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INVESTING IN PUBLIC HEALTH:

LEGISLATION TO SUPPORT PARENTS, WORKERS, AND RESEARCH

WEDNESDAY, JUNE 29, 2022

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 11:00 a.m. in the John D. Dingell Room, 2123 of the Rayburn House Office Building, Hon. Anna Eshoo [chairwoman of the subcommittee], presiding.

Present: Representatives Eshoo, Butterfield, Matsui, Welch, Schrader, Cardenas, Ruiz, Dingell, Kuster, Kelly, Craig, Schrier, Trahan, Fletcher, Pallone (ex officio); Guthrie, Burgess, Griffith, Bilirakis, Bucshon, Carter, Dunn, Curtis, Crenshaw, Joyce, and Rodgers (ex officio).

Also present: Representatives Clarke and Pence.

Staff Present: Lydia Abma, Policy Analyst; Hannah Anton, Staff Assistant; Waverly Gordon, Deputy Staff Director

and General Counsel; Tiffany Guarascio, Staff Director; Mackenzie Kuhl, Digital Assistant; Una Lee, Chief Health Counsel; Aisling McDonough, Policy Coordinator; Meghan Mullon, Senior Policy Analyst; Juan Negrete, Junior Professional Staff Member; Kaitlyn Peel, Digital Director; Chloe Rodriguez, Clerk; Charlton Wilson, Fellow; Alec Aramanda, Minority Professional Staff Member, Health; Kate Arey, Minority Content Manager and Digital Assistant; Sarah Burke, Minority Deputy Staff Director; Seth Gold, Minority Professional Staff Member, Health; Grace Graham, Minority Chief Counsel, Health; Brittany Havens, Minority Professional Staff Member, O&I; Jack Heretik, Minority Press Secretary; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Clare Paoletta, Minority Policy Analyst, Health; Kristin Seum, Minority Counsel, Health; Kristen Shatynski, Minority Professional Staff Member, Health; and Olivia Shields, Minority Communications Director; and Michael Taggart, Minority Policy Director.

*Ms. Eshoo. The Subcommittee on Health will now come to order.

Due to COVID-19, today's hearing is being held remotely, as well as in person.

For members and witnesses taking part remotely, microphones will be set on mute to eliminate background noise. Members and witnesses, you will need to unmute your microphone when you wish to speak.

Since members are participating from different locations at today's hearing, recognition of members for questions will be in order of subcommittee seniority.

Documents for the record should be sent to Meghan Mullon at the email address we have provided to your staff. All documents will be entered into the record at the conclusion of the hearing.

The chair now recognizes herself for five minutes for an opening statement.

Today our subcommittee is examined -- examining 11 public health bills that support patients, health workers, and biomedical research. Seven bills are reducing disparities or increasing access to health care services for medically under-served populations. About 20 percent of Americans live in rural areas, and are less likely to have health insurance, live farther away from health care facilities, have limited access to health care specialists,

and face higher risks of death from heart disease, cancer, diabetes, and stroke.

To address these inequities, we are examining Representative Ruiz's bill, H.R. 8151, the Building a Sustainable Workforce for Healthy Communities Act, which invests in community health workers to address workforce shortages in under-served communities.

H.R. 5141, the Mobile Health Act, introduced by Representatives Lee and Hudson, and H.R. 8169, the Rural Telehealth Access Task Force Act, introduced by Representatives Pence and Craig, bring services to hard-to-reach populations through mobile medical clinics and expanded access to reliable broadband capabilities.

H.R. 8163, the Improving Trauma Systems and Emergency Care Act, introduced by Representative O'Halleran, invests in trauma centers to increase access for the rural Americans who do live near a trauma center currently.

Race also affects outcomes. That is why I am pleased we are considering H.R. 2007, the Stephanie Tubbs Jones Uterine Fibroid and Research Act, sponsored by Representative Clark; H.R. 7565 the NIH Improve Act, sponsored by Representative Underwood; and H.R. 7845, the NIH Clinical Trial Diversity Act, sponsored by Representative Kelly. These bills increase research into diseases and populations that have been ignored for too long.

I look forward to Dr. Bibbins-Domingo's expert testimony. She chairs the National Academies Committee focused on fair representation in clinical trials, and can explain NIH's vital role in increasing diversity in trials.

Ms. Tanika Gray Valbrun will testify about her patient advocacy work on behalf of African American women disproportionately affected by uterine fibroids, including our late colleague, Congresswoman Stephanie Tubbs Jones.

Another research bill is H.R. 3773, the -- Pediatricians Accelerate Childhood Therapies, the PACT Act. This is bipartisan and bicameral legislation introduced by two doctors on our Health Subcommittee, Drs. Joyce and Schrier. The PACT Act invests in pediatric physician scientists and researchers with a focus on opportunities for historically under-represented biomedical researchers.

Finally, our hearing includes three bills authored by Representatives Curtis, Bilirakis, Hudson, and Trone intended to protect the integrity and security of the U.S. research -- biomedical research enterprise from foreign adversaries.

Taken together, this is a diverse slate of impactful bills that will improve American health care from early research to patient care, with a focus on reducing disparities and protecting American ingenuity.

[The prepared statement of Ms. Eshoo follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. The Chair is now pleased to recognize Mr. Guthrie, the ranking member of our subcommittee, for five minutes for his opening statement.

