FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

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

June 4, 2015

Dr. Kathy Hudson
Deputy Director for Science, Outreach, and Policy
National Institutes of Health
1 Center Drive
Bethesda, MD 20892

Dear Dr. Hudson:

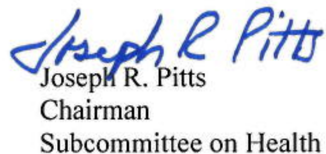
Thank you for appearing before the Subcommittee on Health on Thursday, April 30, 2015, to testify at the hearing entitled "Legislative Hearing on 21st Century Cures."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Thursday, June 18, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment — Additional Questions for the Record

The Honorable Joseph R. Pitts

1. Should there be a link between the unfunded burden of illness relative to typical NIH dollars spent for a similar burden, and program announcements (PAs), requests for applications (RFAs), and requests for proposals (RFPs)?

2. What other mechanisms exist to encourage funding for disorders that are currently underfunded relative to disease burden? How are they currently being applied toward underfunded diseases?

3. What is the best metric for disease impact? The WHO recommends DALYs. Is there a better metric that incorporates both death and disability?

The Honorable Leonard Lance

Dr. Hudson, thank you for testifying before the Committee this morning and lending your expertise as we continue to move forward with this important initiative. One issue which has not been raised today, though it affects five million Americans each year, is what we can be doing to support the furtherance of research in critical care.

As you are aware, critical care medicine is the care of patients whose illnesses or injuries present a significant danger to life, limb, or organ function and encompasses a wide array of diseases and health issues. This care is typically provided by highly-trained physicians using complex therapies in the intensive care unit (ICU). Unfortunately, despite the likelihood of a patient requiring care in the ICU throughout their lifetime, and the economic cost of providing this care – last estimated in 2005 to be $81.7 billion per year, representing 13.4% of hospital costs, 4.1% of national health expenditures, and 0.66% of gross domestic product – very few breakthroughs have been made in therapies and treatments for these patients. One reason for this may be that critical care research is complex and involves many departments, specialties, professional societies and research institutes/foundations. Lack of coordination and collaboration among these stakeholders has stymied progress, particularly at the National Institutes of Health (NIH) where critical care-related projects are ongoing throughout the 27 Institutes, leaving the field without a solid foundation from which to advance new treatments and therapies.

The NIH recently demonstrated the importance and efficiencies that come from increased coordination among stakeholders by establishing an Office of Emergency Care Research, which serves as hub for basic, clinical and translational emergency care research and training across the NIH.

1. Recognizing the distinct difference between emergency care and the unique care occurring in the ICU, Dr. Hudson, what is the rationale for not having a similar office at NIH to coordinate and streamline, as well as identify gaps in, our nation's critical care research?

2. Do you believe the creation of a working group within the NIH to assess the particular needs of this field would fall within the scope of this committee's effort to promote policies to accelerate the discovery, development and delivery of therapies and cures?