulders. So he can take it. But I definitely think there are lots of challenges why we are in this economy. There are lots of chal-

lenges why 4.5 million people quit their job last month because of COVID.

There are lots of reasons why in some cases our hospitals are overburdened because of COVID. We are seeing more violence against nurses in hospitals because of COVID. Well, COVID has caused a lot of concern.

But again, we can't just blame COVID. We have to address the issue, and the President has a plan to address the issue. I was asked the question by the congressman about what am I doing in my little role as Secretary of Labor to deal with inflation. We are working on supply chain issues. Secretary Buttigieg is working on issues. Secretary Raimondo is working on issues.

So this is an all of Government. I am not going to blame anybody for the inflation issue. What we have to do is address the inflation issue.

Ms. FRANKEL. Thank you, Madam Chair.

Secretary WALSH. I know what you meant.

Ms. FRANKEL. But I am thanking you also.

Secretary WALSH. Thank you.

The CHAIR. Congressman Cline. Thank you, Ms. Frankel. Congressman Cline.

Mr. CLINE. Thank you, Madam Chair.

Thank you, Mr. Secretary.

INDUSTRY-RECOGNIZED APPRENTICESHIP PROGRAM ELIMINATION

Talking about the labor shortage, I just can't grasp why, in light of the unprecedented labor shortage and employers' reports of increasing gaps in workers' preparedness, is the Department not supporting and, in fact, now attempting to eliminate industry-recognized apprenticeship programs. And I know you were asked this by my good friend from Oklahoma.

But even without Federal funding, the programs were expanding valuable apprenticeship opportunities for workers and employers alike in fields that are rapidly changing and rapidly developing and in fields that are disproportionately filled by women and minorities. Can you comment on that?

Secretary WALSH. I mean, the administration, we are certainly—I am certainly committed to and the administration is committed to expanding registered apprenticeship in industry-driven programs. That is how they work. That is the best way of doing it. Proven, flexible models that we can go across industry on.

We don't need a disconnect—in my opinion, a disconnected, duplicative program that does not nothing but create confusion. That is what the IRAPs are doing. The IRAPs really haven't been proven. They were created, invented, whenever they were a few years ago, and we have a program, an apprenticeship program that actually works in the country.

And they don't have to be a union apprenticeship program. They can be a—when I am talking about expanding registered apprenticeships, I am not talking about expanding union apprenticeships, I am talking about expanding apprenticeships in industries that actually are proven and work.

Mr. CLINE. And let me just say I hope that they don't duplicate the existing apprenticeship programs because often those are not

working. The Federal Government spends billions each year on job training programs that fail to provide workers with education and experience that helps them to find and retain jobs.

Even the gold standard evaluation, the Federal Government's Workforce Investment Act, which is supposed to provide training for in-demand services, found that only 32 percent of participants found occupations in their area of training, and the majority, 57 percent, did not believe that their training helped them to find employment.

Secretary WALSH. They weren't apprenticeships. They were training.

Mr. CLINE. I know, I know. But moreover, individuals receiving the full workforce training were less likely to obtain health insurance or pension benefits. Their households earned several thousand dollars less, and they were more likely to be on food stamps than participants who received minimal services.

STATE AND INDUSTRY-LED APPRENTICESHIP PROGRAMS

Let us talk about Job Corps for a minute. National Job Corps study found that a Federal taxpayer investment of \$25,000 per Job Corps participant resulted in participants being less likely to earn a high school diploma, no more likely to attend or complete college, and earning only \$22 more a week. It is not surprising that Federal programs, including apprenticeship programs, are out of touch with the needs of employers in high-demand occupations because bureaucrats in Washington can never know businesses' needs better than employers themselves.

And that is why these industry programs, these industry apprenticeships would be much more responsive, different than the Federal Government-run apprenticeship programs, and I think better for the economy, for the supply chain shortages that you are talking about. If you want a way to address the supply chain, supporting these industry-led apprenticeship programs would be a first way to start.

Secretary WALSH. Well, thank you.

Let me just, first and foremost, with Job Corps, I agree with you. I have concerns about Job Corps. I have had conversations with many members of Congress about Job Corps, about strengthening Job Corps. I have talked to mayors in cities that Job Corps exists to ask them to partner with us because, quite honestly, the mayors and the local authority has to be part of the solution there.

Because right now what I see with Job Corps is independent kind of entities around the country. They are doing the best they can, but I think there is an opportunity. We have 37,000 young people that go through Job Corps every year that we potentially have great job training programs right in our own backyard, meaning in the Federal Government. So I want to strengthen that, and I have talked to the caucus. And you will see, I think we have asked for a budget request for Job Corps as well.

On the apprenticeship stuff, I wouldn't necessarily say—I don't know if I would describe it as apprenticeships failing. I think that some of our workforce development programs have not been as successful as they need to be. And what we have done and what I have tried to do at the Department of Labor is really change the way

that we are making investments. And some of it we can do because we have the flexibility.

In a lot of cases, I don't have the flexibility to change the workforce development program or the job training program because the way it comes to me through Congress and the investment I have to make, I have to follow the parameters of Congress. It is not the no strings attached investments that I would like to have more of.

Mr. CLINE. A one size fits all program to address varying degrees of need in States, right?

Secretary WALSH. In some cases, depending on the grant. And we have to change that. Because the challenge is that employers—and I spend a lot of time talking to employers. If you ask the employer—I was at the Chamber of Commerce the other day, the national Chamber of Commerce. I probably—as a Democratic Secretary of Labor, I probably spend more time talking to businesses than probably some of my predecessors.

And I do that because it is important. As we think about creating workforce development and job training programs—again, to your comment, I am taking words out of your mouth—it needs to be created from the employer's side and tell us what they need as far as how they move forward. And that is historically how we have always done it. So we are working to change that way.

When I think of future apprenticeships in this country, I think of a program that is going to be helped built by the business community to help us understand the needs that they have so that we can make the right investments. So they have, to Ranking Member Cole's situation in Tinker Air Force Base, that is—and I said this to the commanding officer down there. There is no point of me creating a program in the Department of Labor when, in fact, you understand what you need.

I can make a program up, but it might not be sufficient to your needs. So my office does that. We reach out to businesses.

Mr. CLINE. We need to cut the strings, give the States more control, give the industry more control. I think we have to help them.

Secretary WALSH. I think we have to monitor the States because not all States do it well either.

Mr. CLINE. I will ask you about transparency in the next round of questions.

I yield back.

The CHAIR. Mrs. Watson Coleman.

Mrs. WATSON COLEMAN. Thank you very much, Madam Chairwoman.

Thank you, Mr. Secretary, for being here.

LABOR SHORTAGE CAUSES

First of all, I have agreed with your assessment of things and our need to ensure that there is better inclusion and better jobs and that we work to put our resources into ensuring that those that are underrepresented have access to good training and to good jobs. What I am not clear on is how you intend to accomplish some of these things.

The unemployment rate is very, very low. Can you tell me what it is again real fast?

Secretary WALSH. Three-point-six percent.

Mrs. WATSON COLEMAN. The unemployment rate for black women is—

Secretary WALSH. Five percent.

Mrs. WATSON COLEMAN. The unemployment rate for black men?

Secretary WALSH. I think it is—it is probably in the 6—I don't have that number in front of me. It is probably in the 6s.

Mrs. WATSON COLEMAN. So is there an employment shortage, an employee shortage because we don't have enough people to work or because we have a significant amount of people, particularly in the black communities, that can't work for one reason, either it is training or it is childcare or whatever?

Secretary WALSH. Yes, I think the answer to that question is for both reasons. But there is a significant amount of folks in the black community and communities of color and women that right now are sidelined or working in jobs that they are not earning a living wage. And through job training programs and workforce development programs, we can quickly get people trained up to get better-paying jobs, into better industries.

INCREASING JOB TRAINING FOR WOMEN AND MINORITIES

Mrs. WATSON COLEMAN. I agree with you. How are we going to accomplish that? What is it that your Department is going to do, either alone or in conjunction with other departments, to get more women and minorities into these training programs for good, marketable jobs? What specifically do you see planning out to reach them and then to engage them?

Secretary WALSH. Yes. We are doing that through our investments in our workforce development grants, the WIOA reauthorization grants. I think Congress is voting on that today.

Mrs. WATSON COLEMAN. Yes, I know that the investments are going there. What are the mechanisms to get a better—better programs and better involvement for disadvantaged specifically, but better outreach, better supports? What is it that you are proposing to do that will manifest these ideals that you have, these new investments that we are willing to support?

Secretary WALSH. Well, first and foremost, I would like a little more discretion with the investments in the grants. A lot of our grants, our funding, they have lots of discretion around them. I would like to be able to do what I would like to do invest in there.

And we are working with—we have to work with and we need to work with States' and cities' workforce development boards around the country. We put the grants through them, and they get the programs. I think that is one way.

And the second way, quite honestly, is continuing to meet with employers where they are at so we understand the challenges they have and create direct programs with some of the employers in our country, the larger employers in our country, and the unions. Unions have a unique opportunity here as well to open their doors to allow people the opportunity to get in there.

So I think, in some ways, we have to I wouldn't say reinvent the process, but we have to do some significant surgically precise investments in communities.

STAFF FOR MONITORING EMPLOYMENT PROGRAMS

Mrs. WATSON COLEMAN. Let me ask you two quick questions. Number one is do you have enough staff that will be able to monitor what is happening to ensure that these programs are moving in the direction and in a manner that you want, or do you need more sort of monitoring staff?

Secretary WALSH. To be completely honest, I need more staff. I mean, we are understaffed at the Department of Labor, and we are understaffed in a lot of different places. And the American Rescue Plan helped us —

Mrs. WATSON COLEMAN. Yes.

Secretary WALSH [continuing]. But we are understaffed. In all of our offices, we could use more people.

REENTRY PROGRAM SUPPORT

Mrs. WATSON COLEMAN. I am very concerned, sir, about the reentry programs and the opportunities for returning citizens, whether or not they are the youth that are really fertile for some new training and the older folks that need to be retrained or redirected and supported. And I was wondering—and they are trying to get jobs—what specifically are you all looking at doing to work with that population, which is coming back into our community?

Secretary WALSH. Yes. First and foremost, the President's budget has several grant proposals that focus on disadvantaged communities. And part of that, the President is also focused on reentry as a major opportunity in our country.

Listen, there are people in our prison system right now that are not counted as potential future workers in America, and if we set the right training programs up and the right job opportunities and meet people where they are at, we can create a whole new pathway.

I have very rarely seen somebody that is incarcerated, comes out, gets into a good job training program and earns a good living, they don't reoffend. They don't go back to jail.

Mrs. WATSON COLEMAN. Absolutely.

Secretary WALSH. They don't have an opportunity—and I have seen it up close and personal in the past. And I think that we have a unique opportunity right now in our country.

We also have a couple Job Corps centers and American Job Centers inside prisons in America that we are working to help train workers up, real training, not fake training. Not giving them some type of certificate, but actually real training that is connected to a job. I think that is going to be the answer to the future. How do we connect folks from job training to a real job?

Mrs. WATSON COLEMAN. Thank you. I think it is very much the quality of training that is available and the preparation. I think is very important that you have the kinds of staff that you need to ensure that this is happening.

Let me be a partner wherever. Thank you.

Thank you, Madam Chair, and thank you, Mr. Secretary.

Secretary WALSH. Thank you, Congresswoman.

The CHAIR. Thank you. Congressman Harder.

Mr. HARDER. Thank you so much, Chair DeLauro, for hosting today's hearing.

And thank you, Secretary Walsh, for being here.

NATIONAL YOUTH EMPLOYMENT PROGRAM PROPOSAL

We have an affordability crisis in our community, and much of it comes down to our young people, who are struggling to find jobs that pay enough. I spend a lot of time talking to our employers, as you did and do, and I hear lots of them about how hard it is to hire locally, how much of a shortage, labor shortage that they are struggling with every day.

But at the same time, I also spend a lot of time talking to students right out of high school, right out of community college, and they tell me how much challenges they are having as well. More than 75 percent of youth in our area express concerns about whether or not they have the skills necessary to secure a job.

This disconnect I think represents an enormous policy failure. We need to do a better job of helping our next generation develop the skills that they need to take those jobs that are right in communities like mine. There are some programs, TREO and YouthBuild, that are somewhat helpful on youth workforce training, but they are not perfect, and they are not nearly enough. And there is, frankly, so many young people who are left behind and overlooked by these programs, and that contributes to brain drain in districts like mine and also to a real crisis for our employers as well.

I know that the President's budget request includes a proposal for a new program, the National Youth Employment Program. I would love to hear a little bit more about this program and how you actually envision this addressing the current gap in workforce development. And what else can we do to address this disconnect that seems pretty prevalent?

Thank you.

Secretary WALSH. Thank you, Congressman.

First and foremost, I think we have a big opportunity here with young people in America to really create them and get them opportunities into innovative careers, and your district is part of that. For many, many years in this country, we have only been focused really on pushing kids into a 4-year college system, and we have an amazing community college system in our country that allows people to work and get grant processes and work with employers, again, on what is needed.

And I think that we need to start being smart about our investments. Young people are smart about what they want their future to be. In some cases, they are uncertain what their future is, but they know they don't want to work at a fast food restaurant and make 10 bucks an hour or 15 bucks an hour. They want to do better than that.

And a lot of these investments the President is making, whether it is in the proposal you mentioned or YouthBuild or even Job Corps, we have to create better pathways for our young people. And we have to, as you mentioned—I will take your words—meet them where they are at and really figure out how do we move forward.

So I think we have to be strategic. Plus, it is an opportunity for us. We saw 2 months ago in the jobs numbers one of the biggest gains was young people that had less than a high school diploma. The highest number of employed people, less than a high school diploma, in the last 25 years in our country.

So we are seeing people look for opportunities. We need to help them and put them on a pathway to some type of career that they are interested in. Now a lot of them are not sure what they want. That is why I think apprenticeship and pre-apprentice is key for that generation.

Mr. HARDER. Absolutely. Well, thank you for that.

And I couldn't agree more. More than 4 out of 5 adults in my district doesn't have a 4-year college degree, more than 80 percent. So if we are telling folks that college is the only route to the middle class, we are certainly leaving a lot of people, a lot of people out.

GRANTS FOR RURAL AND HIGH UNEMPLOYMENT AREAS

This disconnect does feel to be more impactful in certain areas than others. Would the Department of Labor consider prioritizing serving youth in rural areas or areas with high levels of unemployment compared to the national unemployment rate when awarding these competitive grants? Because I am worried with a program that is already fairly small, that it might not be going to the places that actually need it most.

Secretary WALSH. Yes. I mean, certainly I would love to work with you on that. Some of the grant proposals that we have are competitive, and we can't—we can't do that. In other areas, we have some discretionary funds that we can build our programs in rural America or areas that might not have been getting the proper attention they need.

So I would love to work with your office on that. Absolutely, there is no question about that.

Mr. HARDER. Great. Well, thank you so much.

Look forward to working in there. We are in an area with high unemployment just a couple hours away from an area that has very low unemployment, and we want to make sure that those workforce development programs are going where they are most needed.

So thank you again for being here, and I yield back the remaining time I have.

Secretary WALSH. Thank you, Congressman.

The CHAIR. Congresswoman Lawrence.

Mrs. LAWRENCE. Thank you so much, Madam Chair.

Thank you so much for being here, Secretary.

RETRAINING WORKERS THROUGH THE DISLOCATED WORKER PROGRAM

You had the amazing good fortune, as I did, to tour the new ZERO factory. And walking around the factory, we saw that there were more robots than there were people.

Well, in the past, it was filled with hundreds of employees who were working every day. But as new technology progressed, we now need more technicians and more computer programmers than we did assembly workers. So my question is about up-skilling.

There are some people, especially in the auto industry, who have given almost 20 years of their life to being an effective and knowledgeable assembly worker. Can you explain how the Department can use programs like the Dislocated Worker Program to help re-train workers?

I know when GM was talking about closing a plant, shutting it down, laying off everyone, so that they could retool it for new technology, which included the robots that were going to do the work of people, and some people lost their jobs during the pandemic, as we know. But how can we continue to invest in our workforce where we are not discounting hundreds of people who, by no fault of their own, are now displaced or unemployed?

Secretary WALSH. No, thank you very much, Congresswoman.

Let me just say this. In talking and hearing every question that was asked of me today, every question was in some ways geared towards what the future of work looks like in America and the challenges we have, whether it was immigration or H-2B visas or job training and workforce development. And I think that as a government, we have a unique opportunity at this moment in time to make investments in the American workers like they have never seen, whether that is in the previous congressman's concern about workers, young workers not going to college and not getting jobs and job training. When I think about whether it is dislocated worker investment or what have you, it comes down to job training.

When I was in that factory, when we were in that factory at the GM facility, there was a young woman there. She was 16 years on the job—or 14 years on the job, actually. And she was a UAW member, and she talked about when she sat at the job, she used to get dirty every day because she was working with wrenches and lug nuts and things like that.

And now it is all technology. And she is still in that factory working, and she doesn't get dirty every day, but now she is a technician. And she was able to be retrained as a technician to work in that factory to continue her career.

And there is no question that, as a country, we need to do a lot better job of creating opportunities and pathways, whether it is through apprenticeship programs or workforce development programs, or job training programs, or folks in Job Corps, or folks in prison, or women of color, or whoever it is. We have a unique opportunity at this moment in time.

In this committee, in the appropriations that you are going to give us at the Department of Labor through the President's budget is we are going to do everything—I am going to do everything I can, as long as I am Secretary of Labor, to make sure the investments are making a difference.

I am not going to get caught up in the politics, but I am going to do everything I can to make sure that I make a difference in people's lives, whether that is urban America, rural America, downtown Washington, D.C., Albuquerque, New Mexico, wherever it is in this country. I want to make sure the Department of Labor is one of those departments that people say, wow, they really do some great things, and we help build the workforce of the future so that people can raise a family, get into the middle class, and be proud of who they are.

That is my goal, and that is my job. I don't know if that answers your question, Congresswoman. But that is—I think we do have a unique opportunity at this moment in time.

Mrs. LAWRENCE. What I was looking for is a commitment to understand the opportunity that I often see is overlooked. We embrace new technology. We need it for so many reasons. For efficiency, to keep the economy going, to advance technology, and to deal with our climate issues. But we can't turn our back on those people who are going to be dislocated.

EMPLOYMENT THROUGH JOB TRAINING CERTIFICATION

My last concern I wanted to talk to you about are community college investment. Oftentimes, not only community college, but private companies who do the apprenticeship training—and it has been brought up before—at the end of that training, all they have is a certificate, but not a job. And so many employers are saying that they need certain things. How can we match our Federal dollars that we pay to get people certified will equate to them being hired?

It is a gap there that is frustrating to no end.

Secretary WALSH. Well, I think we have to work strongly with our community college system. DOL just recently announced a grant competition for our schools, Strengthening Committee Colleges Training Grants. We are going to award \$45,000,000 to 15 different community colleges.

I have spent a lot of time—I asked my office to put together a list of the community colleges I have gone to in the last several months. I have been Trident Technical College in South Carolina, Kirkwood in Iowa, Montgomery in Maryland, Delgado in New Orleans, Lorain in Ohio—Elyria, Ohio—Thomas Nelson in Newport News, Virginia.

And I spend a lot of time in our community colleges in this country, and I think it is really important that we continue to work with them. And grant programs is the best way we can help them, but also working with their legislatures to strengthen the community colleges because a lot of their money comes from the States. So we need to strengthen to make sure that we support them, to let them know they need to support community colleges.

That is the best—the best networking we have in this country through really with job training and workforce development is our community college system. We have one almost in every district in the country. Congress has—some of you have more than one.

We have an opportunity to strengthen the community colleges to really prepare people for the future. Again, working with our business community on what their needs are and also working with our community colleges and what their needs are.

Mrs. LAWRENCE. The accountability of matching skills with jobs is something that I feel is a very high standard for you and for Congress.

Well, thank you so much. I yield back.

Secretary WALSH. Thank you, Congresswoman.

The CHAIR. Thank you.

I would like to ask Congressman Harris to close, and we are looking at an 11:00 a.m. Greek Prime Minister. So I will be brief, and I am going to ask you to be brief.

Mr. HARRIS. I will, Madam Chair. Thank you very much.

CLOSING REMARKS BY CONGRESSMAN HARRIS

Mr. Secretary, it is good to see you again, and it is interesting. You know, as a physician and a faculty member, I should enjoy the other two parts of what this committee's jurisdiction are, but I enjoy your visit the most of all because you really do want to—I love your enthusiasm about making American workers first. That is it, foremost.

In a global economy, this is not an easy job, and you are addressing some of the issues. The need for technical training, very important. Obviously, temporary foreign workers, important. Prison rehabilitation, huge issue. That is the way we solve some of our crime crisis. There is no question about it, and anything you can do would be appreciated.

Obviously, legal immigration, you are right. We are not going to do anything, but we really should appreciate—I am the son of the immigrants, you are the son of immigrants—look, this is an important source of our workforce, and shame on Congress for not recognizing that.

Look, again, we are not going to agree on everything, but I speak for the members on my side of the aisle, we enjoy very much working with you because you have a “can do” attitude about keeping American workers first, and I appreciate that.

Secretary WALSH. Thank you.

Mr. HARRIS. And with that, I yield back, Madam Chair.

The CHAIR. Thank you.

CLOSING REMARKS BY CHAIRWOMAN DELAURO.

And I think you summed it up in your comments about the future of work and the future of the American workforce, and I don't think it can be said more eloquently. And I am so delighted you were reading Frances Perkins. Frances Perkins is a hero, in my view.

And just very briefly, I was once interviewed for being Secretary of Labor, and when I was asked the question, “How do you see the job?” I said, “I want to be Frances Perkins.” So there you go.

But you are reincarnated here in terms of what you want to do and so forth. But your point is, and that is where we come into play here, is that we have the ability to provide the investments that haven't been made over the years. And that is what is critical.

And working men and women have for a long time felt that they have been on their own and that they don't have the kind of support they need from Government in order to help them with job training, with wages, or if their wages are being stolen from them or if their place of work is not an environment where they can be safe and so forth. They have been through a tough time in the last 2 years, but you said it in your closing, your conclusion in your testimony.

Despite all that we have been through, workers across the Nation are still showing up every day to help meet this moment. We have the responsibility to meet this moment and to help you to meet that moment, and we are committed to doing that. I want you to know that.

Secretary WALSH. Thank you, Madam Chair.

The CHAIR. Thank you for what you are doing and for your support of America's workers.

Secretary WALSH. Thank you very much.

The CHAIR. Oh, I have to gavel.

[Answers to submitted questions follow:]

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

FY 2023 Budget Request for the Department of Labor
May 17, 2022

Questions for the Record for Secretary Marty J. Walsh

QUESTIONS SUBMITTED BY REPRESENTATIVE ROSA DELAURO

COMMUNITY COLLEGE TRAINING GRANTS

Mr. Secretary, this subcommittee created a new program three years ago, the Strengthening Community Colleges Training Grant program, to support partnerships between community colleges and growing economic sectors. The goal is to train workers for good jobs while ensuring a skilled workforce in growing, high-wage regional industries. I am proud to say the WIOA reauthorization bill that is currently moving through the Education & Labor Committee would authorize this new program at \$100 million per year. As you know, our community colleges are a critical component of our education system. Community colleges serve a diverse population of students, including a disproportionate share of single parents and first-generation college students. And community colleges have strong ties to local employers. Last year we held a hearing in this subcommittee to highlight the integral role of community colleges in our local communities and local economies.

Ms. DeLauro: How is the Department of Labor using this grant program to build strong training programs at community colleges — both to prepare workers for high-wage jobs and also to support growing regional economic sectors?

Mr. Walsh: The Department has issued three funding opportunities for community colleges under Strengthening Community Colleges Training Grants to date totaling \$135 million. In January 2021, the Department of Labor awarded \$40 million in grants under the first round of funding to 11 community colleges in 10 states, including seven consortium grants and four single institution grants. Industry sectors represented among these grants include Advanced Manufacturing, Healthcare, and Information Technology (including Cybersecurity), among others. The opportunity to apply for the second-round funding of \$45 million closed on June 2, 2022, and the Department anticipates awarding grants in late August 2022. Because the Department has seen high interest in community college-related funding opportunities and therefore aims to award funds quickly, the Department has opened the third round as an extension of the second round Funding Opportunity Announcement. Information about this third round was published June 1, 2022, third round grant applications are due October 14, 2022, and grants will be awarded in January 2023. All three rounds build the capacity of community colleges to collaborate with employers and the public workforce development system to meet local and regional labor market demand for a skilled workforce by requiring colleges to build or enhance career pathways to local in-demand jobs. While the first round supported the development of accelerated learning pathways and the incorporation of technology to support virtual learning in response to the pandemic, the second and third rounds further the first round's

efforts while also focusing on helping people in marginalized and underrepresented populations overcome barriers to the career and technical education programs needed to connect to quality jobs with career pathway progression.

The grant designs for the Strengthening Community Colleges Training Grants are built on the capacity and knowledge gained from the Department's past investments in community colleges, specifically the Trade Adjustment Assistance Community College and Career Training (TAACCCT) grants, particularly its lessons on capacity building for institutions, advancing innovation, and systems change. In particular, the grants build on TAACCCT's comprehensive efforts for community colleges to engage and strengthen partnership with employers and specific industry sectors that support regional economic development through a strategic partnership model.

Examples of the focus of grantees from the first round of Strengthening Community Colleges include:

- Norwalk Community College (CT) leads the Connecticut Statewide Healthcare Industry Pathways (CT SHIP) project, serving all 12 Connecticut community colleges, which will strengthen the capacity of the consortium colleges to offer demand-driven, accelerated training in three in-demand healthcare career pathways that offer opportunities for advancement and higher earnings. To build this capacity, the project incorporates a clear sequence of education coursework and/or training credentials aligned with employer-validated work readiness standards and competencies; integrates academic and occupational skills training; offers accelerated training opportunities that quickly produce industry-recognized credentials and employment; provides openings to expand the delivery of virtual instruction and services (e.g., online learning, digital badges, simulations); and offers opportunities to earn stackable credentials and advance along career pathways from entry-level occupations to higher-wage careers.
- Grand Rapids Community College (MI) leads the Michigan Coalition for Accelerated Healthcare Pathways, a partnership composed of five community colleges, four workforce system entities, more than seven healthcare employers, and the Michigan Community College Association (MCCA). The consortium project is focused on implementing new and expanded online and hybrid programming in six specialized healthcare pathways, which will allow participants to upskill at an accelerated pace and employers to fill key vacancies. The effort's linchpin is coordinating across the five consortium colleges to transition the courses to MCCA's virtual training platform, Michigan Colleges Online (MCO); the aim is for the six programs to become available to all 28 Michigan community colleges. Currently, the project is preparing to launch the Neurodiagnostic Apprenticeship Program (also referred to as the electroencephalogram or EEG apprenticeship), followed by the Surgical Technician Program. The project anticipates that the EEG apprenticeship program will be the first apprenticeship of its kind in the United States.

- Savannah Technical College (GA) leads The Future is Now: Scaling Statewide Credentials, a collaboration between 12 colleges, 26 employers, five local workforce development boards, and community partners. The grant is addressing the need for faster attainment of credentials through sector collaborations, a statewide micro-credential system, course, and curriculum development, and leveraging the eCampus cloud-based initiative. The project recently launched the Georgia Consortium for Accelerated Training Opportunities (GA CATO), which grew out of employer needs for tailored training and ease of access to upskilling. The grantee will enhance 60 courses and develop many new courses, all of which will qualify as advanced online learning environments; some will also incorporate Virtual Reality and mixed reality technologies. These enhancements replace basic PowerPoint instruction, elevating student engagement and improving retention and comprehension. Additionally, early and ongoing communications and partnership efforts have resulted in the adoption of the project's pathways and digital credentials as one of the Technical College System of Georgia's strategic priorities, a crucial step toward achieving the project's goal of statewide scaling of micro-credentialing, allowing the portability of skills-competency indicators.

HEAT ILLNESS PROTECTION

Low-wage workers and workers of color disproportionately make up the population of employees exposed to high levels of heat in their jobs. The Department has increased efforts to prevent death and illness from heat among workers, including through OSHA's new national emphasis program and rulemaking underway for a national heat standard. Rising temperatures due to climate change increase the danger of extreme heat each year and a national heat standard will prevent many tragic and unnecessary deaths.

Ms. DeLauro: Secretary Walsh, while that rulemaking is underway, what efforts is the Department making to protect workers from the dangers of extreme heat?

Mr. Walsh: The Occupational Safety and Health Administration (OSHA) knows that the dangers associated with heat will continue to get worse with the current trends of climate change. Not only does excessive heat cause heat stroke, heat stress, or even death, it exacerbates existing health problems such as asthma, kidney failure, and heart disease. Because workers of color disproportionately make up the population of employees who are exposed to high levels of heat, the health risk also intensifies socioeconomic and racial inequalities in America.

Last fall, DOL issued an Advance Notice of Proposed Rulemaking (ANPRM) to gather information on how to move forward with rulemaking. However, OSHA is not depending solely on the rulemaking process to start addressing this issue. In April, Secretary Walsh joined Vice President Harris in Philadelphia to announce the launch of OSHA's National Emphasis Program (NEP) on heat-related illnesses that targets over 70 high-risk industries employing both indoor and outdoor workers, ranging from farmworkers to construction and warehouse workers. Through the NEP, OSHA is able for the first time to proactively inspect identified workplaces for heat-related hazards before workers suffer preventable illnesses or fatalities. The NEP also

establishes specific heat inspection goals and aligns OSHA's threshold for initiating inspections with the National Weather Service's issuance of Heat Advisories or Heat Warnings.

In concert with OSHA's rulemaking and outreach efforts, OSHA established a Heat Injury and Illness Prevention Work Group as part of the National Advisory Committee on Occupational Safety and Health. The group is comprised of representatives from organized labor, employers, and the public. The group will focus on evaluating input to the ANPRM and developing recommendations on prevention materials and elements of a rulemaking.

In May, OSHA hosted a six-hour public meeting on its multiple heat initiatives, focusing on its Heat Illness Prevention Campaign, compliance assistance available to workers and employers, and enforcement efforts, including the new NEP. OSHA also provided an overview of the agency's rulemaking process and ways for the public to participate. More than 1,500 people participated in the meeting, and 68 people were selected to provide testimony during the meeting. The docket for the heat meeting is open until August 1, 2022 and OSHA welcomes interested parties to submit written comments on the agency's heat illness and injury prevention efforts (www.regulations.gov, Docket No. OSHA-2022-0006).

MEATPACKING INDUSTRY

Since the start of the COVID-19 pandemic, this Committee has been dedicated to protecting workers in the meatpacking industry, holding hearings on best practices, and ensuring dedicated funding in the American Rescue Plan to protect the health and safety of these essential workers. According to a recent report released by the House Select Committee on the Coronavirus Crisis — during the height of the pandemic, the meatpacking industry stoked false and baseless fears about an imminent meat shortage to keep meat processing plants open, despite knowing the health risks to their workers. According to the report, 59,000 workers at meatpacking plants contracted the coronavirus from March 2020 to Feb 2021 and 284 workers died. The report is damning. Meatpackers need to answer for this deception and be held accountable for endangering workers.

Ms. DeLauro: Mr. Secretary, what is OSHA doing to hold the meatpacking industry accountable? And what is OSHA doing to investigate unsafe conditions in other dangerous jobs like poultry plants and the agriculture industry?

Mr. Walsh: OSHA issued a COVID National Emphasis Program that was revised on July 7, 2021 and was amended to make the NEP a 12-month emphasis program. The COVID-19 NEP, which took effect on March 12, 2021, includes a targeting component in addition to addressing unprogrammed activity. Among the top industries targeted in the COVID-19 NEP are two related to meatpacking:

- Animal (except Poultry) Slaughtering (North American Industry Classification System, or NAICS, 311611); and
- Meat Processed from Carcasses (NAICS 311612).

In addition to the COVID NEP, there are several targeting programs that focus on meat processing facilities indirectly, such as emphasis programs for the prevention of amputations (poultry processing has a high number of amputations), as well as programs focused on powered industrial vehicles, noise, and hexavalent chromium (welding stainless steel fixtures). OSHA focuses its enforcement activities on high-hazard meatpacking establishments in several ways. In addition to responding to reports of fatalities, hospitalizations, amputations, and loss of eyes, OSHA utilizes injury and illness data to develop a Site-Specific Targeting (SST) inspection plan. The SST list allows OSHA to direct its limited enforcement resources to workplaces with the highest rates of injuries and illnesses.

The following OSHA regions have emphasis programs that focus specifically on meat and poultry processing:

- Region 4:
 - Regional Emphasis Program (REP) for Poultry Processing Facilities¹;
 - Regional Emphasis Program (REP) addressing Sanitation and Clean-Up Operations in the NAICS Groups 311xxx & 3121xx²;
- Region 5:
 - Local Emphasis Program for Food Manufacturing Industry³;
- Region 6:
 - Regional Emphasis Program for Poultry Processing Facilities⁴;
- Region 7:
 - Nebraska Local Emphasis Program (LEP) for Meat Processing Industries⁵.

OSHA also recently entered into two settlement agreements with employers in the meatpacking industry that resolve pending citations against those employers. A settlement with JBS Foods USA exceeds the scope of the original inspections and requires the company to develop and implement an infectious disease preparedness program in several of its meat processing plants. The labor union representing the employees will engage with the employer in the development and implementation of the terms of the settlement agreement. OSHA also entered into an agreement with Smithfield Foods that requires the company take significant action to ensure it protects its employees from infectious disease.

¹ <https://www.osha.gov/enforcement/directives/cpl-20-09-cpl-04>

² <https://www.osha.gov/enforcement/directives/cpl-20-06-cpl-04>

³ <https://www.osha.gov/enforcement/directives/cpl-04-05-2201>

⁴ <https://www.osha.gov/enforcement/directives/cpl-2-02-00-030b>

⁵ <http://www.osha.gov/enforcement/directives/cpl-02-16-05e>

QUESTIONS SUBMITTED BY REPRESENTATIVE LUCILLE ROYBAL-ALLARD

WAGE AND HOUR DIVISION STAFFING

President Biden has focused on delivering good jobs that provide fair pay and benefits for working people from all walks of life. As part of this effort, the DOL is rebuilding its capacity to enforce laws designed to ensure that workers receive the wages and benefits they are owed. Doing so will help prevent wage theft by lawbreaking corporations; rebuild trust with immigrant workers and other workers at high risk for wage theft, particularly after the Trump administration undermined these basic protections; and ensure that all government spending supports good jobs for working people, including new Infrastructure Investment and Jobs Act spending and service contracting in industries plagued by wage theft. The FY 2023 Budget adds 289 full time employees to support the agency's wage enforcement mission on top of the January announcement that the agency was hiring 100 new enforcement staff. Yet, a recent report from Bloomberg Law finds that agency staffing is at its lowest point since 1973—despite significant growth in the American workforce—and turnover is troublingly high.⁶

Ms. Roybal-Allard: Is this new infusion of enforcement investigators enough to reach all American workers at risk for wage theft? If not, how many more investigators would a fully functioning DOL need to reach these workers? Can this infusion of new investigators adequately replace the knowledge and experience of longer tenured investigators who leave the agency for other opportunities?

Mr. Walsh: There are approximately 10 million employers in the United States that employ 148 million workers who are covered by the laws WHD enforces. In order to be the most effective, in addition to addressing the concerns of those workers who contact the agency directly, WHD strategically focuses enforcement resources in industries with workers who are most vulnerable to wage theft and least likely to seek our services. This strategic approach to enforcement coupled with a robust staffing level will position the agency to function at its most efficient to protect the most workers. The President's budget includes the addition of 289 full time employees for the Wage and Hour Division (WHD). This investment will greatly advance the agency's efforts to bring its enforcement staff to a robust level of 1,000 employees. To ensure that newly hired investigators can quickly and effectively provide strong worker protections and promote employer compliance, WHD maintains a vigorous training and career development program.

The Budget also includes robust funding for the Office of the Solicitor (SOL). DOL, unlike many federal agencies, has significant independent litigation authority under the statutes DOL enforces, including those statutes enforced by WHD. SOL represents the Department in federal courts and administrative tribunals across the country, enforcing the Department's strategic priorities, obtaining millions of dollars in compensation each year for workers, and ensuring that businesses that violate the law do not profit from a competitive advantage over law-abiding

⁶ Rebecca Rainey, "Low Morale at Labor's Wage and Hour Shrinks Investigative Ranks," *Bloomberg Law*, May 11, 2022, available at <https://news.bloomberglaw.com/daily-labor-report/low-morale-at-labors-wage-and-hour-shrinks-investigative-ranks>.

employers. Where an employer refuses to comply with the law, SOL's litigation resources are necessary to ensure that WHD's work is effectively enforced. Robust funding for SOL allows the Department to follow through with its enforcement work, which has important implications for agency investigations and employer compliance.

Ms. Roybal-Allard: How can DOL retain and support advancement of well qualified workers? Would allowing more advancement opportunities for non-management investigators promote retention?

Mr. Walsh: The increasingly complex mission of the agency across a growing regulated community may justify the creation of higher-level enforcement positions beyond the journey level. However, the agency's appropriation over the past several years has not been sufficient to support restructuring the agency to create greater promotion potential at the investigator level and beyond. Greater promotion potential would likely allow the Wage and Hour Division to compete with opportunities outside of the Division.

Ms. Roybal-Allard: The 2023 Budget request commits that "WHD will develop and implement stakeholder engagement strategies designed to establish and strengthen strategic partnerships around the shared goal of ensuring that workers' rights are protected." Please explain the types of organizations that the department proposes to partner with and how these partnerships will ensure that workers know their rights and are able to come forward without fear of retaliation.

Mr. Walsh: Relationships with community-based organizations, worker advocates, unions, employer associations, and state and local agencies are critical to the Wage and Hour Division's mission. WHD's efforts to establish relationships with these partners have already begun to impact our work and the lives of the workers we protect. In the Southeast, WHD staff recently held a Facebook Live panel in Spanish with an immigrant advocacy organization to teach immigrant workers about their rights under the Family and Medical Leave Act. In Arizona, WHD investigators have worked with unions and worker advocates to identify widespread misclassification and unlawful retaliation in the construction industry. In Pennsylvania, the Division partnered with worker advocates to host a wage clinic so that advocates could serve as trusted allies when workers picked up their back wages. And in Houston, the WHD team is considering partnering with local worker centers to more effectively ensure that domestic workers understand their rights.

QUESTIONS SUBMITTED BY REPRESENTATIVE LOIS FRANKEL
EQUAL PAY DATA COLLECTION

Ms. Frankel: What is your Department doing to collect and report on equal pay data and when can we expect any upcoming report to be made public?

Mr. Walsh: On Equal Pay Day 2022, the Department of Labor released the report “Bearing the Cost: How Overrepresentation in Undervalued Jobs Disadvantaged Women During the Pandemic,” which details the role of occupational segregation in driving the gender wage gap and quantifies the impact of segregation by occupation and industry on women of color’s wages.⁷ The Department estimates that in 2019 Black women lost \$39.3 billion and Hispanic women lost \$46.7 billion based on earning lower wages relative to White men as a result of occupational and industry segregation. This work builds upon research published in 2020 in collaboration with the U.S. Census Bureau, which contains what is currently the most comprehensive analysis and disaggregation of the gender wage gap to date.⁸

The Department’s Women’s Bureau maintains a website showcasing research and data on Equal Pay and Pay Transparency Protections.⁹ This page features a variety of materials and research including: a map providing information on federal and state-level equal pay and pay transparency protections for workers; an interactive tool that shows women’s and men’s earnings and the gender wage gap among full-time workers by race, ethnicity, and occupation group; and an interactive tool comparing median earnings and the gender wage gap in over 350 occupations.¹⁰ The Women’s Bureau also publishes a wide range of additional data and statistics on women’s earnings, including wage gap data by race and ethnicity, educational attainment, and age.¹¹ This summer the Women’s Bureau and the Department’s Office of Federal Contract Compliance Programs (OFCCP) will publish an interactive tool showing the number of workers, share of workers, and median earnings by race, ethnicity, and gender for 236 occupations at the state level.

OFCCP enforces nondiscrimination requirements for federal contractors and promotes compliance with affirmative action commitments. By conducting compliance evaluations of contractors, OFCCP works to address systemic barriers to employment opportunity, including in hiring, compensation, and promotion. These issues often go unaddressed through a complaint process because workers typically do not know the reason for their non-selection or how their pay compares to that of their colleagues. During compliance evaluations, OFCCP collects pay data from contractors scheduled for review along with contractors’ policies, personnel activity, and data on recruitment and hiring to identify and address potentially discriminatory employment practices. OFCCP uses this data for enforcement purposes and keeps these data confidential.

⁷ “Bearing the Cost: How Overrepresentation in Undervalued Jobs Disadvantaged Women During the Pandemic”. US Department of Labor, March 15, 2022, available at

<https://www.dol.gov/sites/dolgov/files/WB/media/BearingTheCostReport.pdf>.

⁸ <https://www2.census.gov/ces/wp/2020/CES-WP-20-34.pdf>

⁹ <https://www.dol.gov/agencies/wb/equal-pay-protections>

¹⁰ <https://www.dol.gov/agencies/wb/data/occupations>

¹¹ <https://www.dol.gov/agencies/wb/data/earnings#earnings-ratio>

OFCCP has prioritized tackling systemic pay discrimination across industries, and its compliance evaluations play an important role in rooting out pay inequities. OFCCP has found systemic pay discrimination in over a third of its discrimination resolutions since the beginning of this Administration. For example, on December 8, 2021, OFCCP resolved allegations of pay discrimination in an agreement with AlliedBarton Security Services LLC providing \$1,175,000 to 2,263 female, Black and American Indian employees working as security officers. OFCCP found the company's assignment practices led to placement of impacted employees at lower-paying job sites.¹² The company also agreed to take corrective action to eliminate discriminatory compensation and job-site placement policies, conduct training, and monitor compensation and job-site placements.

¹² <https://www.dol.gov/newsroom/releases/ofccp/ofccp20211208>

QUESTIONS SUBMITTED BY REPRESENTATIVE TOM COLE

UNEMPLOYMENT INSURANCE IT MODERNIZATION

Mr. Cole: Mr. Secretary, as you know, during the pandemic states suffered enormous inefficiencies in getting beneficiaries their benefits in a timely manner, and billions in fraudulent payments have been dispersed across the United States. The problem of UI fraud was growing long before COVID, but the pandemic created new opportunity for increasingly sophisticated schemes to steal identities and defraud the program. As states continue to work to modernize their UI technology, is this an opportunity to help build enhanced fraud prevention and detection capabilities into these systems?

Mr. Walsh: The significant incidences of the use of stolen, fake, and synthetic identities in the Unemployment Insurance (UI) systems during the COVID-19 pandemic has demonstrated that identity verification is a critical tool in paying unemployment benefits to eligible individuals. Yet many states lacked the resources, expertise, and capacity needed to effectively address the wide-ranging attacks that the UI system has experienced from organized criminal enterprises. The nature of fraudulent activity will require additional support and continuous monitoring for evolving threats. The Department of Labor (Department) is currently engaged with the General Services Administration (GSA) to explore states' use of the identity verification services available through GSA's login.gov. On March 31, 2022, the Employment and Training Administration (ETA) implemented an initial pilot with the Arkansas state UI agency to use login.gov for identity verification purposes — the first state ever to use this federal service. As initial results have been encouraging, we are working through the pilot program with Arkansas to evaluate how we might expand and extend the solution for use in other states. The Department is also in preliminary discussions with the United States Postal Service to explore the possibility of ID verification being offered at post offices.

Recognizing the importance of addressing fraud, the Department has provided additional funding opportunities to states to support fraud prevention and detection efforts. Using American Rescue Plan Act (ARPA) funds, the Department awarded \$133.86 million in grant funds to 50 states and territories, to aid in the detection and prevention of fraud in all unemployment compensation (UC) programs. Specially related to the Coronavirus Aid, Relief and Economic Security (CARES) Act UI programs, the Department provided prior grant opportunities to states using CARES Act funds (\$100 million on August 31, 2020, \$100 million on January 15, 2021, and \$100 million on August 11, 2021) to assist states with their efforts to prevent and detect fraud and identity theft as well as recover fraud overpayments in the Pandemic Unemployment Assistance (PUA) and Pandemic Emergency Unemployment Compensation (PEUC) programs. Another round of CARES Act integrity-related grant opportunities was announced on July 22, 2022, providing up to \$225 million to help states with detecting, recovering, and reporting overpayments in the CARES Act UI programs.

Mr. Cole: Mr. Secretary, the administration of enhanced unemployment compensation benefits under the CARES Act showed that most unemployment systems had great difficulty adapting to serve self-employed, non-traditional, mixed income, independent contract, and similar workers under such special circumstances. Has the Department considered encouraging

states as they modernize their systems to seek to enhance the flexibility of their systems to adapt to special circumstances such as emergency unemployment compensation provisions?

Mr. Walsh: Many state systems are operating on outdated technology, which made it difficult for them to respond rapidly to changes in law and economic conditions. The Department is working to help develop more flexible and responsive open, modular technology solutions that states may adopt as part of their own ongoing modernization and improvement efforts.

We must recognize the important work performed by individuals in the state UI agencies during the COVID-19 pandemic. They are responsible for delivering over \$870 billion in UC to over 53 million workers during the pandemic, which played a major role in mitigating the pandemic's negative impact on the U.S. economy during very volatile times. These individuals worked long hours and had to be creative in implementing new programs quickly and meeting the highest demand for UC in the history of the program. We must also recognize that many states had never been asked or expected to provide unemployment benefits to the types of workers mentioned in the questions. Their systems were simply not designed to provide benefits to this population.

We acknowledge that states were not prepared to respond to the unprecedented level of unemployment caused by the COVID-19 pandemic. And as a result, customer service suffered, benefits were delayed, and criminals attacked the system perpetrating unacceptable fraud.

The President's Fiscal Year (FY) 2023 Budget includes a clear statement on Principles of Reform for the UI program, including one that states: "The UI systems must reflect the modern economy and labor force. . . . In addition, the Administration supports finding a way to address the lack of support in the existing UI system for many workers, including independent contractors, low-income and part-time workers, and workers with nontraditional work histories."

Additionally, the PUA program, which created benefits for individuals during the pandemic who traditionally have not been covered by unemployment insurance, was unprecedented in its eligibility requirements and temporary in nature. This structure made it difficult for states to plan ahead. A better option would be to improve inclusion in the base UI program to reflect the workforce of the 21st century so that the core unemployment benefit delivery system can provide income security in economic downturns, as well as provide pre-defined framework for emergency compensation benefits so that states can plan for such situations.

The Department stands ready to provide legislative technical assistance to Congress on this topic upon request as well.

QUESTIONS SUBMITTED BY REPRESENTATIVE CHUCK FLEISCHMANN

ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM

Mr. Fleischmann: What is the Administration's timeline for reviewing applications and filling the Ombudsman position for the Energy Employees Occupational Illness Compensation Program?

Mr. Walsh: The Department of Labor understands the importance of the Office of the Ombudsman and the role it plays in helping to ensure the success of the EEOICPA program. The Ombudsman is independent of the EEOICPA program (by statute), and reports to the Benefits Review Board (BRB) which is responsible for hiring the new Ombudsman. The hiring process for the Ombudsman position is currently underway through the BRB and will hopefully conclude shortly.

Mr. Fleischmann: What is the Administration's plan of action once this position has been filled?

Mr. Walsh: The Department plans to continue supporting the important activities of the Ombudsman in the areas of claimant support and assistance, as well as resuming the Ombudsman's pre-2020 regular schedule of in-person meetings with claimants and potential claimants to hear first-hand their complaints and grievances. The Department has been very interested in supporting the Ombudsman in the past and will continue to strive to support the new Ombudsman once the selection process is completed.

Mr. Fleischmann: Is the Administration open to expanding the EEOIC program to include trainees and their survivors as a covered class?

Mr. Walsh: The Office of Workers' Compensation Programs (OWCP) will administer any changes to the law that Congress proposes. However, it should be noted that trainees are covered under the EEOICPA already if they can establish that they were employed at a covered DOE facility during a covered time period. Whether a trainee qualifies as a member of a Special Exposure Cohort (SEC) "class" depends on how the National Institute for Occupational Safety & Health (NIOSH) defines the SEC class. NIOSH defines the SEC classes on a site-by-site basis and OWCP adheres to the NIOSH definition.

ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH

The Advisory Board on Toxic Substances and Worker Health officially requested a support contractor 3 years ago. It is my understanding that the contract is still in the procurement process and has not yet been sent out for bids.

Mr. Fleischmann: What is the Administration's plan to provide a support contractor?

Mr. Walsh: OWCP began the market research process for procuring a support contractor and has been actively engaged in efforts to acquire the needed support. A Request for Information

(RFI) was posted in the summer of 2021, and responses from potential contractors were received. Using the information from the RFI, OWCP drafted the necessary procurement documents and determined the availability of funds to procure the requested work.

The Advisory Board on Toxic Substances and Worker Health offers highly technical advice to the EEOICPA program on specific scientific and medical topics under its purview. Any support contractor would be required to have the necessary expertise and education in particular specialties in order to provide the services needed by the Board. The Board's Chair has been very helpful in providing feedback on the specific expertise required. We are rapidly moving forward with our evaluation of the requirements and hope to reach a decision soon on the best means to procure the requested support services.

Mr. Fleischmann: When do you expect this process to be completed?

Mr. Walsh: OWCP is moving forward rapidly with their evaluation of the requirements and hopes to reach a decision soon on the best means to procure the requested support services.

UNEMPLOYMENT INSURANCE SYSTEM MODERNIZATION

The President's budget request includes \$3.4 billion to help states modernize their UI systems. During the pandemic, states suffered enormous inefficiencies in getting benefits to applicants in a timely manner while billions in fraudulent payments were dispersed across the United States.

Mr. Fleischmann: What is the Administration doing to prioritize the modernization of UI systems?

Mr. Walsh: While the 2023 Budget includes \$3.4 billion for Unemployment Insurance (UI) administration, it is important to clarify that the majority of the funding is for state administration of regular workload activities. The funding includes \$150 million designated for program integrity and anti-fraud activities, including IT and process modernization.

Using funding provided in the American Rescue Plan Act (ARPA), the Department is working with states to develop technology and best practices that states can use to support a continual approach to the modernization of their UI systems. These efforts involve developing and piloting specific solutions and approaches with and for states and scaling their impact based on the results of real-world testing. These solutions are focused on the following broad areas:

- Improving customers' experience;
- Improving the resiliency of state systems;
- Reducing fraud; and
- Ensuring equitable access to benefits.

We plan to continue to develop additional pilot projects in the future with the goal of helping states offer timely payment of benefits, along with improved integrity, equity, and customer service in future mass layoff events.

In addition, the Department engaged with 24 states to use multidisciplinary teams (known as Tiger Teams) to identify quick actions states can take to rapidly improve equitable access, detect and prevent fraud, improve customer experience, and support timely delivery of unemployment compensation. Many of the recommendations include better use of technology. As part of this project, the Department is making grant opportunities available to states participating in this Tiger Team initiative to implement the recommendations developed through the engagement.

Using ARPA funds, the Department awarded \$133.86 million in grant funds to 50 states and territories to aid in the detection and prevention of fraud. The Department also is making grants to states to advance equity, having awarded \$85 million in grants to 18 states. The Department continues to review additional applications from other states that were received by the deadline of December 31, 2021. The Department also is using ARPA funds to pilot a new UI Navigator Program. The purpose of this program is for state UI agencies to partner with community-based organizations in helping historically underserved workers learn about, apply for and, if eligible, receive UI benefits and related services, as well as to support state agencies in delivering timely benefits to workers. On June 10, 2022, the Department awarded more than \$18 million to seven states for UI Navigator pilots.

Mr. Fleischmann: Do the Administration's efforts to modernize UI account for non-traditional workers like mixed income, independent contract, and gig workers?

Mr. Walsh: To provide unemployment benefits to the types of workers described in your question across all states requires Congressional action to define such work as covered employment in the laws governing unemployment insurance. The President's FY 2023 Budget includes a clear statement on Principles of Reform for the UI program, including one that states: "The UI systems must reflect the modern economy and labor force. . . . In addition, the Administration supports finding a way to address the lack of support in the existing UI system for many workers, including independent contractors, low-income and part-time workers, and workers with nontraditional work histories."

The Department stands ready to provide legislative technical assistance to Congress on this topic upon request.

Mr. Fleischmann: What can states do to prevent UI losses due to fraudulent claims?

Mr. Walsh: The Department is providing technical assistance and funding to help states address the issue of fraudulent claims, including, but not limited to, creating a website resource for victims of unemployment identity fraud; providing 50 states with \$133.8 million in fraud prevention grants; funding the national UI Integrity Center; providing states with access to prisoner data; participating in workgroups focused on combatting fraud in the UI system; and aiding states in the recovery of funds stolen by fraudsters. In addition, the Department's Employment and Training Administration (ETA) collaborates on a regular and ongoing basis with the Department's Office of Inspector General (DOL-OIG), including but not limited to facilitating joint meetings with ETA's regional offices, DOL-OIG, and the states. The states can also engage the help of the Department's multidisciplinary teams (known as Tiger Teams) to

identify means to bolster fraud prevention and detection processes and systems, as well as receive grant funding to implement the Tiger Teams recommendations.

Specifically, with regard to the UI Integrity Center, states have the opportunity to use tools, resources, and services described below at no cost to the state. The UI Integrity Center maintains and operates the Integrity Data Hub (IDH), which is a secure, robust, centralized, multi-state data system that allows participating states to cross-match, compare, and analyze state unemployment compensation (UC) claims data against a variety of datasets. The IDH continues to evolve as more states submit data for cross-matching and identify suspicious claim attributes and as new data sources are added. The IDH currently offers the following cross-matches/datasets: Suspicious Actor Repository (SAR), Suspicious E-Mail Domains and Patterns, Foreign Internet Protocol (IP) addresses, Data Analysis, Multi-State Cross-match (MCSM), Fraud Alerting, Identity Verification (IDV) solution (including a cross match to the SSA Death Master File), and Bank Account Verification (BAV) service. Since the pandemic, states' use of IDH and its services has increased significantly. In March 2020 only three states were using MSCM and now 47 states are using MSCM. The IDV service was added to the IDH in July 2020 and currently 39 states are using IDV. The BAV service was added to IDH in February 2022 and currently 25 states are using it. In addition to the cross-matches/datasets available in the IDH, the UI Integrity Center offers additional services and resources to states, including technical assistance and consultative services, a Knowledge Exchange Library (which is a searchable repository of UI Integrity Center resources), and the UI National Integrity Academy (which provides training programs and materials to state UI agencies, such as UI Operations Integrity and Fraud Investigations).

Mr. Fleischmann: How much will it cost to implement modern technology into the UI benefit applicant and approval systems across the United States?

Mr. Walsh: The unprecedented demands on, and risks to, the UI program seen in the COVID-19 pandemic require ongoing innovation and resources to keep the federal and state systems resilient, responsive, and safe. The \$2 billion in ARPA funds are being invested carefully in a variety of ways to assist states, but it is a down-payment on what must be an ongoing Congressional commitment to this essential safety-net for workers and families. Given the varying levels of the 53 state systems (some relying on 50-year-old mainframes, while others have more recently developed systems) and the wide range of possible technology needs, it is difficult to estimate an absolute cost of modernizing each of the 53 states UI system — instead, we support ongoing investment with demonstrable results and measures that deliver the three ARPA goals of improved timeliness of benefit payments, reduced fraud, and more equitable access. By working in close partnership with states, we hope to raise the standards of systems nationwide and have an ongoing modernization effort in UC programs.

QUESTIONS SUBMITTED BY REPRESENTATIVE HERRERA BEUTLER

WORKER MISCLASSIFICATIONS

The State of Washington recently enacted legislation (HB 2076) that would provide several work-related benefits to rideshare drivers while preserving their status as independent contractors. This was overwhelmingly supported by drivers and local unions. Repeatedly, we see voters, drivers, and policymakers rejecting the notion that independent contractor drivers are “misclassified,” and industry and labor even working together to find a solution.

Ms. Herrera Beutler: Instead of spending time and resources to enforce the notion of “misclassification of gig workers,” shouldn’t this Administration be requesting funding to develop constructive solutions for the millions of workers who want to remain independent?

Mr. Walsh: Employers in many industries misclassify employees as independent contractors to reduce labor costs at the expense of millions of workers and to gain an unfair advantage over competitors. These misclassified workers are denied key labor protections and benefits guaranteed to them under the laws that the Labor Department administers, including minimum wage, overtime compensation, family and medical leave, unemployment insurance, and safe workplaces. This problem is not unique to the gig economy — it affects nearly every industry.

Working together with businesses and worker advocates, we can develop solutions to provide worker protections in a modern economy that benefit both employers and workers.

Recently, the Department announced that it plans to engage in new rulemaking on determining employee or independent contractor status under the Fair Labor Standards Act (FLSA). We remain committed to ensuring that employees are recognized correctly when they are, in fact, employees so that they receive the protections the FLSA provides. At the same time, we recognize the important role legitimate independent contractors play in our economy. We need to hear from workers and employers as we develop our proposal. We held public forums in June and heard diverse perspectives from those who may be affected by employee or independent contractor classification.

Ms. Herrera Beutler: Why is the Administration not prioritizing funding and resources for the enforcement of misclassification to address the exploitation of low wage, vulnerable workers, instead for independent contractors who want the flexibility and independence of gig economy work?

Mr. Walsh: Protecting low wage, vulnerable workers is our most fundamental priority. Our investigations have found restaurant employers claiming dishwashers are independent contractors. In another case, we found that a home healthcare agency willfully misclassified more than 500 home health aides as independent contractors and denied them their earned overtime wages. Following litigation of the case, the U.S. District Court for the Eastern District of Pennsylvania entered a consent judgement requiring the home healthcare agency to pay affected workers \$2,272,436 in back wages and an equal amount in liquidated damages. The work that members of the DOL team do to put wages back in workers’ pockets changes lives.

The Department's team is frequently talking with many of these workers. We need to listen carefully to what workers are saying when they talk about flexibility. We hear people say they want living wages, a predictable schedule, job security, a safety net if something goes wrong. When I hear workers talking about flexibility, I hear them saying, "If my child gets sent home sick from school, I need time off to pick them up." Or maybe, "I need to bring my aging mother to physical therapy on Thursday afternoons."

It is not true that the only way to offer some flexibility to workers is by misclassifying them as independent contractors. Employee protections can give workers the right to take family and medical leave, either more time with their families or the right to extra pay after a 40-hour week, and so much more. Labor laws do not restrict workers' flexibility — they increase it.

COMMUNITY COLLEGE AND WORKFORCE DEVELOPMENT

Community colleges are essential to respond to current workforce shortages and retrain workers to support local economies

Ms. Herrera Beutler: How will the Department of Labor FY23 budget support training programs at community colleges?

Mr. Walsh: The FY 2023 budget request continues funding for the Strengthening Community Colleges (SCC) training grants, proposing double the amount authorized in FY 2022. These grants focus on building capacity for community colleges to be effective workforce development partners, supporting industry-specific curriculum development and industry partnerships that benefit employers and workers, as well as focusing on addressing equity gaps that create inequitable employment outcomes for underrepresented populations. Beyond the SCC grants, many of the budget requests in FY 2023 include community colleges as eligible lead applicants for grants or as required partners within the local workforce system, such as the \$100 million SECTOR program proposal that will align industry with education and training providers in a purposeful sector-driven regional workforce development strategy.

Ms. Herrera Beutler: How will the Department of Labor partner with industry to create flexible apprenticeship programs that can help address current workforce shortages – especially in STEM fields?

Mr. Walsh: On February 17, 2021, the Department announced several actions to accelerate the expansion of apprenticeships, as well as to modernize, strengthen, and diversify the proven Registered Apprenticeship Program (RAP) model to meet the current and future needs of the U.S. workforce. One of these actions included the re-establishment of the Advisory Committee on Apprenticeship (ACA). The Department's decision to re-establish the ACA followed its recognition of the value and need to engage and partner with industry leaders and practitioners from labor management organizations, educational institutions, and workforce and community organizations across the public and private sectors. These engagements and partnerships help to bolster, expand, streamline, and diversify apprenticeships, as well address any current or future

workforce shortages, including in the STEM fields, that may exist. In September 2021, the Department appointed 29 members to the ACA, comprising leaders in industry/business, labor, and the public sector to explore and provide advice and recommendations on issues related to the Registered Apprenticeship Program, including ways to increase diversity, equity, inclusion, and accessibility in Registered Apprenticeships; the expansion of apprenticeships into new industries and sectors; the modernization of the Registered Apprenticeship System; and the diversification of apprenticeship pathways (i.e., pre-apprenticeships, youth apprenticeships, and degree apprenticeships).

Recently, the ACA approved and issued a six-month Interim Report to the Secretary, which includes the identification of critical apprenticeship issues and best practices and recommendations, particularly in connection with strengthening, diversifying, and modernizing Registered Apprenticeships. The Department has and will continue to implement many of the ACA's recommendations, including:

- Promoting better engagement and outreach efforts with industry groups to ensure that the Registered Apprenticeship Program is responsive to the needs of both workers and industry;
- Expanding apprenticeships into new and emerging sectors in a way that avoids “splintering” occupations into overly specific occupational subsets (enabling apprentices to apply learned skills in an occupation across several employers);
- Engaging with industry associations and/or employers to ensure the continued alignment of apprenticeship program standards with industry needs and that such standards provide apprenticeship flexibilities (e.g., determining the appropriate balance between in-person and virtual learning, while maintaining the in-person safety and training elements that have made apprenticeship successful);
- Promoting the development and use of consensus-based occupational frameworks, incorporating input from industry, labor, education, and other entities, to increase employer participation in RAPs; and
- Updating and enhancing apprenticeship program standards and apprenticeship guidance to reflect new and emerging technologies (e.g., modernization of the Standards Builder Registration On-line Tool).

Over the years, the Department has made tremendous strides in partnering with industry to develop high-quality apprenticeship programs to fill critical labor shortages. In 2015, the Department introduced the American Apprenticeship Initiative (AAI), which was designed to accelerate the expansion of Registered Apprenticeship and aimed to register new apprentices in high-growth and high-tech industries, such as health care, information technology, and advanced manufacturing and from underrepresented populations. The AAI grantees—which included industry associations, labor unions, local workforce boards, nonprofit organizations, post-secondary educational institutions, and state and local agencies—have been able to successfully expand the RAP model into new industries and extend RAP opportunities to more diverse populations. In addition, the Department has established partnerships with industry intermediaries in an effort to launch, promote, and expand the number of RAP opportunities

across industries throughout the nation, including industries that have not traditionally used apprenticeship. Industry intermediaries are charged with increasing awareness through industry outreach, connecting employers and labor organizations with workforce and education partners, and providing technical assistance to launch and expand RAPs. They are also tasked with helping program sponsors with recruitment, hiring, and retention strategies as a way to increase the number of apprentices, especially from populations traditionally underrepresented in apprenticeship, including women, people of color, and individuals with disabilities.

REGISTERED APPRENTICESHIPS AND CONSTRUCTION

Currently, the construction industry is facing an estimated 650,000 vacant construction jobs in 2022 alone. The DOL's Registered Apprenticeship Partners Information Data System (RAPIDS) found that in 2021, a total of 32,068 apprentices completed construction industry registered apprenticeship programs from RAPIDS participating states. Therefore, at 2021 rates of completion, it would take roughly 14 years for all government-registered construction industry apprenticeship program completers to fill the estimated 650,000 vacant construction jobs needed just in 2022.

Ms. Herrera Beutler: Why is the Administration not encouraging all programs across the workforce development ecosystem, including industry programs and programs provided by educational institutions that are not affiliated with the government, as opposed to championing only government-registered apprenticeship programs?

Mr. Walsh: The Biden Administration has supported the development and expansion of proven workforce development strategies, including Registered Apprenticeships and other programs that use sector partnerships that align education and training with industry needs and worker voice to fill the skills needed for in-demand industries locally and regionally. A key example of a sector strategy grant is the H-1B-funded "America's Promise" Job-Driven grants that were just completed in late 2021. America's Promise grants were designed to create or expand regional partnerships between employers, economic development, workforce development, community colleges, training programs, K-12 education systems, and community-based organizations that make a commitment — or a "promise" — to provide a pipeline of workers to fill existing job openings, meet existing employer needs for expansion, fuel the talent needs of entrepreneurs, and attract more jobs from overseas. The best practices from America's Promise grants have informed subsequent sector-focused H-1B grant initiatives and inform the \$100 million SECTOR proposal included in the FY 2023 budget.

Additionally, it is important to emphasize that Registered Apprenticeships have always constituted an industry-driven workforce development model under which a wide range of non-governmental sponsors — including private-sector employers, labor unions, trade organizations, intermediaries, and educational institutions — may develop, deliver, and administer quality apprenticeship training programs on either a state-wide or national basis. The role of government — namely, the Department's Office of Apprenticeship and DOL-recognized State

Apprenticeship Agencies — is largely focused on the evaluation, registration, and oversight of such apprenticeship programs to ensure that they satisfy the regulatory requirements for quality and equal opportunity that are stipulated in 29 CFR part 29, subpart A and 29 CFR part 30.

Ms. Herrera Beutler: What is the Administration doing to address the current workforce needs of the construction industry?

Mr. Walsh: On November 15, 2021, President Biden signed into law the Bipartisan Infrastructure Law (BIL). This landmark piece of legislation, which passed Congress with bipartisan support, will provide approximately \$550 billion for new federal investments over the next five years to finance rebuilding and modernizing the nation's critical infrastructure, including projects for the construction and rehabilitation of roads, bridges, rail, ports, water systems, airports, broadband, and public transit. In addition to creating hundreds of thousands of well-paying construction jobs that will afford workers the opportunity to join a union, the Federal funds provided under the BIL will serve to strengthen the nation's supply chains, thus helping to ease inflationary pressures. In this vein, the Administration recently announced the awarding of more than \$241 billion in grants under the BIL to finance the construction of 25 port projects, including the building of an off-dock container support facility in Tacoma, Washington, which will be located less than 40 miles from the congressional district that you represent.

Furthermore, the Department has made significant strides in increasing Registered Apprenticeship Program (RAP) opportunities across diverse industries. This includes using Federal funding to support RAP expansion in in-demand industries, including construction. Since 2015, the Department has awarded numerous grants and Industry Intermediary contracts that support expanding RAPs in the construction industry. Most recently, the Department published the Apprenticeship Building America funding opportunity announcement for \$113 million, which includes a focus on growing RAPs in the construction industry. Awards were announced in June 2022.¹³¹⁴

UNEMPLOYMENT INSURANCE FRAUDULENT PAYMENTS

The Department of Labor OIG found that there was potentially \$163,000,000,000 in pandemic unemployment benefits that could have been paid improperly, with a significant portion attributable to fraud.

Ms. Herrera Beutler: How much of this \$163 billion has the Department of Labor recovered to date?

Mr. Walsh: States have reported the following data to the Department regarding overpayments established and overpayments recovered:

- Total Overpayments Established = \$39,537,441,421;

¹³ https://www.apprenticeship.gov/investments-tax-credits-and-tuition-support/awardee-search?awardee_name=&industry%5B%5D=5916#top

¹⁴ https://www.apprenticeship.gov/sites/default/files/ierap_nabtu.pdf

- Fraud Overpayments Established = \$2,896,874,427;
- Total Overpayments Recovered = \$4,492,350,134; and
- Fraud Overpayments Recovered = \$701,469,417.

The above data is the result of queries run by the Office of Unemployment Insurance on June 8, 2022. This data reflects the actual overpayment establishments and overpayment recoveries reported by states on a quarterly basis for all unemployment compensation (UC) programs. The data includes state data reported from April 1, 2020, through March 31, 2022, and includes overpayments established and overpayments recovered for all programs operational at that time, which were the three largest permanently authorized UC programs (State Unemployment Insurance [UI], Unemployment Compensation for Federal Employees [UCFE], and Unemployment Compensation for Ex-service members [UCX]) and also includes data for the temporary programs (including Extended Benefits [EB] and temporary programs like the UI-related programs created by the Coronavirus Aid, Relief, and Economic Security [CARES] Act of 2020, including Pandemic Unemployment Assistance [PUA], Pandemic Emergency Unemployment Compensation [PEUC], and Federal Pandemic Unemployment Compensation [FPUC], and Mixed Earners Unemployment Compensation [MEUC]).

QUESTIONS SUBMITTED BY REPRESENTATIVE BEN CLINE

TREE CARE INDUSTRY – OSHA STANDARDS

Mr. Cline: Many of my constituents in the Tree Care Industry are eager to see OSHA issue a standard that clarifies and codifies safe work practices for tree care operations. My understanding is the federal government currently regulates the tree care industry with standards intended for other industries, and this has created confusion for enforcement officers, tree care companies and clients and workers. The industry has been asking OSHA to address the problem for more than two decades. Some states have acted and issued tree care specific standards, but OSHA has been slow to do so as it pursues other priorities, most of which do not enjoy the same level of support. The Fall 2021 regulatory agenda listed June as the target date for a proposed standard. Will OSHA meet this target date and if not, when do you anticipate OSHA will issue the proposed standard?

Mr. Walsh: OSHA's standard-setting process is a long process that includes a multitude of procedural and legal requirements, as well as OSHA's evidentiary requirements and public participation. OSHA began working on a Tree Care Operations standard in 2008, with the publication of an Advanced Notice of Proposed Rulemaking (ANPRM). This document provided significant background information and gave stakeholders the opportunity to answer questions on work procedures, costs, and their experience with safety and health in the tree care industry. In 2016, OSHA continued with the rulemaking process and held a stakeholder meeting. In May 2020, OSHA completed the Small Business Advocacy Review (SBAR) Panel, a required step to obtain early input from small business representatives. These phases are crucial for OSHA to develop a complete and robust standard to protect all employees performing tree care. Transcripts and reports from the previous phases of rulemaking can be found on the OSHA website: <https://www.osha.gov/tree-care/rulemaking>.

Due to the pressing nature of the COVID-19 pandemic, since the beginning of this Administration, OSHA has focused its attention on COVID-19 Healthcare rulemaking—in addition to Heat Illness Prevention rulemaking. As a result, OSHA will not meet the target date of June 2022 for the development of a rule for Tree Care Operations. OSHA is reevaluating the time frame for rulemaking and anticipates publishing a proposed rule for Tree Care Operations in fiscal year 2023. The rulemaking team participates in monthly American National Standards for Arboricultural Operations – Safety Requirements (ANSI Z133) meetings with the tree care industry and has held several meetings with the Tree Care Industry Association (TCIA), providing updates, as appropriate. OSHA also provides robust guidance for the industry on its Tree Care Industry Safety and Health Topics Page at: <https://www.osha.gov/tree-care>. Tree Care Operations rulemaking is a priority, and the agency is consistently working towards a published proposed rule.

TUESDAY, MAY 24, 2022.

MEMBERS' DAY

The CHAIR. Well, it is fully virtual, so let me just address a couple of matters here.

For today's meeting, the chair, or staff designated by the chair, may mute participants' microphones when they are not under recognition for the purposes of eliminating inadvertent background noise. Members are responsible for muting and unmuting themselves.

If I notice when you are recognized that you have not unmuted yourself, I will ask the staff to send you a request to unmute yourself. Please then accept that request so you are no longer muted.

I remind all members that the 5-minute clock still applies. If there is a technology issue, we will move to the next member until the issue is resolved, and you will retain the balance of your time.

You will notice a clock on your screen that will show how much time is remaining. At 1 minute remaining, the clock will turn to yellow.

I want to say a thank you to Ranking Member Cole and other members of the subcommittee who are here and thank all the Members of Congress for joining us for Member Day.

This is a unique opportunity to gather input. We are focused on the Labor, HHS, Education appropriations bill, but it is a wonderful opportunity to hear from our colleagues on their district's priorities for the fiscal year. The bill that this subcommittee builds is the largest of all of the non-defense appropriations bills and impacts the lives of every single American.

Through the subcommittee's fiscal year 2022 bill, we made investments to start tackling our Nation's toughest challenges. We increased investments in high-poverty schools, for students with disabilities, to expand access to postsecondary education. We strengthened lifesaving biomedical research with increased funding for the NIH. We bolstered America's public health infrastructure with more resources for the CDC and State and local governments.

We tackled the health crises, including maternal health, mental health, gun violence, substance abuse, while looking to reduce unacceptable health disparities. Supported middle class and working families with increased funding for childcare and development, Head Start, preschool development grants. We worked at sustaining good-paying jobs through investments in job training, apprenticeship programs, and worker protection. And we included community project funding requests to meet the needs of communities directly.

None of the achievements would have been possible without the input from our colleagues. So I am glad the President's budget re-

quest for 2023 proposes continued investments in the programs that impact the lives of Americans.

So as we begin to draft the 2023 appropriations bill, it is important to hear from our colleagues about your top priorities, as you speak up on behalf of your constituents. So, many thanks to all of you for being here.

And with that, let me turn it over to Ranking Member Cole for any opening remarks he cares to make.

Mr. COLE. Well, thank you very much, Madam Chair. And I want to thank you for holding this hearing today and providing a forum for our colleagues to come and present ideas to the subcommittee.

I don't have a lot to say, other than I want to associate myself with your remarks about the good work of this committee. I am always pleased to point out that in the 7 years we have had the opportunity to work together, each in a different role—sometimes chair went back and forth—but the reality is we found common ground seven times in a row, and I am looking forward to doing that an eighth time.

But these hearings are a very important part of that process. And I remember one occasion a number of years ago when one of our colleagues brought to our attention a relatively minor item in a program for a budget as large as ours. It was \$12,000,000 program named after Helen Keller, but it was important to train teachers who were going to work with students that were deaf and blind. Obviously, a crippling condition, but one that we know the right education can do.

And the Member came in and made a pitch for that program. I wasn't familiar with the program, and I happened to ask our chief clerk at the time could she look at that? And came back and said, yes, it is funded at about \$12,000,000 and hasn't been raised in over a decade.

And I said, well, I think we can fix that, and we did. And we were able to get a fairly substantial boost. We would have never known that probably had the Member in question not brought it to our attention.

So, again, I encourage all of you that are testifying today to help the committee do its job. As the chair appropriately pointed out, we are proud of the things this committee does. It helps a lot of people in a lot of work.

I again want to congratulate you, by the way, Madam Chair, for getting our hearing room named after our former chairman, Dave Obey. That was a wonderful event to be at, and I saw a lot of old friends there, of course, including the chairman and his wife, Joan.

But again, this is a good committee that does good work. We appreciate it when other Members come and provide their input. So I look forward to working with my friend, the chair, and hopefully, we can bring in another good bill. And hopefully, that bill will be improved by what we learn today.

With that, Madam Chair, I yield back.

The CHAIR. Thank you very, very much. And let me just say thank you for your participation, but just being engaged and involved with the effort on behalf of David Obey is much, much really—it was really so much of a bipartisan effort. And you could feel the warmth and love in the room.

And I will just add one more piece. You will recall a number of our colleagues coming to this subcommittee to talk about the issue of Down syndrome. And from that hearing, we have made a very significant increase in funding for research for Down syndrome.

So lest my colleagues think that this is just a perfunctory appearance, it is not. We really are interested in what your concerns are and how we can really look at how we can appropriate funds for them.

And I should also say that I enjoy the best of a relationship with the ranking member on this subcommittee, and we write seven bills. We are on to our eighth, and we are going to make it happen. So thank you very, very much.

And with that, I have got the order here, and everybody has got their allotted time here. So if I can, let me recognize Congresswoman Mikie Sherrill from New Jersey to talk about her interests in the Labor, HHS appropriations bill.

**HON. MIKIE SHERRILL, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF NEW JERSEY**

Ms. SHERRILL. Well, thank you, Chairwoman DeLauro, Ranking Member Cole, and members of the subcommittee, for providing me the opportunity to testify today.

I also want to extend a special nod of acknowledgment and thanks to my good friend and colleague from New Jersey, Representative Bonnie Watson Coleman, for her outstanding work to represent and support our State's priorities.

This subcommittee has done crucial work to advance the needs of Americans throughout the country through the funding of community projects in fiscal year 2022 and through consideration of community projects for funding in fiscal year 2023. To that end, I want to speak today about a number of crucial projects that I have submitted on behalf of my district and the communities and constituents I represent.

First, I would like to submit to the committee the vital importance of funding the Community EMS Physician Response Expansion Initiative at RWJBarnabas Health through the Health Resources and Services Administration. This initiative, already in place with one team based in Newark, incorporates many of the lessons we have learned from our military's overseas engagements into an innovative care approach that will help to provide critical life-saving assistance at the scene of emergencies in our communities.

The program will build on an already-successful initiative at RWJBarnabas to bring ER physicians on ambulances to needed sites of crisis. For too many Americans, including in my district, crucial medical interventions are not available in time when they are desperately needed in the aftermath of an emergency. This funding will improve access to this care when it is needed most and will improve health outcomes and save lives in my community.

The proposal received broad support from Essex County elected officials, who attested to the significant benefits this project would provide.

Second, I would like to submit to the committee my strong support for funding a new pilot program to help the Jewish Service for

the Developmentally Disabled incorporate technology in residential group homes, day habilitation, and private residential settings in northern New Jersey to provide greater independence and accessibility to residents. This funding will allow more of my constituents to live independently at home in their communities and will also help to address the home healthcare staffing crisis in residential homes.

Furthermore, this technology already has a strong record of success nationwide, with communities that have utilized it reporting a significant decrease in need for State funding of up to 50 percent per individual served. Adults with intellectual and developmental disabilities have historically been underserved in terms of access to funding and technological innovation, and this community project will take one step towards righting that wrong.

This proposal received strong support from the Healthcare Foundation of New Jersey, the Township of Livingston, and impacted members of the community.

Third, I would like to submit to the committee my strong support for funding to renovate and expand the Morristown Medical Center Emergency Department, which would replace the existing patient monitors and increase monitoring capabilities, construct additional negative pressure rooms to control airborne pathogens, and modernize the triage space. The Morristown Medical Center had over 100,000 emergency department visits in 2019 and is a vital lifeline to hundreds of thousands of families in northern New Jersey.

However, the center's emergency department has not undergone a major renovation since 2011, and much of its equipment and infrastructure is already beyond its expected useful life. This investment will help improve access to effective, affordable medical care for so many people in my district and will improve quality of life throughout our community.

It is no wonder that this proposal received broad community support from Morris County elected officials, including members of the State Assembly and our sheriff.

Finally, I want to submit to the committee the crucial importance of funding student scholarships at William Paterson University to support college completion for students impacted financially by the COVID-19 pandemic. Over the past 2 years, many students have temporarily or permanently withdrawn from their institution of higher education, and approximately 40 percent of William Paterson University students who have not returned to school have cited financial-related reasons.

Access to higher education is a critical path to the middle class for millions of Americans, including so many in my district. But the pandemic could take away much of that opportunity unless we act to support students.

This funding will be used to ensure that students can reenroll in the university, continue their studies, and access supportive services and programming. It will play an important role in helping to increase college attainment levels in Passaic County, which currently has the third-lowest rate in New Jersey.

This project received letters of support from both the County of Passaic and from several local mayors who indicated the significant community impact these scholarships would have.

These four community projects will make a crucial difference in the lives of tens of thousands of people in my district and will provide a sizable return on investment through improved health, reduced cost to taxpayers, and expanded educational attainment.

I greatly appreciate the subcommittee's work to support Members' proposals, and I urge you to include these valuable projects in the fiscal year 2023 L-HHS appropriations bill.

Thank you again.

The CHAIR. I thank the Congresswoman for her testimony and the quality of the community projects that have been submitted.

I think overall that we are very excited, given what happened in 2022 and our ability to fund community projects, and on both sides of the aisle. I know I have heard from my colleagues on both sides of the aisle how successful this effort has been in really demonstrating the community need because we know that there has to be documented community support for these efforts and not just one's own wish or hope or Members', that it is directly related to the community. So it really proving to be almost really a necessity for some of our local communities in order for them to address some of these efforts.

Let me ask my colleagues if they have any questions of Congresswoman Sherrill.

Mr. COLE. I don't, but I want to just quickly associate myself with your remarks again. Sometimes Members really do understand their district better than officials far away in Washington, D.C. And it is just invaluable when they come in and point out what the local needs are and that there is support for these things.

So, again, I want to thank all our colleagues that are doing that today, and again, thank you, Madam Chair, for holding the hearing.

The CHAIR. Thanks.

And I will just add one more thing. We are going to do as best we can to acknowledge and be able to fund the projects. So much will depend—and I might add, there are increasing numbers coming in. Let me just put it this way, we are going to do the best we can to see how many that we can get done this go-around because we understand the value, and we understand the need.

So thank you very, very much for your testimony this morning, Congresswoman. Very appreciated.

Thank you.

And with that, let me recognize—oh, I see Congressman Van Drew is not going to be joining us this morning. So then let me recognize—

Oh, I didn't ask my other colleagues. Congressman Harris, Congressman Cline, do you have any questions?

Mr. HARRIS. No, I am fine.

The CHAIR. Fine. Thank you. Thank you.

So let me ask Congresswoman Veronica Escobar for her testimony this morning. Congresswoman Escobar—and I see you have a guest.

**HON. VERONICA ESCOBAR, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF TEXAS**

Ms. ESCOBAR. I know. I am so sorry.

The CHAIR. That is fine. That is fine. [Laughter.]

Ms. ESCOBAR. He loves the Zoom. So my apologies.

The CHAIR. That is no problem. No problem.

Ms. ESCOBAR. Well, thank you so much, Chairwoman DeLauro and Ranking Member Cole, for hosting this Member Day hearing.

I have the honor of representing El Paso, Texas, in Congress, and I am so grateful to have the opportunity to be advocating for the needs of my community.

This subcommittee has played a critical role in helping communities like mine overcome the many issues the COVID-19 pandemic has presented us over the past 2 years, and I look forward to working with you this fiscal year to address the many challenges still facing El Pasoans.

I would like to begin by first thanking the subcommittee for the \$900,000 increase allocated in the fiscal year 2022 omnibus for the U.S.-Mexico Border Health Commission. Unfortunately, for years, the U.S. section of the Commission was overlooked and underfunded. This became increasingly apparent at the beginning of and during the COVID-19 pandemic when the border region was disproportionately impacted by the virus.

The funding increase this subcommittee allocated is giving the U.S. section the ability to again reengage with their Mexican counterparts, begin work on Healthy Border 2030, and perform basic functions like hire more staff and maintain a permanent office in El Paso.

However, it is critical that we keep providing the U.S. section of the Commission with the resources it needs to continue to play a role in binational health policy. That is why I support the President's fiscal year 2023 request to increase the Commission's funding by \$900,000 and urge the subcommittee to include this funding in your final bill.

Next, I would like to thank the subcommittee for providing funding for my community projects in fiscal year 2022. These projects will have immediate impact on those who need it most. That is why I am excited to discuss the projects I submitted for your consideration for the fiscal year 2023 community project process.

The first project is the El Paso Children's Hospital Pediatric Mobile Clinic. If funded, this project will play a key role in expanding healthcare to traditionally underserved parts of El Paso, like colonias.

El Paso Children's Hospital would use these funds to purchase and outfit a mobile clinic, with the goal of providing both basic and specialty pediatric healthcare throughout El Paso County. It would also allow the hospital to provide several other services, like administering flu shots to young El Pasoans who are unable to visit a doctor regularly.

The second project is the Texas Tech University Health Sciences Center El Paso Border Health Center. I truly believe the border region is a unique place that faces its own challenges when it comes to healthcare. Our majority Latino population has seen dramatic increases in chronic diseases like heart disease and diabetes, but because the border region is vast and diverse, it is difficult to keep track of these trends.

The proposed Border Health Center would create a telemedicine and monitoring program to provide early interventions to slow the rise of chronic diseases while also conducting research to benefit Federal agencies. This transformational project would help change lives by trying to better understand the root causes of the healthcare challenges we face on the border.

The final project is the El Paso Independent School District After School Community Learning Center. This project would allow the school district to expand after school learning programs to parts of the community that are traditionally underserved, like Segundo Barrio. By extending more resources to these parts of the city, the school district will be able to reach more students and give them the tools they need to succeed.

I would like to once again thank the subcommittee for your leadership and for this opportunity and thank you in advance for consideration of my requests.

And I yield back.

The CHAIR. There we go. Unmute myself here.

So I am going to ask my colleagues if you have any questions. Congressman Cole.

Mr. COLE. No.

The CHAIR. No. Congressman Harris.

Mr. HARRIS. No.

The CHAIR. Congressman Cline.

Mr. CLINE. [Nonverbal response.]

The CHAIR. I want to just say—it is not a question, but thank you for taking such an interest. I know that this is the Labor, HHS Subcommittee, and these are the issues you are focused on. But I have watched what happens with mobile clinics—I think we all have—which can get around to the underserved areas, as you point out, and how critically important they are.

I am a product of the after school program. And I say “a product,” I taught in an after school program many, many years ago. And it is just we don’t warehouse children in these programs. We actually provide them with learning experience and art and culture, et cetera, and it is a wonderful way for parents who are working to make sure that their kids are safe.

So I thank you for your focus on the health issues and on the education issues that are really so critically important to youngsters today and in a region that has an underserved population that we need to try to focus on.

So thank you very, very much for your testimony this morning. Thank you.

Ms. ESCOBAR. Thank you, Madam Chair.

The CHAIR. Let me now recognize Congresswoman Kim Schrier from Washington State, and love to have your testimony.

**HON. KIM SCHRIER, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF WASHINGTON**

Dr. SCHRIER. Good morning. Chairwoman DeLauro and Ranking Member Cole, thank you very much for the opportunity to testify to your committee about a few issues of great importance to me and my district.

Specifically, I want to address funding for the Pediatric Subspecialty Loan Repayment Program, funding for the Public Health Emergency Preparedness Cooperative Grants, and two of my community project submissions, Central Washington's Student Medical and Counseling Center air ventilation upgrades and the Heritage Heights Memory Care at Lake Chelan.

So the first program I want to speak about is the Pediatric Subspecialty Loan Repayment Program. The goal of this program is to make sure that children in rural areas get the care that they need.

Millions of children reside 1½ hours or more away from access to specialty care. This was always a problem, but the pandemic has increased the need particularly for mental healthcare, and the cost of pediatric subspecialty treating is steep. Few students coming out of medical school think that they can pay back their loans if they practice in small or rural communities. So we need to incentivize specialty providers to practice in these communities.

This program rewards providers who practice in rural and underserved areas for at least 2 years. When providers train and start practicing in rural areas, they often become part of the community and are more likely to stay. And this important targeted investment works to address the overwhelming medical school debt that serves as a barrier to training in pediatric medical, surgical, and mental health subspecialties. And I respectfully request \$30,000,000 in funding for the Pediatric Subspecialty Loan Repayment Program.

The second program I want to discuss is the Public Health Emergency Preparedness Cooperative Agreement, or PHEP grants. This is the main Federal program that supports the work of health departments in preparing for and responding to all types of disasters, including bioterrorism, natural disasters, and infectious disease outbreaks.

The response systems, personnel, and infrastructure that States require to respond to public health emergencies like COVID-19 would not exist in most States without PHEP funding. These grants help States swing into action in all sorts of disasters.

In my home State of Washington, PHEP grants allowed the health department to form an epidemiology task force in response to a mumps outbreak, for example. And this task force supported local health departments with case investigation, disease surveillance, and risk communication activities.

We know COVID-19 caused substantial burnout in the public health field, and resources are stretched thin. Substantial funding will allow these entities to rebuild and move forward, and I respectfully request that the committee provide \$842,000,000 for this program.

Last, I would like to speak on two community projects that I submitted to this committee. The first is a project to upgrade the Central Washington University Student Medical and Counseling Center medical grade air distribution.

Central Washington University needs to upgrade their air filtration system. The current HVAC system has not been updated since the 1970s, and an upgraded air system will keep both staff and students safe as they await for needed medical and mental health appointments.

The rural city of Ellensburg depends on the university, and the university depends on healthy staff and faculty and students to keep it running. And especially in light of the COVID-19 pandemic, these upgrades are necessary, and I respectfully request \$2,000,000 for this project.

The second is for Heritage Heights at Lake Chelan. This is a senior care facility in a rural part of my district that is converting part of their facility to memory care. Currently, there are no memory care facilities within 40 miles of Lake Chelan, and no nearby facilities accept Medicaid. This means that seniors with dementia and their families have few options in the Chelan Valley for memory care, and the conversion will allow for seniors who need assisted living and memory care to get their care close to home.

It will make possible for them to age nearby their families, their doctors, and existing support systems, and I respectfully request \$800,000 for this project.

Thank you again for the opportunity, the opportunity to testify on issues that are very important to my constituents, and I yield back.

The CHAIR Thank you.

Let me yield to my colleague, Congressman Cole. Any questions?

Mr. COLE. I actually do want to make a couple of quick comments.

The CHAIR. Sure.

Mr. COLE. First of all, I want to, again, thank the gentlelady from Washington for coming. But I want to associate myself with the two programmatic requests that she made.

It is a little bit early to talk about dollars because we obviously don't know what our top line for the full agreement is, let alone our allocation by the subcommittee. It is a little early. But I think she puts her finger on two really important programs in terms of long-term preparedness.

And I represent a district that has the same challenges in terms of getting specialty care into relatively remote areas, and I think the emphasis on pandemic preparedness, I mean, we shouldn't have to learn this lesson again. I think this committee did a lot of good work leading into the pandemic, and I am proud of what it did. But this is an area where we probably just simply need to do more.

So, again, I think those are both excellent requests, and certainly, the specific community requests, again, I have the same issue with, for instance, constituents with dementia that can't get care anywhere close to where they live. So I understand the utility of those kinds of requests and, again, thank the gentlelady for coming and testifying before our subcommittee.

Dr. SCHRIER. Thank you, sir.

The CHAIR. Thank you. Congressman Harris.

Mr. HARRIS. No, no questions. Thank you.

The CHAIR. Thank you. And Congressman Cline.

Mr. CLINE. No, thank you, Madam Chair.

The CHAIR. Thank you.

I just want to say as well I do associate myself with the ranking member's comments about the programmatic requests, that I think they are really critical efforts. And we are right, we don't know

about what the dollar amounts are yet, but really in terms of preparedness, it is we need to continue to look at how we support efforts and the CDC's efforts on preparedness.

And I think I look at teacher shortage, I look at pediatric subspecialties here, and all of these of areas I think we do need to look at how we deal with loan repayment programs so that we can encourage people to move in.

I just want to say this one last comment. We are really very fortunate in this Congress, Dr. Schrier, your background in pediatrics, your background in health really brings to the fore the critical issues that we need to—that we need to face, and that kind of knowledge, you make these proposals out of the science and the knowledge of the medical profession. And for that, we are really, really very grateful.

So thank you so much for the testimony.

Dr. SCHRIER. Thank you, Madam Chair, Mr. Ranking Member. We are very grateful for you. And a point of privilege, thank you for your work with the USDA to get so many of our projects—

The CHAIR. Hear, hear. We are done. It is done. It is done. Thank you.

Dr. SCHRIER. Thank you.

The CHAIR. Take care.

And with that, let me recognize Congresswoman Sylvia Garcia from Texas about community projects. So, Congresswoman Garcia.

**HON. SYLVIA R. GARCIA, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF TEXAS**

Ms. GARCIA. Thank you, Madam Chair, and thank you, Mr. Ranking Member and all the committee members, for having me here this morning to talk about my priorities for the Labor, Health and Human Services Subcommittee for this next year.

Madam Chairwoman, earlier this year, the 2020 Census Community Survey revealed that my district, my district has the highest number of uninsured rate in the Nation. Madam Chair, this is not a number one that I sought. This is incredibly alarming, and that is why many of my appropriation requests this year revolved around healthcare and creating jobs where employees could attain high-quality health insurance.

I would like to flag several of my community project requests for the committee. First, El Centro de Corazon, a Federally Qualified Healthcare Center, an FQHC, is in my district. We are requesting \$5,000,000 in funding for construction and equipment costs to build an additional 10,000 square foot healthcare facility.

This facility will increase capacity to provide more women and children with accessible and affordable healthcare services. Services will include prenatal care, contraceptive management, ultrasounds, and well woman exams.

Madam Chair, as you are well aware, women's healthcare is under attack in Texas. So this project will be a step in the right direction to put and maintain more healthcare for women in my district.

Additionally, I have nearly \$4,000,000 in community project dollars for an Access2Health SmartPods project. This community project seeks to address the healthcare disparity in multiple loca-

tions across my district through the deployment of innovative, award-winning Access2Health SmartPods developed by Baylor College of Medicine.

A SmartPod is like a mobile healthcare facility unit. There will be 10 pods, half of which are equipped to provide primary care, and half of which are tailored to provide mental health services, will be deployed across 4 popular community centers and 1 county park. These self-contained pods cost effectively provide the full range of primary care and mental health services to areas that lack healthcare services.

I have visited these pods. There is one or two already in action, and I could tell you that, firsthand, I have seen this, and it works. It is about taking the healthcare services to the underserved and hard-to-reach communities, and it will be a great addition to services in my district.

Finally, Madam Chair, I will flag a project for one of my school districts, Pasadena Independent School District, called the High School to High Wage Project. This project will help Pasadena ISD ensure their students have access to proper and up-to-date equipment, resources, and training so that they are prepared to enter the workforce and fill employment gaps in high-demand, high-wage occupations.

These are not just any jobs. These are jobs vital to the economic and socioeconomic success of my district and the greater Houston area.

Statewide and regional data indicates that jobs in the healthcare industry, trades, and STEM-related fields are being impacted the most by the shortage of qualified employees, and Pasadena ISD is addressing that. The school district, working closely with business and industry partners, work together to ensure that they are preparing their graduates to fill these high-wage, high-demand positions. Giving our students the opportunity to get into high-paying, high-quality jobs means they are more likely to attain high-quality health insurance as well, which, of course, will improve our numbers.

I am happy to answer any questions you may have. Thank you again.

And I, too, think that Dr. Schrier is a great addition to the Congress, and I thank her and your committee for acting swiftly on our baby formula crisis.

Thank you, and with that, I yield back.

The CHAIR. Thank you. Let me yield to my colleague, Congressman Cole, for questions.

Mr. COLE. No questions. All seem very worthy projects.

Ms. GARCIA. Thank you.

The CHAIR. Congressman Harris.

Mr. HARRIS. No questions. Thank you, Madam Chair.

The CHAIR. Congressman Cline.

Mr. CLINE. No questions. Good to see my colleague from Texas.

The CHAIR. Thank you.

Again, startling, the highest rate of uninsured in the country, something to be concerned about. And I am, over and over again, just taken with the quality of the projects that are really bubbling up from communities, and your district, you know, in Pasadena

Independent School District and where you want to go there and the health issues that you want to—again, these SmartPods, I would love to see one myself to see how that works. But any way in which we can be better delivering services, which is what your focus is here.

So I think Members, including yourself, Congresswoman Garcia, really are focused in and work very closely with the local groups, with local government in trying to really ferret out the very specific and critical needs of your communities.

So many, many, many thanks for your work and for your testimony and for the submissions. Much appreciated.

Thank you.

Ms. GARCIA. Well, thank you, Madam Chair. And any time you want to come to Houston, I would certainly invite you during our great Rodeo Week.

The CHAIR. Okay.

Ms. GARCIA. But any time would be great. I know I have spoken to Secretary Becerra, and he hopes to come down and help me bring the issue of the uninsured and sites in several areas. So anything I can do and certainly would welcome your help in decreasing that.

Because, as I said, that is a number one I did not seek and I don't want to be on. So working very, very hard to turn those numbers around.

The CHAIR. Hear, hear. I know you will.

And with that, thank you very, very much for your testimony this morning.

Ms. GARCIA. Thank you so much. You all have a great day.

The CHAIR. Thank you.

To my colleagues, there are no more Members who are testifying. I think people being at home for this week and running around their districts, which is a good thing to do, that has had fewer Members participating. But I want to just say thank you for your help here this morning, and I guess we go on this Thursday, I believe, to listen to public witnesses and of which there are a number. So we will have a full schedule on Thursday. But thank you very, very much.

And again, to all of us, in a very bipartisan way, I think people have really honed in, and it is really so reassuring to see the quality of the projects that people are bringing forward. There was so much skepticism around revisiting community projects, and I just feel good.

And that is a testament to all of you here and our colleagues who understand, as you pointed out, the ranking member, that Members know their districts the best. They really do. And I think we are seeing evidence of that.

So thank you all very much.

And with that, I got to gavel. The hearing is adjourned. Thanks.

WEDNESDAY, MAY 25, 2022.

TACKLING TEACHER SHORTAGES

WITNESSES

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The CHAIR. I want to say a thank you to Ranking Member Cole and all the members of the subcommittee joining today's hearing.

Before we begin, I want to take a moment to address a tragedy that occurred in Texas yesterday. I am angry, I am in disbelief to be here once again. Yesterday, the students and the teachers at Robb Elementary School in Uvalde, TX woke up ready to learn, they woke up ready to teach, but 19 children, and one teacher, and a school employee went to school, only to be taken from us forever. It is a senseless attack. It is absolutely heartbreaking, but it isn't anything new. Mass shootings are taking the lives of babies, of parents, of brothers, and sisters everywhere, and, you know, my community knows all this too well. A tragedy occurred at Sandy Hook Elementary School nearly 10 years ago. It took the lives of 20 beautiful, innocent souls—babies—and six teachers, and it shook us to our very core.

We are gathered today for this hearing to find ways to support our educators, but how can we begin to speak of support of our teachers if they are not physically safe at school? It is alarming and it is outrageous that so many children in America's schools and their parents and teachers worry that a senseless act of gun violence could take their lives. The American people and our Nation's children are waiting for us to take immediate action to save innocent kids and to save their teachers.

In today's hearing, we will examine the root causes driving the teacher shortage. While we were not expecting yesterday's tragedy to loom over our conversation today, we must keep it at the top of our mind as we consider the challenges that our educators confront each day nationwide. So I welcome our witnesses today: Desiree Carver-Thomas, researcher and policy analyst at the Learning Policy Institute; Dr. Lindsey Burke, director of the Center for Education Policy, The Heritage Foundation; Ms. Randi Weingarten, president, American Federation of Teachers; Dr. Jane West, education policy consultant.

It is a selfless act to choose teaching as a career. The Americans who choose this path go in with the admirable goal of educating future generations and helping students of all ages and backgrounds

succeed. I am sure everyone here today remembers a teacher who inspired us along the way. Teachers can change the course of their students' lives, sharing knowledge and starting students down a path for successful futures. Good teachers are essential to our progress as a Nation.

You know, as a substitute teacher early in my career, I bore witness to the challenging work that educators do and the demands that they are put under every day, something that is hard to grasp unless you are in the position yourself. I trust our teachers, and I know it is our job to provide them with the resources and the support that they need to thrive. The witnesses with us today know this well. They represent a diverse group focused on the wellness of our students and their education, but they also know that the teacher shortage plaguing our Nation threatens all those teachers provide to our students. If there are not teachers to educate our kids, the very foundation on which our Nation's progress is built gets dissolved.

Every student deserves a high-quality education, but teacher shortages threaten our ability to provide that education. The pandemic exacerbated the existing challenges our Nation faced to ensure every student has access to the diverse and well-prepared educators they deserve. In the 2017–2018 school year, nearly every State, including my State of Connecticut, experienced teacher shortages in high-needs subjects and in special education. In that same year, more than 100,000 teaching positions around the country were vacant or staffed by people unqualified for the job. In New Haven Public Schools in my district today, there are over 150 vacancies for certified teaching positions.

Teachers are unfortunately leaving the profession. There has been a significant increase in retirement and a dramatically-shrinking pipeline into the profession with over 300,000 fewer students enrolling in teacher preparation programs over the past decade. Potential teachers struggle with financial concerns, with the high cost of preparation, with the subsequent burden of student debt and with a lack of competitive compensation. K–12 teachers earn 20 percent less than other college graduates do, further creating recruitment and retention issues. A Rand Corporation report found that the top reason for teacher departures was that pay did not match the stress or the risks of the job.

Alongside these issues is a high turnover rate, a rate double that of other high-achieving nations. A lack of administration support, dissatisfaction with testing and accountability pressures, lack of opportunities for advancement, and disappointing working conditions lead teachers to other professions. And this was all before the pandemic imposed new burdens on our schools and their teachers. The total enrollment in undergraduate institutions dropped by 6.6 percent, including 14.1 percent for community colleges. This concerns me greatly since 80 percent of our educators start their teaching career with a bachelor's degree, and community colleges that link with a 4-year institution are a unique source of diverse teachers.

Tragically, as a result of teacher shortages and the impact of the pandemic, 55 percent of educators reported in a January National Education Association survey that they will leave the profession sooner than they had planned. These are not just numbers. These

highlight the very real crisis impacting students across the Nation. The achievement gap that students of color, low-income students, and students with disabilities tragically experience is in large part due to inequitable access to qualified teachers. Every student and every child benefits from having diverse teachers, and in a Nation where the majority of students are people of color, a workforce made up of just 20 percent of teachers of color is not enough. And tragically, data reported to the Department of Education for this year projected a shortage of educators trained to meet the needs of students with disabilities in all but two States.

Congress has a lot of work to do to address teacher shortages, and I intend to lead these efforts. Since becoming chair of this subcommittee, we have increased funding in a bipartisan way for comprehensive educator preparation programs, including the recently-passed fiscal year 2022 omnibus. We included \$59,000,000 for teacher quality partnership grant programs to fund educator residencies and other high-retention pathways; \$95,000,000 for the IDEA Personnel Preparation Program to prepare special educators and higher education faculty, and researchers who support their training; \$8,000,000 in first-time funding for Hawkins Centers of Excellence. We are supporting educator training at HBCUs and at MSIs, and we provided \$2,200,000,000 in Title II, a critical source of funding for the preparation and professional development of teachers.

There is more we must be doing. Our witnesses lay out solutions to many of the problems we face. I share their view that proactive investments in pipeline and preparation programs will help us reduce shortages in the years to come. As we build this subcommittee's fiscal year 2023 funding bill, we must consider the funding and policies necessary to help increase recruitment and retention, improve working conditions, and support teacher advancement.

Our first Secretary of Education and a woman who made the Department and Federal support for our teachers into what it is today, Shirley M. Hufstедler, said, "To the teacher, America entrusts her most precious resource, her children, and asks that they be prepared to face the rigors of individual participation in a democratic society." As we all know, we are experiencing emergency-level teacher shortages. From our witnesses, I look forward to learning how this committee and the Federal Government can continue to address this crisis and ensure that every student has access to a well-prepared, well-paid, diverse, stable, and supportive teacher.

In our country, teaching has always been one of our most highly-revered professions, and we must do everything that we can to keep it that way. After all, we do entrust our teachers with our most precious resources and, ultimately, the future of our democracy.

And now, let me turn to our ranking member, Mr. Cole, for his opening remarks.

Mr. COLE. Thank you very much, Madam Chair. Obviously this is a difficult morning for all of us, and I want to associate myself with your opening remarks. I can't imagine what our friends and neighbors are dealing with Uvalde, Texas, this morning, what each one of those families are going through, what everybody in that

school is experiencing. Obviously, we are most sympathetic to those who lost loved ones, but the trauma of an event like that for every child that was there, for every teacher that was there, for every parent who's, hopefully, child made it through but went through hours of wondering, I can't imagine it. So I want to express my deepest sympathy and just prayers, and thoughts, and sadness at this enormous event.

It always touches you, but when you have a hearing like the one we are having this morning, I had the great privilege of having our teacher of the year in Oklahoma in my office yesterday. She actually teaches in the Norman School District, where I am broadcasting from, Jessica Eschbach, a terrific young person, went into teaching almost by accident, began a career in accounting. It started that way and said that really wasn't for her. She was going to be a teacher. She ended up moving to Oklahoma and getting her degrees here and has been just a star. And I think of somebody like that having to deal with, you know, what her colleagues in Uvalde are dealing with, or my own son who is a public school teacher as well in my home system in Morehead. My heart goes out to everyone involved.

I want to thank you, Madam Chair, for calling the hearing, and I particularly want to thank all of our witnesses for being here today. I always look forward to these discussions.

Parents, teachers, and children across the country are still reeling from what I believe was one of the biggest policy missteps of this pandemic, and that is the closure of many of our Nation's public schools for nearly 2 years. The school closures hit the most vulnerable children the hardest: those with disabilities, those without access to technology or parents who could help them in a virtual environment, children in minority communities, and those who had a difficult time learning through a computer screen. But all children have suffered. The lasting impact of the pandemic on our students has been profound. We have seen concerning rates of mental health illness, missed preventive care, self-harm, an ongoing lack of engagement, not to mention the loss of academic and study skills.

And the impact on teachers has been profound as well. When this hearing topic was first announced and I asked the staff to prepare some background materials on why teachers leave the profession, we expected to get into a list of some reasons such as, "I can earn more from outside the classroom," and that is certainly true, or there is just simply too much red tape. We probably all agree on that, too, or even things like mask and vaccine mandates and pandemic exhaustion, and I expect those are reasons you will find in many policy papers on this topic.

But then we started to ask the actual teachers why they left, or are you considering leaving, and their answers were very sobering and saddening. Almost uniformly, teachers from different parts of the country who left or who are thinking of leaving teaching gave some of the same reasons: "a lack of respect from parents," "lack of respect from students," "pressure to keep passing students who haven't mastered the material onto the next grade level," or "students don't come to class, and there is no consequence," "administrators don't understand the stressors teachers are under and just

keep adding more to our plates.” This sense that many teachers feel undervalued, unappreciated, and not understood or respected, to the point of choosing to leave their jobs, is deeply troubling to me. Teaching should be one of the most valued, most appreciated, and most respected professions in the country as teachers are laying the foundation not only to train all future professions, but also to foster that common bond of civility, understanding, and patriotism that will sustain us as a Nation in the next generation.

There is no single program we can create at the Federal level to change this. This requires a shift in our culture. I don’t have the answers today, but I do think we need to confront and talk about this very real problem. And I want to thank our witnesses, again, for all they have done professionally over the course of their career, for focusing on this problem, and for coming before us today and sharing their time and their expertise.

Madam Chair, I want to thank you again for holding the hearing, and I yield back the balance of my time.

The CHAIR. I thank the gentleman from Oklahoma, and with that, I am delighted to introduce our witnesses for their testimony. Our first witness today is Desiree Carver-Thomas. And, Ms. Thomas, your full written testimony will be included in the record. You are now recognized for 5 minutes for your opening statement.

Ms. CARVER-THOMAS. Thank you. Chair DeLauro, Ranking Member Cole, and members of the subcommittee, thank you for the invitation to participate in this hearing. I am Desiree Carver-Thomas, and I am a researcher and policy analyst at Learning Policy Institute. We have been deeply engaged in synthesizing the research on teacher diversity.

The large body of evidence demonstrates that teachers of color provide cultural knowledge and role modeling that enrich the whole school community, with particularly strong benefits for black students taught by black teachers. One analysis found that black elementary students with black teachers had higher reading and math test scores than students without black teachers. Another showed that black students assigned to a class with a black teacher at least once in grades 3 to 5 were less likely to drop out of high school and more likely to aspire to go to college. In other words, the benefits of having a black teacher for even 1 year in elementary school can persist over several years. Other studies showed declines in suspensions, expulsions, and chronic absenteeism, and high rates of feeling cared for and academically challenged. And many of these studies suggest that other students, including white students, experience similar benefits.

The share of teachers of color has increased from 12 percent of teachers 30 years ago to 21 percent in 2017. Still, that share is low compared to the 40 percent of people of color in the Nation. Further, high turnover rates offset successful recruitment of teachers of color in recent years. In addition, student loan debt impacts teacher diversity. Research shows college students of color are more likely than white students to say that they changed their career paths because of their loans. Student loan debt is also much greater for black students than for white students, with a widening gap over time. Given loan debt issues, college students of color are less likely to enroll in teacher preparation programs than are white col-

lege students and more likely to enter through alternative certification pathways. These teachers tend to complete less pre-service coursework in student teaching, if any, and teachers who do not get comprehensive pre-service preparation leave at 2 to 3 times the school rates of those who do. Nearly half of newly-hired black teachers enter through alternative certification pathways compared to just 22 percent of other 1st-year teachers.

Challenging teaching conditions can lead to higher turnover. Teachers of color most likely to teach in schools serving a majority of students of color, schools that often contend with a lack of resources and support. In addition, some teachers report facing discrimination and stereotyping. Effective school leaders can influence these teaching conditions. Poor school leadership, however, more than doubles the likelihood the teachers will turn over.

Congress support diversity and high-quality preparation through the appropriations process and other legislative vehicles, including the \$9,000,000,000 Road Map for the Workforce in the American Families Plan, and while Federal recovery funds are and can be used to support a diverse and well-prepared workforce, sustained Federal investments are needed. All of the existing programs I will discuss were created or updated on a bipartisan basis.

First, underwriting the cost of teacher preparation can encourage more students of color to pursue teaching and to do so through a high-quality program that promotes greater teacher retention. Service scholarships and loan forgiveness programs cover or reimburse a portion of preparation costs in exchange for a commitment to teach in a high-needs school or subject area. These programs are most effective at recruiting teachers when they underwrite a significant portion of costs. In teacher residencies or district university partnerships, residents apprentice with effective metro teachers for a year in a high-need school and subject while completing related coursework. Residents receive financial support and commit to teach at least 3 years in their district with ongoing mentoring. Nationally, about half of residents are people of color, and residents tend to have higher retention rates than other teachers.

Congress could update Federal service scholarship and loan forgiveness programs, which have not been substantially updated by Congress since George W. Bush was President. Since 2008, student loan debt has grown by over \$1,000,000,000,000. Congress can increase the TEACH grant award to \$8,000 and can change the Teacher Loan Forgiveness and Public Service Loan Forgiveness programs to have the Federal Government make teachers' monthly loan payments until they meet the service requirement and retire the debts. Congress could also expand investments in high-retention pathways into teaching. The Teacher Quality Partnership Program, IDEA, Hawkins Center of Excellence Program, and supporting effective instruction programs fund high retention pathways like residencies. Additionally, we do not have a program dedicated to making high-need and advanced credentials more affordable.

Next, mentoring and induction, including collaboration and coaching, can support beginning teachers of color. New teachers who do not receive induction supports are twice as likely to leave teaching as those who do. There is no Federal funding dedicated

to this purpose. Finally, robust Federal funding for high retention pathways into leadership can develop strong school leaders who improve school conditions, which can help teachers of color teach for the long haul.

In closing, research demonstrate there is an urgent need for a well-prepared and diverse educated workforce and a strong bipartisan role for Congress to play in this endeavor. Thank you for your focus on the issue, and I look forward to answering any questions members have.

The CHAIR. Thank you very, very much. Let me next introduce our witness, Dr. Lindsey Burke. Dr. Burke, your full testimony will be entered into the record, and you are now recognized for 5 minutes. And thank you for being here.

Ms. BURKE. Thank you. My name is Lindsey Burke. I am the Mark A. Kolokotronis fellow in education and the director of the Center for Education Policy at The Heritage Foundation. Thank you, Chair DeLauro and Ranking Member Cole, for the opportunity to testify today.

We are brokenhearted about the events that transpired in Uvalde, Texas, yesterday at Robb Elementary School, and our prayers are with the families. We are here today to talk about teachers, and two educators died protecting our students yesterday. We know that is who our teachers are. In America, that is why we treasure and value our teachers because that is who they are.

Although there has been teacher turnover as a result of the COVID-19 pandemic, teacher vacancies have to be considered in the larger context of ongoing increases and school staff hires. Today, teachers comprise only half of education jobs. This is part of a longer-term trend that Dr. Benjamin Scafidi has been tracking for many years. Since 1950, public schools have added personnel at a rate nearly 4 times that of the rate of growth and student enrollment. While the increase in new teacher hires was nearly 2-and-a-half times the increase in students, the number of non-teachers that is, administrative and other staff—increased more than 7 times that of student enrollment. So if school districts wants to attract more high-quality teachers to local classrooms, what policy should State legislatures and school boards pursue?

First, they should remove barriers to entry into the classroom. The teaching profession is constrained by policies that mandate aspiring teachers obtain paper credentials, often at substantial cost. However, research has demonstrated there is little, if any, connection between teacher certification and a teacher's impact on student academic achievement. The absence of a relationship between teacher certification and teacher effectiveness is most noticeable and of negligible difference in outcomes between traditionally-certified, alternatively-certified, and uncertified teachers. As researchers Robert Gordon, Thomas Kaine, and Douglas Stager found, "To put it simply, teachers vary considerably in the extent to which they promote student learning, but whether a teacher is certified or not is largely irrelevant to predicting his or her effectiveness." So how can we ensure excellent teachers find their way to the classroom and are encouraged to stay? By making it easy easier to enter the profession but rigorously evaluating teachers once they are there.

Second, States and districts should tackle pension reform. States should move from defined benefit pension plans, in which 85 percent of public school teachers are enrolled compared to just 15 percent of private sector workers, to defined contribution retirement plans, like 401(k)s, which are popular in the private sector. Switching from defined benefit to defined contribution plans could provide retirement account portability across State lines for teachers, allow them to roll over account balances if they change jobs, and accumulate equal benefits even if they switched employers.

Third, districts should eliminate last in/first out policies and reward excellence in the classroom. Too many schools continue to use the seniority-based layoffs when staffing decisions have to be made. These last in/first out policies should be abandoned in favor of staffing decisions based on teacher effectiveness and competence, not years in the school building. Finally, States and school districts should end the non-teaching staff hiring spree. Total inflation-adjusted/per-pupil spending has increased 152 percent from 1970 to 2018. Teacher salaries increased just 7.3 percent over the same time period. If districts want to attract and retain high-quality teachers, they should refrain from continuing to increase the number of non-teaching staff in public schools and, instead, revamp teacher compensation systems to better reward those teachers who have a positive impact on student performance.

Public school districts have the tools and considerable financial resources at their disposal to attract and retain quality teachers, but that outcome requires making different decisions than school districts have made historically. They can begin by eliminating certification barriers, tackling pension reform, ending last in/first out policies, and curtailing the non-teaching staffing surge.

I look forward to answering any questions. Thank you.

The CHAIR. Thank you very, very much. Let me just now recognize our next witness, Randi Weingarten for your full testimony, which will be included in the record. You are recognized now for 5 minutes.

Ms. WEINGARTEN. Thank you, Chair DeLauro, and thank you, Ranking Member Cole. I am Randi Weingarten. I am the president of the American Federation of Teachers, and I am still a teacher on leave from my social studies position as a high school teacher at Clara Barton High School in Brooklyn, New York.

We are all in mourning today. It is only in America that parents are not assured that their kids will be safe from gun violence at school, and while educators had a really important job yesterday, they are more important today than ever.

And I am here to talk about the staffing shortages facing America's public schools. I have been working on this issue for about 40 years or so, and about how to solve the crisis, and how Congress can help. And, you know, staffing shortages are not just a school problem. They are a national crisis. Every year, nearly 300,000 teachers leave the profession, two-thirds of them before retirement. Frankly, we have many, many, many, many surveys, and the pensions are one of the things that keep teachers in teaching. Teacher turnover is almost double that of any other occupation of their peers in schools that serve majorities of students of color, and those

students who live in poverty experience a higher teacher turnover rate, and COVID has made this worse.

So I am going to kick off four different things that I suggest that we do, but it all goes to the question, what would make you recommend a career in teaching to your own child or to your grandchild, particularly in public schools, and what can you do to help.

Number 1, we can actually do much more in terms of recruitment and preparation of a high-quality, diverse teaching force. Over 80 percent of teachers are now white and female, while students of color make up about 50 percent of the student population. Our ranks should reflect this diversity, and so the Grow Your Own Programs, which educate support staff to become certified teachers, are really good programs, and historically black colleges and other minority-serving institutions will prepare half of all teachers of color in this country. We can actually fund them more.

Number two, retaining teachers is as important as recruiting teachers. And so I would urge us to give educators the time, the tools, the trust to teach well. That means reducing class size to have more individual attention, and that means increasing planning time, which is what the countries that compete with us do. And it also means enabling educators to create teams in terms of sharing workloads. The investment in community schools and mental health supports will keep more teachers. Full-service community schools, wrapping around services of schools will actually help kids and help teachers teach, and identify the problems that we see before we see these kind of awful situations that we saw last night.

Let's actually try to deal with paperwork. Last week, New Mexico Governor Stephanie Lujan Grisham signed an executive order to reduce paperwork and administrative burdens on educators, enabling them to focus on students. This, as well as salaries, is the number one issue that teachers talk about as well. And as a result, if we actually tried to start thinking about how to change the accountability systems, we can reduce paperwork. We need to make an accountability system that is aligned to what kids need to do, be able to do, and know as opposed to the paper/pencil system we have now.

Obviously, compensation is important. Teachers make 20 percent less than what they can earn in other similarly-skilled professions, and we are a profession. Let's find ways to deal with that, and there are a whole bunch of Federal programs that can help us do that. We can also do something in terms of public service loan forgiveness. As some of the other speakers have said, the Public Service Loan Forgiveness Program can help us reduce teacher debt, and that can be changed in that way. The TEACH Program can also do the same thing. And the last thing I would say is let's actually increase collective bargaining. Pass the Public Service Freedom to Negotiate Act. Give teachers the right to bargain. Make them part of the solution. That is what we have done in places that are moving forward. That is what we should do everywhere. When teachers have voice and agency in their work, kids thrive.

Thank you very much.

The CHAIR. Thank you, and let me now recognize Dr. Jane West. And, again, your full testimony will be read into the record, and you are now recognized for minutes.

Ms. WEST. Thank you, Chair DeLauro. Thank you, Ranking Member Cole. Thank you, members of the committee. I am pleased to be here to talk about the critical shortage of special educators facing our Nation.

In 1975, the Congress enacted the Individuals With Disabilities Education Act—IDEA—enabling students with disabilities to gain full access to education after decades of exclusion. For 47 years, the law has required a free, appropriate public education for every student with a disability, no matter how significant that disability. As a special educator before the enactment of the law and afterwards, I can tell you what a difference it makes.

The challenge we face today is one of fully implementing the law. While IDEA requires its services are delivered by qualified personnel, that is increasingly not happening. The critical obstacle is the crisis of a special educator shortage among special education teachers, paraprofessionals, school psychologists, early intervention providers, speech therapists, specialized instructional personnel, and more. Our shrinking capacity in higher education to prepare special educators threatens the pipeline for the future. The pervasive challenges that other witnesses have outlined of high student debt, low teacher salaries, declining respect for the profession, and the stress of coping with the pandemic affect special educators as well.

For special education, the combination of a dearth of fully-prepared new teachers and the high attrition rate has generated an urgent challenge for today and the future. The scope of the shortage is alarming. Forty-eight States and the District of Columbia report a shortage of special education teachers, outpacing shortages in other fields, including math and science. Ninety-eight percent of school districts report special education shortages. The proportion of uncertified teachers grew by 50 percent from 2014 to 2016, and that number continues to grow. In some States, like California, over half of new special educators are not fully prepared. The enrollment in special education preparation programs has also declined by 16 percent in recent years for initial licensure programs, which does not bode well for the future. We confront this crisis at the same time the number of students requiring special education services has increased, 17 percent since 2000–2001.

States and districts have had to scramble to fill special education positions in ways that are unsustainable over time and will exacerbate the problem rather than solve it. Lowered standards for certification, an increase in the use of long-term substitutes, and the expansion of short term programs which place people as teachers without the needed skills and knowledge will keep the schools open, but they will not generate the results that we want for students with disabilities, nor expand the qualified workforce. The shortage leads to larger caseloads for special educators with less time for students with complex needs, and stretched too thin, special educators burn out and students are underserved.

We know preparation matters. Generally, teachers who are underprepared, such as those entering the profession through emergency and alternative pathways that do not offer robust student teaching and a full curriculum, are 2 to 3 times more likely to leave than those who are fully prepared. Research shows that

comprehensively-prepared and credentialed educators are more likely to stay in the field and are best equipped to deliver results for students. Without the qualified personnel, student outcomes suffer. A parent recently shared with me her journey with her son with dyslexia, which was presenting great obstacles to him in learning to read, resulting in tremendous frustration. When he gained access to fully-prepared teachers with expertise in reading instruction, he blossomed. Today, at age 27, he is applying to a doctoral program. This is the difference that highly-qualified and trained teachers make.

Multiple innovative solutions are in place across the country, including teacher residency programs, recruitment strategies for high school students, Grow Your Own programs, and use of teacher candidates as substitutes for part of their teacher training programs. We know what strategies work. A greater investment will enable them to meet the moment. Two, Federal programs have solid and proven track records in carrying out these solutions, and a newly-funded one will address the dire lack of diversity in our workforce. I urge the subcommittee to provide greater investments in the Personnel Preparation Program under IDEA, the Teacher Quality Partnership grants, and the Hawkins Center For Excellence programs.

In summary, students with disabilities need access to a well-prepared, diverse, experienced, and stable educator workforce. A greater investment in these programs is urgently needed. Thank you.

The CHAIR. Thank you, and I want to say thank you to all the witnesses for outstanding testimony this morning, and thank you. It is a struggle, I think, today for all of us and for those of you have been engaged been involved with the teaching profession and educating students, and understanding what allows them to learn. And I know your hearts are full, and thank you for carrying on. It is important. It is an important discussion.

And by the way, this is the first teacher shortage hearing that we have had since the pandemic, so it is particularly important. In addressing the teacher shortage, some States are lowering the qualifications of becoming a teacher, for example, Connecticut. The State Board of Education voted to authorize emergency certification that allowed individuals to fill teaching positions for subjects in which they are not certified, a practice that the State ended nearly 30 years ago.

I have two questions here. Ms. Carver-Thomas, what does the research say about the importance of having access to fully-certified teachers, and, Dr. West, what is the real-life impact on students with disabilities and their families when students are faced with a person serving as a special educator who does not have the training or skills to teach them? Dr. West? No, Ms. Carver-Thompson first.

Ms. CARVER-THOMAS. Thank you for the question, Chair DeLauro. The research is clear that teacher certification matters for our students and for our schools in several ways, and I can talk about a few of those, including student achievement, teacher shortages, which we are here to discuss, and financial costs. So when it comes to student achievement, there is research showing that there is an association between full certification and student outcomes.

A study led by Learning Policy Institute researchers, our Positive Outlier study, looked at California districts and the relationship between teacher characteristics and student outcomes, and found that districts with more fully-credentialed teachers had better student outcomes, particularly for black and Latino students, and this was after controlling for a range of other school and teacher characteristics. When it comes to shortages, we know that when there aren't enough fully credentialed teachers to go around, districts and schools will turn to emergency credentialed teacher, teachers who are not fully prepared to teach their subject matter, and these are teachers who are more likely to leave that school or the profession entirely, creating a level of churn that creates instability in schools, disrupts the transfer of institutional knowledge, disrupts professional learning, disrupts student learning. And we know that that sort of churn disproportionately impacts students of color and students from low-income families who really bear the brunt of that kind of teacher demographics where more under-credentialed teachers are serving those students.

And then when it comes to financial costs, it costs money for districts to recruit, hire, support, train teachers who they bring into the classroom. And if those teachers are coming in and out, having to constantly be replaced, those costs walk out the door with those teachers. Those investments do, and those are investments that could be put to better use for our students.

The CHAIR. Thank you. Dr. West, the impact on students with disabilities?

Ms. WEST. Thank you. You know, Chair DeLauro, I would like to start by reminding us who we are talking about. We are talking about students with autism. We are talking about students with intellectual disabilities. We are talking about students who are deaf, students who are blind. We are talking about students with learning disabilities. These are the students we are talking about. Imagine going into a classroom without the proper preparation and seeking to teach a nonverbal student with autism. These are significant skills that need to be acquired and developed during comprehensive and intense preparation. There simply is no way, no substitute for developing that skill set.

I was talking to a parent yesterday who has a 6-year-old with Downs syndrome, and she was sharing with me that he has developed sort of wandering away behaviors, which is not uncommon in students with Downs syndrome. And the strategies that one might commonly use, such as being very firm and, you know, "come back here, don't do that," particularly if it is a situation at home or something, reinforces behavior. And research shows us there are other ways to manage this behavior that will not reinforce it, and if you aren't aware of that, the behavior escalates, and that is just one example.

I also want to point out that many students with disabilities, most students with disabilities, are in general ed classrooms most of the time. So that partnership between special educators with that unique skill set and the content knowledge of general educators is critical to the delivery of strong academic services and social-emotional support to all students. So special educators also

have a great investment in fully-prepared, fully-credentialed educators in other fields. Thank you.

The CHAIR. Thank you. Just a note. I mentioned in my opening comments that early on in my career, I finished graduate school and was looking for a job. And one of the things I decided to do while I was looking was to make myself available to be a substitute teacher, okay? I graduated with a B.A., an M.A., and, you know, not in the teaching profession, and I would tell you that I was called as a substitute teacher just about every single day. You know, in essence, you are trying, but, you know, you are merely trying to manage the classroom and keep it together and not have that. But we do have substitute teachers in all the time and without the training. There is a loss, especially if a teacher is ill and out for a length of time.

I have one comment on the special ed. I went through a special ed class one day, and the teacher, who was well qualified, left the lesson, and it was around the holiday, and that was to make Christmas decorations from macaroni. Well, I am not trained as a special ed teacher. I don't know the balance between discipline and compassion in that sense. My instincts were all on the compassion side, you know. Whatever these children were going to do, they were going to do. I will just tell you that by noontime, we were almost knee deep in macaroni in this classroom. It is humorous, but nevertheless, I don't have the skills to be there, and you need to have trained people, to your view of using trained people, to be substitute teachers.

So with that, I have gone over my time, and I yield to our ranking member, Mr. Cole.

Mr. COLE. Well, thank you, Madam Chair. You are pretty good at keeping order among unruly students on this committee, so I think your earlier training did well. [Laughter.]

Mr. COLE. Let me start with you, Dr. Burke, but any of you I would invite to answer. You know, we know we obviously have a shortage overall, but we have acute shortages in specific areas. Special ed obviously has been mentioned, math and science usually also, and yet, in most school systems, pay is pretty uniform. It is based on seniority and credentials overall. Is there merit in doing what they do at the college level, which is, as a guy that was a history professor in college, I can tell you I didn't make what anybody in the engineering department made or anybody in the business school made, and I don't begrudge them that. I don't mean that critically of anybody. It was just my skill was more common, more available than the others. So would it be worthwhile having pay differentials in specific shortage areas to try and attract more people and retain them for longer?

Ms. BURKE. Thank you, Representative Cole. That would definitely be worthwhile, thinking about how districts can differentiate pay for high-demand areas, not only for high-demand areas, but to differentiate pay to reward teachers who are doing excellent work in the classroom, who are getting their cohorts of students to learn a year or a year-and-a-half worth of learning in a year's time, to really reward those exceptional teachers. But schools have largely made a decision to take existing resources, which as I mentioned earlier, have increased significantly over the past half century, and

to use those taxpayer resources to fund and hire non-teaching staff instead of putting that into something like differentiated teacher salaries. So again, if we just look at the recent data, if you go back just to the year 2000, from 2000 to 2019, while the number of students and teachers in public schools just increased about 8 percent, the number of principals and assistant principals increased 37 percent, and the number of school district administrative staff increased 88 percent.

So, again, this is about decisions, about choices the districts are making, and we can look at those overall aggregate numbers. To go back even further back to 1950, I mentioned spending increasing significantly since that time period. A big part of that is this increase in non-teaching staff. The number of students increased about 100 percent from 1950 forward, but the number of teachers increased 243 percent. The number of administrators and non-teaching staff increased 709 percent over that time period.

So you are absolutely right. Differentiated pay is critically important. Rewarding excellent teachers with differentiated pay is important, but that will require making different decisions than schools have made in the past.

Mr. COLE. Let me ask you a quick follow up, and, again, I would invite anybody else if they have got thoughts on this to participate. You know, we are the Federal Government. We can't and should not, in my opinion, be mandating these kinds of things from here. We can incentivize behavior, though, through programs, and we try to do that on some occasions. As you think broadly across the country, is there anybody doing what we are talking about? I mean, is there any particular system you would say they approach this a little bit differently than most of the States, and this is working better?

Ms. BURKE. Well, I think what we can point to is something that we saw in the wake of COVID, which is how diverse the delivery of instruction is becoming, and the way in which that has enabled individuals to enter teaching and to be rewarded. So if we think about something like learning pods and micro schools, these really innovative approaches that are on the ground, these options enable teachers to be paid directly from families. And really, you know, you can imagine a situation where the sky is the limit in terms of earning potential for these instructors. And hopefully, that is where we get to, to a point where these excellent in-demand teachers are rewarded handsomely.

Mr. COLE. Ms. Carver-Thompson, I don't have a lot of time left, but let me turn to you because I couldn't agree more with your basic point about the importance of diversity in teaching and kids seeing people that look like themselves pursuing the profession. We know our record is not what any of us would want it to be in that regard. Again, is there a particular place, or State, or system, in your opinion, that are handling this better that we should look at, that these are folks that are aggressively recruiting for diversity or achieving this goal?

Ms. CARVER-THOMAS. Thank you for the question, Representative Cole. Absolutely, there are programs like those funded by some of the programs I talked about today, the TQP, like teacher residencies, that have become very popular across the country. And

there are States, like California, that are investing, making considerable investments in teacher residency programs, and we know that these programs tend to have much higher levels of diversity than the teacher workforce at large. And that is largely because it is comprehensive preparation, but residents also receive a stipend during their residency year. They receive ongoing mentoring support. They receive aligned clinical experience that is really deep. It lasts, typically, a full school year while they are also completing coursework, and they tend to have a much higher retention rate than do teachers prepared through other pathways. So it is a very promising model that we see being invested in.

And, you know, in California, we are starting to see an uptick in teacher preparation enrollments, which really defies the national trend because of those considerable investments. But there is still quite a bit of need, and so these kinds of investments are still much needed.

Mr. COLE. Thank you very much. Madam Chair, just for purposes of notifying you, for whatever reason, I don't see time on my schedule, so I am guessing I have about used up my time. If I have gone over, I apologize, but it might help if there was some way we could get that displayed on the screen. With that, I yield back.

[No response.]

Mr. COLE. I think you are muted, Madam Chair.

The CHAIR. I thought I did that. In any case, Ms. Weingarten had her hand raised to answer your question, so—

Mr. COLE. Oh, I am sorry. I apologize.

The CHAIR [continuing]. Additional time here. Go ahead, Ms. Weingarten.

Ms. WEINGARTEN. So, Congressman Cole, I think that there are ways in which we can do that, and there have been various different collective bargaining agreements that have differentiated paid for shortage areas, for special needs, like, you know, Dr. West was talking about. We have done that a lot. The programs that paid for performance did not work. In fact, they actually hurt. You know, you are seeing a slow walk away from all the Race to the Top pay for performance because what was happening is that people actually left the high-need schools where you actually need to have kids. You need to have the best and most well-prepared teachers. So the pay for shortage areas is a really good idea, and we have done that in a bunch of different contracts, but the bottom line is you actually have to have decent pay as the basis of it. People have to rely, year after year, on being able to feed their families and being able to rely on that kind of income, and that is important as well, and then you can do various different differentials.

And the last thing I would say is I agree with Dr. Burke that there have been too many non-classroom positions that have been created, but a lot of that is because of paperwork and the Federal accountability systems. And that is part of the reason why we are seeking to actually change the accountability systems to really focus on what kids need to know and be able to do, and make sure that the data is there. But what has happened is that there is a search for data, and there is more and more time that is focused on data collection as opposed to on teaching. And that is why it is one of the number one issues that current teachers have in terms

of saying, let me teach, give me the time, tools, and trust so that I can actually meet the needs of my kids.

Mr. COLE. Yeah. I am shocked the Federal Government would generate paperwork. [Laughter.]

Mr. COLE. Thank you, Madam Chair. I yield back.

The CHAIR. Thank you. Mr. Pocan.

Mr. POCAN. Thank you very much, Madam Chair, and thanks for having this hearing. I know I brought it up about 3 weeks ago maybe, if even that, and this is a very quick coming together of the hearing, so thank you for having this, and thank you to all the witnesses. All of you provided very concrete examples of suggestions of what we should do.

Ms. Weingarten, a number of yours rung the most true, at least in my State, in Wisconsin. In Wisconsin, in 2010 when Scott Walker was governor, he did an attack on public employee unions and, in doing that, an attack on public employees. And the outcome of that, within a year or two, the UW Madison School of Education, one of the best in the country for a public university, had a drop to about 40 percent of the applications going to the school that they had prior to that. There really was a respect issue for the profession that we saw directly out of what happened. Right now, in Wisconsin, the starting teacher salary that I could look up, so this might be a couple years old, was as low as \$26,535, and the average pay for starting teachers in Wisconsin is in the lowest 25th percentile in the country according to Zip Recruiter. Right now, I have fast food restaurants advertising \$17 to \$20 an hour. If you are equating teaching with a fast food job, certainly you are not going to have a lot of people perhaps looking at that as a career path.

My own sister-in-law taught for over a decade and quit teaching because of the disrespect that has now happened, and she taught in a couple different States, through the laws in Wisconsin. So the disrespect for the profession, I think that we saw the pay issues, and then throw on top all the challenges of COVID and everything else, it has had a real impact in a place like Wisconsin. In fact, Madison School District used to be an unattainable school district for many first-time teachers. Now, they are getting two or three applications for some positions. That is it.

There is a significant change, at least in my State, that I can look at. A lot of it resonates to what you said specifically. What can we do around that issue, giving teachers respect again for the profession within the districts and the respect of a salary that is not in the bottom 25th percentile?

Ms. WEINGARTEN. So number one, one of the first things, that is why I said to all of you, because there is a lot of common sense that is involved here and a lot of the research about what actually happens in schools. You cannot control for every single factor that happens in schools, so that is why I say and I asked you, what would make you as a person recommend a career in teaching to your child or grandchild, and it comes down to actually two things. Teachers, thank God, they go into teaching because they want to make a difference in other people's lives, and that is something that you can't recruit. That is who teachers are. But what we can do is we can make their lives such that they don't walk into school

with a pit in their stomach or a pit in their throat, that they can actually have freedom and latitude to meet the needs of their kids when they see those needs. You can call that trust, you can call that tools, you can call that time, you can call them that respect, but it comes down to we are not automatons. We have to actually have some latitude to teach and some kind of benefit, a sense that we are doing is right, and have that. That is No. 1.

Number 2 is the preparation for it. And Dr. Carver-Thomas said this about how the residency programs, the Grow Your Own programs, really help you walk in with that preparation. It is both the book preparation as well as the preparation so that you know the circumstances you are walking into. And the second big thing is pay so that people can actually raise a family on the pay that they have.

Mr. POCAN. So in this appropriations process, I think there are some very specific suggestions from Dr. Carver-Thomas that we could do immediately, and I appreciate that. In this budget, what could we do most immediately, Ms. Weingarten, that you think would be helpful?

Ms. WEINGARTEN. So there are three things you can do. You can increase the investments in terms of the Augusta Hawkins Investment Program so that we can actually really focus on Grow Your Own residency programs, particularly with HBCUs. Number two, you can really increase the amount of money that goes to community schools and to wraparound services so that teachers can actually meet the needs of kids. And number three, just like the ARP money, and the IDEA money, and things like that, these things can go into how we can increase the compensation of teachers.

Mr. POCAN. Great. Thank you very much, and I yield back, Madam Chair.

The CHAIR. Okay. I think that is where we are. Yes, Dr. Harris.

Mr. HARRIS. Thank you very much. Thank you very much, Madam Chair. Thanks to everyone who is appearing today. You know, I don't know what is going on in Wisconsin, but in Baltimore County, the starting salary is \$49,900, so it is probably a local issue, and certainly the Federal Government shouldn't be involved in that. That should all be negotiated at the local level.

Anyway, I just have a question for Ms. Weingarten. Do you think that teachers should be able to strike?

Ms. WEINGARTEN. Dr. Harris, I think that we should have these kind of collective bargaining programs all throughout the country.

Mr. HARRIS. Ma'am, I have 5 minutes. I have a lot of questions to ask. Do you think teachers should be able to strike?

Ms. WEINGARTEN. I think that teachers should do everything that they can, as we do, to—

Mr. HARRIS. Ma'am, do you think teachers should be able to strike? It is a simple question because other public servants, for instance, our law enforcement, they can collective bargain, but they can't strike because we think their role is very important in the community. And as professionals, we think they shouldn't strike.

Ms. WEINGARTEN. So, sir—

Mr. HARRIS. Do you believe that teachers should be able to strike?

Ms. WEINGARTEN. So, sir, I—

Mr. HARRIS. It is a very simple question. It is a “yes” or “no.” You either believe it or you don’t.

Ms. WEINGARTEN. So, sir, I believe that every single worker in America should have a path—

Mr. HARRIS. Okay. Let me go on to Ms. Burke—

Ms. WEINGARTEN [continuing]. Should have a path to dignity—

Mr. HARRIS [continuing]. Because you are not answering my question. You are not answering my question, and I understand why.

Ms. WEINGARTEN. If you would let me—

Mr. HARRIS. Ma’am, you are not answering the question, and I understand why, because it is embarrassing that teachers go out on strike.

Ms. WEINGARTEN. I am not—

Mr. HARRIS. These are professionals who are supposed to be some of the most important parts of our children’s lives, their education, and they go on strikes, sometimes for weeks, without these children getting an education. Now, Ms. Burke—Dr. Burke—let me ask you, what’s the history to unionization—

Ms. WEINGARTEN. Sir, if you would let me answer it, I would love to.

Mr. HARRIS. Ma’am, I am moving on. I only have a limited amount of time. No filibustering allowed for you. Dr. Burke, what is the history of unionization, because it appears that we have gotten worse teaching over the last 50 years and, at the same time, unionization of teaching has increased. So is there a connection? Is it the inability to, I won’t say weed out, but to discourage teachers who really aren’t good because, for instance, merit pay is discouraged where if you teach better, you get paid more instead of just a negotiated salary scale? Could you just run through the history of unionization?

Ms. BURKE. Sure. So unionization, it has been with teaching profession for a long time, borne out, in part, in the early 20th century as an effort at teacher professionalization. However, to your point, that has really worked into something entirely different. We see capture of institutions, like colleges of education, which if we want to talk about ways to reward effective teachers and lower their costs of entering the teaching profession, union-supported policies, like rewarding teachers for getting a master’s degree, forces teachers to go into college of education and take on more debt than they otherwise would have, while we know at the same time that has no impact on their ability to be an effective teacher or increase student outcomes.

If you look overall at the American wage and salary workers, union membership rates are about 10.3 percent overall. However, among public school teachers, that rate soars to 70 percent. It is the highest unionization rate of any employment sector, and so that means millions of members are paying tax exempt dues, revenue to the National Education Association, the American Federation of Teachers annually. And that matters for the conversation because, generally speaking, unions end up opposing many of the reforms that actually hold promise for attracting qualified teachers, the reforms that I mentioned earlier: removing certification bar-

riers to entry, addressing unfunded pension liabilities, providing merit pay for exceptional teachers, et cetera.

So, and I would add, and I think many would agree, that many of these union policies really exacerbated teacher frustration during the pandemic by forcing schools for nearly 2 years to remain closed, and forcing educators to engage in emergency remote instruction. And so many of these policies that have really plagued public education for over a century now are rooted in policies that are supported by special interest groups.

Mr. HARRIS. Sure. And just on the pension reform, is the lack of pension reform an impediment to mobility of teachers between districts?

Ms. BURKE. Not necessarily between districts, but it is between States, an impediment to their mobility to move State to State, or to consider if they want to exit the profession and find other employment to do that. And that could weigh on your mind ahead of time if you are considering entering the teaching profession, not having that flexibility.

Mr. HARRIS. Thank you very much. I yield back.

The CHAIR. Sorry. Ms. Clark.

Ms. CLARK. Thank you, Madam Chairwoman, and thank you to all the witnesses for being here today. I just want to echo the comments of some of my colleagues about just how horrifying it is to watch what happened, and to underscore that we are not powerless to act. And we haven't been powerless, but we have failed our students. We failed our teachers by not acting to reduce gun violence in this country. School massacres are not freedom. Shooting children and their teachers in their classrooms is not some extension of a constitutional right. We have to do better, and we will.

I want to talk to you about another issue that is facing our country and will not allow us to recover and address this teacher shortage issue fully if we don't tackle the lack of childcare. And when we look at early educators, the median hourly wage in this country is \$12.24, not enough to raise a family on. And one-third of Head Start positions are unfilled, citing compensation as the number one reason why they are not taking those jobs. So my question for Ms. Weingarten, and it is good to see you, is, can you speak to why a reliable childcare system and the availability of childcare benefits is an important tool for teacher recruitment and retention, and how, as we are working to raise compensation and benefits for teachers, we can also focus on early educators, and why that is so important?

Ms. WEINGARTEN. So thank you, Representative Clark. I just also want to say, you know, I grew up in a system with the Taylor Law where did not have the right to strike. The right to strike should only be a last resort. It should never be a first. It should only be a last resort, and that is what most teachers do, and I just wanted to make it clear that, you know, I would have said that to that answer.

In terms of childcare, one of the things that all of you were working on in the child tax credit, childcare, is how do we actually in, you know, America reduce the cost for families so that people can actually do the kind of work, deal with the kind of things that they want to do? You know, unfortunately, in America, you know, if you

are wealthy enough, you know, childcare is not an issue. If you are not, childcare is a huge issue. And so that is an issue, you know, when you have jobs that are anything, you know, outside of being an investment banker or a, you know, equity manager, or things like that.

So incoming jobs for a teacher, whether it is, you know, the \$50,000 to \$60,000 that you see in Baltimore, or it is the, you know, substandard wages in early childhood, if you don't have childcare, how are some going to be able to do that? And so it is how you drive down these costs. In Western Europe, there is a package of things that happen for workers so that they don't have to think about paying for that that way. They don't have to think about healthcare. They don't have to think about childcare. They don't have to think about retirement security. They just live on those kind of wages. So cutting costs, whether it be student debt costs or whether it be childcare costs, are hugely important.

Ms. CLARK. Thank you for that. And to Ms. Carver-Thomas, I also want to ask, as we are looking at trying to increase our amount of teachers and early educators so that we can help solve this childcare crisis and have the robust public schools that we want, what are you seeing as some of the key barriers that are keeping interested students from entering the teaching profession?

Ms. CARVER-THOMAS. Thank you. I would say that one of the key barriers is affordability of comprehensive preparation. We know that student debt has increased in the past couple years, and yet our programs that are designed to help college students afford those costs, like the TEACH grant, have not been substantially updated by Congress since 2008. And so those barriers are even higher for potential teachers of color, who research shows are more sensitive to debt and potential wages.

Ms. CLARK. Thank you so much. I see my time has expired. I yield back.

The CHAIR. Mr. Moolenaar.

Mr. MOOLENAAR. Thank you, Madam Chair. Dr. Burke and all the members of the panel, thank you for joining us, and, Dr. Burke, I had a question for you based on your research. Where are you seeing more interest in aspiring teachers? Is it a geographic issue? Are there certain fields of study that you are finding there is more interest or less interest in being teachers?

Ms. BURKE. Well, I think it might actually be the type of school that teachers can teach in. We are seeing a real renaissance in classical education. In particular, we are seeing a growth in the classical charter school movement, and we are seeing, as a result of that, that classical charter sector is actually working to create their own teacher education pipeline for entering those schools. And I think that is partly in response to the fact that we are seeing so much interest in that particular sector.

Mr. MOOLENAAR. And how are they creating that pipeline? One of the things that strikes me is, often, you will have students, and I am sympathetic. We have heard a lot about the debt that students have as they finish their preparation for teaching and the length of time. What kinds of innovations are you seeing in that area that is making it easier for people to transition into teaching?

Ms. BURKE. So within the classical sector, some of these schools are partnering with existing colleges of education at universities where they are philosophically aligned in terms of the pedagogy, the curriculum, et cetera. But then some of these K–12 schools, classical schools, are working really in-house to educate and prepare teachers to enter into their classroom. At the undergraduate level, you know, if you have the foresight to end up majoring in education, you can enter the teaching profession relatively easily. However, if you decide later on and after getting your bachelor's degree that you want to enter the classroom and become a teacher, for most people then that means going back to school, going to get a master's degree, spending \$40,000, whatever it might be, to earn that master's and 2 years of time commitment, and that is untenable for a lot of people.

So, again, it really does come back to reducing those barriers to entry across every type of K–12 education sector, whether it is the classical charter sector or public/private charter, et cetera, and making sure that those new career professionals, in particular, who would be excellent educators have the ability to do so without spending a lot of time and money to obtain paper credentials.

Mr. MOOLENAAR. You know, I am sensitive to the role of the Federal Government versus the State government, and local school boards, and everything. What role would the Federal Government have into making those kinds of innovations, that kind of flexibility more widely available?

Ms. BURKE. Well, one really good option would be allowing flexibility with all existing Federal education dollars. It is always important, of course, to remember that the Federal Government is a small, small stakeholder, in overall K–12 financing, 8.5 and 10 percent overall K–12 financing in a given year. And so these reforms, both from a spending perspective and just a good constitutional governance perspective, largely have to happen at the State and local level. But the Federal Government should provide flexibility with that small slice of funding that it currently does provide through the taxpayer purse and allow States to put those existing education dollars toward any lawful education purpose under State law. So if a State wanted to take those funds and use it to revamp future compensation, or advance education choice options for students, or focus on reading achievement, whatever a State might want to do in conjunction with districts, they should be able to do that with those existing funds.

Mr. MOOLENAAR. Thank you. Ms. Weingarten, I wonder if you could respond. You know, I hear a lot from people in Michigan, concerns by parents who feel like in public schools, that their values are being undermined and their voices are not being heard. Are you hearing that message, and, if so, what can be done to restore the confidence that parents have in our public education system?

Ms. WEINGARTEN. So thank you for that question, Congressman. What I hear a lot is a lot of frustration. Teachers and parents want more of a voice in terms of, you know, what is happening in terms of the day-to-day basis, and, frankly, what I am hearing this year is that a lot of people wanted more of a way for us to meet the needs of kids. You know, kids came back with an awful lot of needs, and so we wanted to try to figure out how to meet those

needs. So I have heard a lot of we don't have enough guidance counselors, we don't have enough nurses, we don't have enough of these kinds of things. But what we are also seeing, and this is part of the reason why the AFT is pushing our Reading Opens the World Program, is that we really need to get back to the basics of focusing on reading, focusing on the kind of community school work that Chair DeLauro has really championed, and focus on how we create the pathways to, you know jobs, into colleges.

Mr. MOOLENAAR. Thank you, and, Madam Chair, I see I have overextended my stay here, so I yield back.

The CHAIR. That is okay. The discussions are good. And with that, Ms. Bustos.

Mrs. BUSTOS. Thank you, Madam Chair. Quickly before I get to my questions, I do want to want to briefly echo the sentiments that many of my colleagues have shared about the horrible shooting and at the school in Texas. And, you know, obviously all of our hearts are broken, those of us, you know, who are moms or grandmas, or dads and grandpas. You know, there is really nothing worse than learning about these terrible incidents that we have got to do something about. That is my call to action to everybody. We have got to do something legislatively and play a role in helping to get our Nation in a better place. Lots of ideas out there, but we need to take that up as well.

Thank you, Chair DeLauro, thank you to Ranking Member Cole as well, for holding this hearing. I know on a very personal level how important the topic of teacher shortage is. We have done a series of these rural economic roundtables across the 14 counties that I serve in this congressional district in Northwestern Illinois. And at every single one of them, I kid you not, at every single one of them, we heard about teacher shortages. And, you know, obviously when we have got something that is so important, this foundational profession of teaching, and that we are having trouble attracting and keeping educators across the country, that is why this hearing is so important.

In the State of Illinois, we have about 4,100 unfilled teaching positions, paraprofessionals, other staff. So 4,100, and, you know, so obviously, you know, there are a lot of factors that lead into that. But when you get down to it, and Randi Weingarten, I know you know this probably as well as anybody, if not better than anybody on this Zoom. You know that we are asking a heck of a lot of our teachers and our staff while paying them too little.

So we have got a bill that creates incentives for teachers to stay in the profession. One of them that I am part of, it is called the Retaining Educators Takes Added Investment Now Act—we call it the RETAIN Act—that would give fully-refundable tax credits for teachers in Title I schools. So the credits would start at \$5,800 and ramp up two \$11,600 to retain staff. So, Ms. Weingarten, can you talk a little bit about why incentives like those under the RETAIN Act are really important, and maybe even essential, if we are going to bring teachers into the workforce and really incentivize them to stay in the workforce?

Ms. WEINGARTEN. So thank you, Congresswoman. Look, so let me just say we have a shortage task force that will present its findings and will do a big focus on this as part of our convention in July.

Some of what I talked about today is some of what we are bringing forward. But what you just focused on is so important because what happens is teachers are better their third year than they are in their first year. Dr. Burke, I started as a lawyer before I was a teacher. I was one of the alternatively-credentialed teachers. I wish I had a residency program. I was not a good teacher, in my judgment, my first year. I needed the support that I got from other people. And so by my 3rd year, my 4th year, I was a much better teacher.

Those retention bonuses, when people are deciding are they going to stay in teaching or not, teaching is a high attrition field. That kind of retention bonus is really important, that kind of retention bump is really important, because then we can keep people in the profession, and they can raise their family, and live in communities, and teach. So that kind of work that you are doing, Congresswoman, is really important in terms of giving us the funding to be able to retain people in their 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th year.

Mrs. BUSTOS. So if we can kind of keep along these lines in my questioning, of the 14 counties that I mentioned, 11 of the 14 are very, very rural. In fact, 85 percent of the towns in the congressional district that I represent have 5,000 residents or fewer in the towns, and 60 percent are 1,000 or fewer. And so we are seeing these shortages in rural areas in a really big way. I am wondering if you have any thoughts about are there different ways that we should tackle this problem in rural areas versus more urban settings?

Ms. WEINGARTEN. Yes, there are, and we are starting to think about that. Look, you and I have had the conversation around what we did in Peoria and having that kind of housing of a career tech ed facility that ended up being used for several rural counties and rural areas. We had to deal with the transportation issues and things like that, but you can then figure out how to cluster magnets together so that we have the expertise of a physics teacher, or, you know, of a teacher of calculus. We have been doing that, frankly, in McDowell County, West Virginia, where we, with Gayle Manchin, have been running a public/private partnership adjacent to the school district about how we make sure that we have expertise so that rural areas do not have this kind of deficit. We need to get great teachers who are deeply knowledgeable about these things.

Mrs. BUSTOS. Thank you, Ms. Weingarten. My time has expired. With that, Chairwoman DeLauro, I yield back. Thank you so much.

The CHAIR. Thank you. Thanks very, very much. And Congressman Cline.

Mr. CLINE. Thank you, Madam Chair. I want to thank the witnesses for being here today on this hearing. You know, according to the Virginia Department of Education's Annual Report On Critical Shortage Areas, the top 10 shortage areas this year are special ed, elementary, pre-K through 6, then grade 6 through 8, then career and technical education, and math grade 6 through 12. You know, it is our priority to ensure that students get a good education, and that stems from good teachers. We need to address the

issue head on and find a way to help our States to get students back on track after the closure of schools for almost 2 years.

Virginia had an especially aggressive shutdown under our Democrat-led governor and General Assembly, and Virginia schools are struggling as a result according to a new report presented to our current governor. The data demonstrates lower student achievement and reading in math, wider achievement gaps, reduced transparency, and eroding parent confidence in the Commonwealth's public schools. Our governor mentioned that the significant lowering of expectations, the lack of transparency with data, the weak accountability for these results, that ends today. So I am hopeful that our new governor will help us get in the right direction.

Let me ask, Dr. Burke, how would you define a teacher shortage? Is there a national definition or is this more of a State and local nuanced issue?

Ms. BURKE. Thank you, Representative Cline. I think it is just that, a local nuanced issue, as you put it. We see, you know, differences across the country, State to State. It is certainly not a national problem that needs to be addressed by Congress. And, again, I would point to decisions being made by local public school districts and States across the country. If we look just from 1992 to 2014, we saw per-pupil spending increased 27 percent, inflation adjusted, while teacher salaries actually fell 2 percent over that same time period. So public schools have really chosen to fund a non-teaching staffing surge rather than direct these ever-increasing taxpayer-funded dollars to higher teacher salaries.

Mr. CLINE. Absolutely. I saw in your testimony the statistics. Inflation adjusted per-pupil spending from 1992 to 2014 increased by 27 percent, but teacher salaries fell by 2 percent because public schools chose to fund a non-teaching staffing surge rather than direct ever-increasing taxpayer-funded spending to higher teacher salaries. And I am sure that that problem is worse in some States as opposed to others. Some States are probably doing better. It just goes to show why we should encourage States to address the problem, as needed, as opposed to imposing a one-size-fits-all requirement. Can you talk about how the COVID-19 mandates contributed to the loss of teachers?

Ms. BURKE. Sure, and, Representative Cline—

Mrs. WATSON COLEMAN [continuing]. And encourage them. So I think unions are vitally important to the education of our children, and I am glad that the NEA, and AFT, and every other union is standing up for them. Thank you, Madam Chair. I yield back.

The CHAIR. Thank you. Congresswoman Lee. Oh, wait a minute. Hang on a second. I am being told here—excuse me—technological difficulties appear to have arisen. We can't proceed with a fully-virtual hearing until the livestream is working. Unlike a situation where one or a couple of remote members who are unfortunately left out of participating in a hybrid hearing because the equipment in the hearing room breaks or their equipment at a remote location breaks, having a virtual hearing with no livestream breaks House and committee rules that have no flexibility apparently.

VOICE. It is working.

The CHAIR. Is it working now? Give me a break here. Come on, guys, with this technology, all right? We are done. We can move on.

Congresswoman Lee, go ahead.

Ms. LEE. Thank you, Madam Chair. Thank you, Chairwoman DeLauro and Ranking Member, for this hearing. Boy, what a day. Let me also thank all of our panelists for being here today, especially, and for your tremendous work and leadership in securing the future, and that is what you are doing. And let me associate myself with all the remarks about the tragic, horrific massacre yesterday. Gun violence is continuing to kill students, teachers, and staff. It is an epidemic. It is a public health epidemic, and it has got to stop. And I am getting so worried that this trauma is settling in and people are becoming numb to this.

And I am wondering now, just in terms of a barrier to the teaching profession, how are teachers now viewing the epidemic of gun violence in terms of wanting to go into the profession? I mean, this is heartbreaking, and so we have got to move quickly on legislative solutions, which my colleagues have cited. So let me just ask Dr. Carver-Thomas a question following up with Congresswoman Bonnie Watson Coleman, and good to see my sister from Oakland, California, who is doing a phenomenal job with regard to students of color and teachers of color, and being able to not only relate to these students, but also to teach a curriculum that empowers students to learn and makes it more interesting in terms of reading.

I did not have one black teacher until I got into college, and it was awful because there was no connection to, for example, black history and the curriculum, or African history, no connection to who I was as a human being, which really created a lot of trauma for not only myself, but most black people who are my age. And so can you talk about just the relationship between teaching one's history also in the context of having teachers of color being able to teach one's history within the context of each and every one.

And then secondly, with regard to the Augustus Hawkins Centers of Excellence, I had the privilege to work with Congressman Ron Dellums and knew Gus Hawkins very well. I spoke at his memorial. I cannot believe that this is just the first time we put \$1,000,000 per grantee into the program. This committee did. So can you just tell us what we need to do, given the importance of HBCUs, as it relates to teacher education and our young people, because HBCUs really train, what, 50 percent of the Nation's black teachers.

Ms. CARVER-THOMAS. Thank you, Representative Lee. Yeah, I want to reiterate the importance of teachers of color as cultural translators that teachers of color are able to connect what their students are experiencing to what they are learning in the classroom, and that is, you know, important. We see from other research the importance of culturally-responsive to pedagogy or essentially disconnecting students' experience to new information that they might learn that has an impact on students' ability to achieve. And we see that borne out in the research that those practices lead to better academic outcomes for students, which can go a long way toward addressing some of the longstanding disparities

in student opportunities and outcomes that we have seen for decades.

And, you know, HBCUs, and also tribal colleges and universities, and other minority-serving institutions play an important role in developing teachers who will go into classrooms and serve that important role. And as you mentioned, HBCUs disproportionately prepare teachers of color. They are preparing more teachers of color, you know, by proportion than other kinds of institutions. And so it is incredibly important that they have the resources they need to be able to create high-quality programs, like residencies and other kinds of high-quality teacher preparation programs, that offer the kind of rigorous coursework, closely-aligned clinical practice in schools, mentoring from expert mentor teachers, and that experience in the kinds of schools where teachers will ultimately teach

Teachers of color are more likely to teach in schools serving mostly students of color, and it is important that they are able to have experience teaching in those settings so that they feel confident and well prepared when they enter the classroom and are more likely to stay for the long haul.

Ms. LEE. Can I ask Randi, real quickly before my time is up, to comment on the gun violence and how that is affecting young people entering into the teaching profession?

Ms. WEINGARTEN. So, thank you, Congresswoman. Look, all morning long, as you can imagine, my phone has been ringing off the hook. "What can we do? "How do we move through this?" So teachers across the country are thinking about two things at the same time. Number one, they are thinking about grandmothers in Buffalo and kids in Texas. Number two, they are thinking about grandmothers in Buffalo and kids in Texas. And then number three, they are thinking about how do we create a safe, welcoming environment for all of us. That is why I leaned into in this hearing the whole issue about community schools and wrapping around services.

Schools are relational. If we create the trust and we connect in terms of relationships, particularly in a post-COVID era, that is going to be really, really helpful, and that is what teachers are thinking about, not hardening schools, not arming themselves, but how we can create a safe, welcoming environment.

Ms. LEE. Thank you, and thank you, Dr. Carver-Thomas, very much, both of you for your response.

The CHAIR. Ms. Frankel.

Ms. FRANKEL. Madam Chair, thank you for this hearing. Thank you to all the panelists today, and I am going to follow up with something Ms. Weingarten just said. Look, I am going to express, of course, my just heartbreak for the brutal murders we saw yesterday in Texas and also across this country just in the last several weeks. What we are seeing is not just proliferation of guns. We are seeing a proliferation of hate.

I come from Florida. We have a big teacher shortage. It is predicted to be about 9,000 teachers next year. We call ourselves the Sunshine State. It is the sunshine State except in the classroom. We have had two policies that the governor and the legislature have just enacted, Ms. Weingarten, and I would like your opinion on them. There is a bill that bans any classroom discussion on gen-

der identity, sexual orientation, in grades K through 3, and bans discussion that any parent might find inappropriate in grades K through 12. It has been called the Don't Say "Gay" bill, but obviously it is much more than that. And then there is the Stop WOKE Act, which limits workplace and classroom discussions on race, gender, and oppression, stifling education and dialogue about race, diversity, inclusion, and truths in America's founding. In other words, I mean, they banned something like 40 math books because they actually asked the question in one of them, how do you feel about math. So you don't have to understand what children are feeling, respecting their family life.

And I am just wondering if you have thought about how these restrictions can contribute to recruitment challenges and driving teachers out of the workforce.

Ms. WEINGARTEN. So, Congresswoman, as you can imagine, of course I have, but part of what has happened over the course of generations is that when there is uncertainty in communities, there is fertility for a culture war in schools. You saw that back in the Scopes trial, you know, years and years ago on the issue of evolution versus Bible studies. And I say this as someone who is married to a rabbi and very religious. You see this now in terms of the anxiety that parents have, and it is fertile ground because we have to make sure that we help kids recover and thrive in the aftermath of COVID. It is the aftermath of COVID as opposed to all the other things. We all tried to do the best we could. In fact, parents get this. The last NPR poll showed that 88 percent of parents thought that teachers did the best they could.

So what we need to do is create an environment in schools where kids are free to dream, and free to think, and to be themselves. And that is why the Don't Say "Gay" law is so negative because if a child says something in a class that is under, you know, grade 3, what is a teacher supposed to do? And it hamstring the relationships between teachers and kids. And in terms of history, I am a history teacher. We have to teach honest history. There are people right now who can't figure out how to teach about what happened in Buffalo because there are things they can't say. We have to trust our kids and make sure parents know what we are doing to actually make sure that kids feel the relationships, the agency, the empathy, so that we can be a more perfect union. We got to trust people to be able to do this.

Ms. FRANKEL. Yeah, thank you. And, you know, we don't know yet what the motive was for yesterday's shooting. We do know that some of these other shootings these past several weeks were definitely racist in nature, and we have seen, you know, for the past several years, I mean, certainly mental health issues. But just getting back to this Florida law, you know, it seems to me if teachers have to be on pins and needles that they can't say anything that would make somebody uncomfortable because they talk about racism is just an idiotic law and really is going to cause more racism, more hatred, more violence in this country.

And with that, I thank you all again for being here today. I yield back.

The CHAIR. Thank you. We are going to be able to have a second round, and I know that Congresswoman Lee is there. Congressman

Cole, I believe, is still on. So if there are others, just please let us know. But with that, let me ask, and this is a question to Ms. Weingarten. I am concerned, and I know you are, and there was a question about parents and teachers working together earlier. I am, frankly, concerned by a lot of the false narratives that are out there by opponents, quite frankly, of public education, pit educators and parents against each other, make the conditions much more difficult now. And, you know, the efforts to scapegoat, target teachers, I think, are counterproductive. They don't reflect, in my view, but I want to test this, how parents actually feel about their children's teachers and schools.

There was recent data from Hart Research that finds that 72 percent of parents say their school provides excellent or good quality education. Seventy-eight percent endorsed the quality performance of their teacher. And, Ms. Weingarten, you represent many members of the communities that are the first responders to the societal issues, like poverty, grief, children's mental health challenges. How have you seen parents and teachers working together to support student learning and to support their success?

Ms. WEINGARTEN. Look, I don't disagree. I actually agree that hybrid learning was one of the worst things that happened, and many of us, and I think my record—I can speak for myself—was pretty clear from April 2020, wanting to see how we could get schools reopened. I served on the Cuomo task force to get schools reopened in New York. I wrote endless numbers of op-eds about it, and safety was one of the ways that we did it in a very, very uncertain time.

So the question really becomes, how can we create the parent-teacher partnership that is absolutely essential for kids to thrive? And we do it in lots of different ways and lots of different places, but schooling is one of the only places that government gives to parents to actually help their families. This is part of the reason why, Chair DeLauro, your bill for, you know, full service community schools is so important because we can get the Title I coordinators the money to wrap services around, to have 25,000 of these community schools. And Jeff Canada has taught about this, too, in terms of the charter sector. If we can actually do this, we have an infrastructure by which parents can always feel comfortable in a school, always get answers in a school, have the kind of childcare that Representative Clark was talking about. Those are the kinds of things we need to do. We need to make sure that the parent-teacher relationship is one that is open and one that is really respected. And what we see is that schools that work have that, and that is what we are trying to do all across the country.

The CHAIR. I am excited to hear you talk about the community schools because, as you know, we put in \$75,000,000 for community schools for 2022, which is about a \$45,000,000 increase, and it is my intention, anyway, to increase that effort. I volunteered, again, when I was unemployed, in the community school. I watched the school open at 6 a.m., close at 9:00 or 10:00 p.m. I watched parents, grandparents, kids interacting with each other, you know, all through the day, and it was an environment in which parents were deeply involved with their youngsters and what was happening. So I think we are on a track to move back on that. The other piece

of that as well, if you might just talk about, isn't it true, I mean, elected school boards in this country, aren't parents represented on elected school boards so that they have a role in what is happening in the classroom with their kids? And they are on the board, but their kids are in the same school.

Ms. WEINGARTEN. Look, I am a big believer in local governance of schools, and, you know, I have worked in many systems. I worked with Mayor Bloomberg, who had mayoral control in New York City, and, yes, the two of us actually raised salaries—he is very proud of this—43 percent for schoolteachers, and it did actually hugely reduce the number of uncertified teachers in New York City. And, Dr. Burke, it actually did hugely raise scores the next year after we did some of that work.

But what happens is that when you have local boards and you create trust, every parent has issues that they are struggling with. Every teacher has issues. It is a tough time in America right now, but it creates trust to have local boards elected by people in the community, and trust is what we are going for. And we see that opponents sometimes say, like Christopher Wolfel and others, that they are trying to create distrust to actually, you know, disconnect people from public schooling. But public schooling is something that Republicans, and Democrats, and Independents really think is important in communities, and the boards and locally-elected boards help create that trust.

The CHAIR. Thank you. Congressman Cole.

Mr. COLE. Thank you very much, Madam Chair, and, again, thank all of our witnesses. This is a really good discussion.

Let me go to COVID first, and I want to do this without pointing fingers at anybody because I think we were dealing with an unprecedented situation, and people basically did the best they could wherever they were at, and, you know, we have learned some things. My personal view, shutting down schools was probably a big mistake, and we have in my State two different examples because the two largest school systems in Tulsa and Oklahoma City did shut down, but most of the rest did not. They shut down early in, you know, right at the end of the school year in 2020, but most of them reopened in the fall of 2020 and remained open under difficult circumstances. And they seemed to have better results, honestly, in terms of their kids and all the social problems that we have explored at length in this committee.

So I am just going to ask each of you, if you had one or two lessons learned out of COVID, I would be very interested in what we should think about going forward should we ever confront something like this again, and hopefully we don't. This was a once-in-a-century event, so we may even, in some ways, be overthinking it right now. But we know we are going to be dealing with it on this committee for a long time, and we know in your school systems you are going to be dealing with it because the aftereffects of this thing has a very long tail to it.

So let me start, Ms. Weingarten, with you, and then anybody else on the panel. If you had a couple of suggestions or things we ought to think about, lessons learned from COVID, I would love to hear them.

Ms. WEINGARTEN. So No. 1, and thank you for the question, Congressman Cole. Number one, we need real consistency, to the extent possible, in what the public health positioning is. People were very confused. Yes, you know, COVID changed and the rules changed, but to the extent that we could have real consistency coming from all quarters that would have helped create trust, would have been very, very helpful, because we believe that safety and resources were the way to reopen schools. And there are many other people on this committee that I had many conversations with about how we create both safety and in-person learning. That is number one.

Number 2, we learned how to trust teachers a lot at the beginning of this pandemic. There were no real platforms in lots of different places. There had been lots of virtual learning beforehand. The former Secretary of Education pushed it really hard, but we learned how to trust teachers a lot. Let's not stop trusting teachers now that we are back in person. They were ingenious. They were creative. So were bus drivers. So were food service workers. Let's actually trust them the same way we did when we were in an unprecedented pandemic.

Mr. COLE. Thank you. Ms. Carver-Thomas.

Ms. CARVER-THOMAS. Thank you.

Mr. COLE. "Doctor," I should say. I am sorry.

Ms. CARVER-THOMAS. It is "Ms." Thank you.

Mr. COLE. Oh.

Ms. CARVER-THOMAS. So I think something that we learned from the pandemic was that there is sort of a distinction between short-term and long-term solutions to shortages and all of the staffing issues that we have been dealing with during the pandemic. And, you know, the teacher shortage far predates the pandemic and was really exacerbated by the pandemic. And so I think it is important, moving forward, to think about what are those long-term solutions that can be enacted now so that we are not looking for short-term solutions when we are in crisis mode that really undercut the ultimate outcomes that we want to see for our students.

Mr. COLE. Thank you very much. Dr. Burke.

Ms. BURKE. Thank you, Representative Cole. The number one lesson that we should take away from COVID is that we should fund students and not systems. That was a big part of the reason parents did not have educational continuity for their children is that dollars go to school districts and not students themselves. And so when schools shut down, they had very few, if any, choices to make sure their children did have access to in-person instruction. And so that is a really important lesson moving forward is that every single dollar that we spend should go directly to families to allow them to select into learning environments that work for them, reflect their values, and are open for instruction, and safe and effective long term.

Mr. COLE. I am out of time, but, Dr. West, if you could quickly respond. I think the chair is always generous with the gavel.

The CHAIR. Please, take your time, Mr. Cole.

Ms. WEST. Thank you, Mr. Cole. I appreciate that question. I think, just to echo what Desiree said, our shortage in special education has been with us for, you know, as long as I have been doing

this work, at least 40 years. And like with many situations, COVID exacerbated what was already there, so we were able to really see this, and these long-term solutions are really important. I would also point out that there are many students with disabilities with significant health conditions for whom a return to school posed an accelerated threat. So I think that is important to think about when we think about these public health kinds of situations. Clearly, it is preferable to be at school in person. Delivering something like speech therapy online or if you need one-to-one assistance is very challenging to do virtually. Thank you.

Mr. COLE. Thank you very much, and thank you, Madam Chair, for your indulgence on time. I yield back.

The CHAIR. Absolutely. Thank you. And Congresswoman Lee.

Ms. LEE. Thank you very much. Madam Chair, let me just say I helped found a community school and worked in a community school. It was the Black Panther Party Community School, and, Ms. Carver-Thomas, you know the history in Oakland. But the kids who went to this community school soared for all the reasons we know. They had teachers who cared about them, teachers who looked like them. There was a curriculum that they could relate to. They excelled in math, and science, and music, and it was unbelievable. And so I think community schools are really effective, as long as they are public. I don't support vouchers or any of the privatizing of public schools, but I think community schools really are a very interesting and excellent structure for low-income kids, and especially kids of color, you know.

And having said that, I actually worked, when I was in California legislature, I worked a lot, and now in Congress, on suspension and expulsion of black boys. A couple of years ago, there was a study that was done. Like, 40 percent of African-American babies were expelled and suspended from preschool, and we have asked the Department of Education to get a handle around this. And also, in California, in the day, kids were kicked out or expelled from public schools because the code was so vague, that there were no real guidelines on what to do if there were issues with children. And, of course, there were no resources for alternatives in terms of truancy and making sure teachers had a path to, you know, some support system for children that, for whatever reason, they thought, you know, needed to be expelled.

So I am wondering now, Ms. Carver-Thomas, if in California, have we helped tighten that up so kids have and teachers have alternatives so they could teach and so they don't have to be mental health counselors, so they don't have to be public safety officers? And then secondly, if anyone knows what is happening with these young black boys in preschool and are they still being expelled like they were few years ago.

Ms. CARVER-THOMAS. Yes, thank you, Representative Lee, for the question, and there are quite a few different pieces. And the first I will say is that one of the studies that I mentioned, an LPI study, on positive outliers looked at student outcomes that included things like suspension and expulsions, disciplinary rates, and showed that teacher certification matters for that. And there is other research showing that when students have more new teachers, novice teachers, they are also more likely to be suspended or expelled, or expe-

riencing exclusionary disciplinary practices. And so both of those sort of ideas suggest that comprehensive preparation really matters for making sure that teachers are prepared with the instructional strategies that they need to be able to teach without suspending students. The research shows that when students of color have more teachers of color, they also have fewer rates of suspensions, and expulsions, and chronic absenteeism.

And so it is clear that there are instructional practices that make a difference, and having that access to comprehensive preparation really matters for students' experiences in the classroom. I couldn't speak to the preschool rates of suspensions. It is troubling, but I will say that preparation can make a difference as far as we know.

Ms. LEE. Randi, can you, or Jane, or anybody can respond to that issue with regard to black boys, black babies?

Ms. WEST. Just a quick point on that. We do know that students with disabilities and students of color are disproportionately suspended from school and have disproportionately experienced this rejection from school that does not help them advance. We also know that students of color are disproportionately included in special education, particularly black boys, and it goes back to the skill and expertise of the educators being able to work with them in a research-based way and their knowledge.

Ms. LEE. Ms. Weingarten.

Ms. WEINGARTEN. It is a problem, Congresswoman Lee, and it is part of why data is collected to make sure that we change this. And one of the ways of doing that is all the restorative justice programs plus ensuring, as Dr. West, just said that people actually are trained to meet the needs in a culturally-competent way of all kids. And it is kind of why we are, you know, getting at it in a lot of different ways. How do you have a more diverse teaching staff? How do you actually deal with all issues? How do you create more play time in schools? How do you make sure that teachers are prepared?

Ms. LEE. Thank you. Ms. Burke, would you like to respond?

Ms. BURKE. I don't have any hard data to respond to you, Representative Lee, but we do know that when you control for behavior, that some of those differences do shrink, but I don't have hard numbers that are—

Ms. LEE. Okay. Thank you. Thank you, Madam Chair. Very important hearing, again, the day after such a tragedy. It is kind of overwhelming to be here with all of you, and you have lifted our spirits and remind us how much work we have to do. But we have got to stop the gun violence on campuses.

The CHAIR. I would just say, Congresswoman Lee, I think a Yale Child Study Center has done a lot of work in this area. Dr. Gilliam has, you know, worked on this. I could put you in touch with them about what they have found in terms of research and data of what is happening to, you know, preschool youngsters, et cetera, and expulsions. We at one point did a briefing on that issue, and it may be that we can, you know, work on something like that again—

Ms. LEE. I would like to do that. We have got to get this under control because we have written a lot into our approps bills direction, you know, appropriations, you know, language to address this report. We haven't gotten many reports back from the Department

of Education. I mean, this goes back 10 years, you know, that I've been working on this here. So that would be very helpful, and maybe from this point on, we can get a good grasp on what we need to do. Thank you, Madam Chair.

The CHAIR. Thank you. Let me ask Congressman Cole, Tom, if you want to make any closing remarks, and then I will wrap up.

Mr. COLE. I will quickly, Madam Chair. First of all, thank you again for the hearing, and I marvel at my colleague, Ms. Lee from California, because it is 4 hours earlier out there. And so when you get up early to participate—

Ms. LEE. No, I am here, Mr. Cole. [Laughter.]

Mr. COLE. Well, okay. Well, I still marvel at your stamina anyway.

Ms. LEE. Thank you.

Mr. COLE. But kudos for anybody that is out West that managed to tune into our hearing for any length of time. But is a very important hearing, and I want to thank each of you witnesses for taking the time. It has been a difficult day, and we have all acknowledged that. But like my friend from California, I appreciate the fact that you do give us some optimism about where we are headed and what our potential is and without shortchanging any of the problems that we do have.

I sometimes think, you know, we try to do too much at the Federal level, and I am not talking in terms of money. You know, I have often thought we just have too many programs and not enough money. We would be better off to focus, narrow down on a number of programs and spend the same dollars that we do today rather than spread ourselves quite as thin as we do, but, you know, that is probably the subject of another hearing.

And I also do think that we have a larger cultural problem right now. I mentioned in my opening remarks, and I probably should have pursued some of that in questioning, but it is amorphous. But I do think the profession has lost a lot of respect, and I regret that. As I said, my son is a public school teacher. When I began my career, it was to be an educator, certainly not to be a politician. I think it is one of the most noble professions that there is, and the fact that we have people literally leaving out of discouragement, I mean, part of that is there is greener pastures and other opportunities. But I think part of it is just exhaustion, and we need to rethink, you know, some of the burdens we put on the teachers.

Ms. Weingarten talked about just the sheer paperwork with which we excel at the Federal level. You know, we never give you money for free, and we always send a list of requirements, and reports, and what have you, and that is something we ought to think about ourselves. There is a certain level of trust. You either trust people at the local level to make good decisions or you don't, and I am not talking here about normal safeguards in terms of making sure money is not misappropriated. But at the end of the day, I like Ms. Burke's idea of money following students and empowering students and their families to make good choices. There is a lot of merit in that, I think, and it puts the decision making and the dollars closer together, and that usually works out better, I think, in the long run. But regardless of that, I appreciate everybody's participation. It was a lively discussion. I thank Mr. Pocan, Madam

Chair, for suggesting it to you, and I thank you for following up so quickly and giving us this opportunity today.

With that, again, I look forward to continuing to work with my friend, the chair, on these issues, and I yield back.

The CHAIR. Thank you very, very much. I, too, want to say thank you to Mr. Pocan. I know he isn't on, but in the course of the last hearing, he suggested this. And, quite honestly, as I said earlier, this is the first hearing that we have had on the shortage of teachers since the pandemic, but two things let me just say. I mean, this has been such a really elevated conversation, and I really appreciate the richness of it and the discussion.

Something that the ranking member said is that, you know, always revered in our society were teachers, you know. Most families in, you know, another generation, you know, wanted you to, you know, pursue teaching. That was the thing to do, and especially for women that was very true. And I think that Ms. Weingarten's, you know, comment about how would you advise your child or your grandchild to go into the teaching profession, how would you want to give them that sense of the nobility of the profession, and we have lost a lot of that recently. And what I think is that what we focused here on today is that our teacher shortage is a national crisis. It existed before the pandemic, and it was exacerbated by the pandemic.

Retaining teachers is a crisis and we need to try to do that. So how do we address that? I mean, I think, again, the richness of this conversation has been the suggestions that we have had from witnesses: comprehensive preparation, service scholarships, teacher residencies, mentorships, induction support, improve teaching conditions, Grow Your Own programs, dual certifications, more planning time, reduce class size, improve teacher pay, special education. How do we train more people to be special ed teachers? Teachers of color, that is a big issue today. Expand access to collective bargaining, community schools. I am so proud that we are having a resurgence of the importance of community schools. We did that a number of years ago, and then they just shut down, and they were vital and dynamic, and then creating that atmosphere for students, children, families, academics, you know, teachers coming together in the place; mental health support, investing in critical preparation programs.

I mention all those because I want to say, and this is encouraging, that we are looking at the Federal level recently, and this committee has really made some investments, and that is in teacher quality partnerships, which we increased about \$60,000,000. The Hawkins program, my colleague, Congresswoman Lee, it is \$8,000,000. This is the first time we moved in this direction with the Hawkins Centers of Excellence. IDEA, personal preparation. I mentioned community schools, the \$75,000,000. School-based mental health, you know, which we are investing in.

A number of these suggestions that you all made come under, you know, these categories up. We have an opportunity to make the investments at this time in areas that have really been either flat funded or underfunded for years, understanding the breadth of the problems that we face today. And the fact is we need to prioritize these investments and understand their value in terms

of the system that educates our young people, provides them with the opportunities for their future, gives them the path to success.

And there is no more noble calling, there is no more greater achievement. Everyone here, parents told them to get an education. If you get an education, you can succeed, and that is what you are all in the business to do. The biggest increases have been for HBCUs and MSIs. I only say that because I feel good about that we are on track. I want us to be able, you know, to do more. And when I think about what happened yesterday and how we go forward, because we have to go forward, that we have to reassure. We are not talking here today about gun violence, but we need to address that and the Congress needs to address that in a very serious way.

But we need to assure teachers that they are safe and their families know that they are safe. In the Sandy Hook tragedy, a young woman named Victoria Soto, she, protecting her students, was shot and killed. It may be the same circumstances for the young woman yesterday who had, what, I mean, 15, 17 years of teaching. Talk about an experienced teacher. So we have to assure teachers and their families that, yes, they are safe, and we respect them, and we respect what they do, and put aside those who want to just foment dissension amongst our teachers and our parents.

For our students, what can we all say? I went to school. I went every day. We all did. Never for a moment did either my parents or I felt I wasn't going to return home that day, and, today, it lives with each one of our kids, and it lives with their parents. This is a moral responsibility that we have to address this issue, and to the extent that we can provide the moment not only to solace, not only to thoughts, not only to prayers, but addressing the situation.

And I will speak for myself, and I don't know about everybody else, but that we cannot ban assault weapons in this country is pretty much something that I cannot abide. But we need to provide also the kinds of mental health, kinds of efforts that can reassure people, and the kinds of things that we assure people, that our schools are a safe environment for their youngster and for the people who teach our youngsters, because after parents, teachers have the most time with our children, spend the most time with our children. And we cannot ever forget that, and we cannot ever understand the commitment that they make.

We want to work with you. We are willing to address these issues in terms of, you know, the various shortages and gaps in the current system that we have. We are trying, but we can try harder, and with all of your help, we can succeed. So thank you so, so much for giving your lives to this profession and making sure that kids our kids are well educated and can realize their dreams and their aspirations. Thank you so much for today.

Ms. WEST. Thank you, Madam Chair. Thank you, Ranking Member Cole.

Ms. WEINGARTEN. Thank you very much.

The CHAIR. We will bring it to a close. Thank you very, very much.

Ms. CARVER-THOMAS. Thank you. Pleasure to be here.

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