*Mr. Guthrie. Thank you, Madam Chair. I appreciate the recognition. I hope everybody is doing well home working for a few days, and I look forward to being back together.

Today's hearing includes an examination of the ongoing work at the National Institutes of Health, and ensuring the U.S. remains the leader in biomedical research. A few of the proposals included in today's legislative hearing are designed to promote greater oversight over how U.S. taxpayer dollars are spent on federally-funded biomedical research.

It is important to protect U.S. biomedical intellectual property from being stolen by foreign governments. Some adversarial governments such as the Communist Party of China are using their own research programs to recruit researchers in the United States who also receive U.S. taxpayer-funded research dollars and take U.S.-funded IP back to China. This scheme poses a very real threat to U.S. biomedical intellectual property.

Perhaps the most widely reported example of this alarming trend is Dr. Charles Lieber, a world renowned researcher and former chair of Harvard's Chemistry and -- Chemical Biology Department. Dr. Lieber was charged with lying to Federal investigators about his connection to the

Chinese Communist Party's Thousand Talents program, and about income he received from Chinese Communist Party's aligned [sic] Wuhan University of Technology.

This continues to be a problem. A watchdog agency published a reported -- a report earlier this month showing there are still lingering research integrity issues that could significantly undermine U.S. biomedical research if they are not appropriately addressed. After concerns were raised regarding NIH guarantees failing to make disclosure about ties to foreign countries, the IG at the HHS surveyed over 770 grantees that were collectively rewarded -- that were collectively awarded over $20 billion in grant funding from NIH in fiscal year 2020.

The findings were alarming. Of the 716 entities that responded, the IG found that over two-thirds of those surveyed failed to meet certain disclosure requirements set forth by the NIH as a condition for receiving Federal funding. These disclosure requirements are designed to protect the type of activity that Charles -- Dr. Charles Lieber was engaged in. These include requiring entities to report all types of foreign financial interests and support, training researchers about their responsibilities, and how to make these disclosures and performing reviews -- to make determinations about whether existing foreign financial interests could compromise the federally-funded research.

The IG report came at the heels of a years-long investigation undertaken by top NIH officials to ensure U.S. taxpayer research dollars were being spent appropriately. In fact, the top oversight official at NIH charged with overseeing the department's extramural grants program, Dr. Michael Lauer, even confirmed these concerning -- this concerning trend dating back to 2016.

In one of the most egregious examples -- Dr. Lauer himself characterized it -- an NIH-funded researcher failed to disclose a $5 million startup package from the -- a Chinese university to both the NIH and to the American university employing this researcher.

To the credit of NIH, in addition to the existing HHS requirements, the agency issued guidance in 2019 expressly stating grantees must report participation in a foreign talents program like China's Thousand Talents program. The Trump Administration Department of Justice even launched a China initiative to combat malign foreign influence in U.S. research.

Despite of all this, more oversight is clearly needed to protect the integrity of U.S. research dollars. I am glad we are here today to finally discuss these issues. Taken together, Mr. Curtis's, Mr. Hudson's, and Mr. Bilirakis's bills before us today would help address the issues highlighted in the OIG's report.

The bills would specifically require NIH to transparently report to Congress the number of grantees investigated for non-compliance with grant disclosure requirements; require HHS to develop tools to effectively protect U.S. biomedical research; and to explicitly require NIH grantees to disclose participation in foreign talent programs as a condition of funding, which is currently required by HHS, but not by Federal law.

Above all, NIH can and should remain a primary vessel for fundamental scientific research. We can ultimately unleash the agency's full potential without stifling future research if we effectively increase transparency on how these research dollars are spent. I look forward to advancing these critical pieces of legislation toward that end.

I look forward to addressing the other bills before the committee this morning. I appreciate the witnesses for being here.

[The prepared statement of Mr. Guthrie follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. And I will yield back, Madam Chair.

*Ms. Eshoo. The gentleman yields back.

The chair now is pleased to recognize Mr. Pallone, the chairman of the full committee, for your five minutes for an opening statement.

*The Chairman. Thank you, Chairwoman Eshoo. Today the committee continues its critical work to improve our public health systems, advance access to care, and enhance the capacity, quality, and integrity of our country's biomedical research system. And we will discuss 11 bills that collectively address critical aspects of these public health issues.

Already this year we have passed legislation to reauthorize the Food and Drug Administration's user fees, and to enhance its ability to bring safe and effective treatments and devices to market. We have authorized ARPA, the Advanced -- ARPA-H, the Advanced Research Projects Agency for Health to transform how we detect, treat, and cure the deadliest diseases affecting Americans. And last week the House overwhelmingly passed bipartisan legislation to respond to the mental health and drug overdose crisis.

And our bipartisan work to improve the health of all Americans continues today. So we have four bills that address the health needs of our rural and under-served communities.

One bill would allow federally-qualified health centers to use New Access Points Grants for establishing mobile health units in order to increase access to health care in rural and under-served areas.

Other bills will establish a task force to study barriers to the adoption of telehealth technology in rural areas; promote positive, healthy behaviors and outcomes for populations in medically under-served communities through the use of community health workers; and reauthorize grants for trauma care to support the improvement of emergency medical services and trauma care readiness and coordination -- again, particularly in rural areas.

We will also examine legislation that would continue to fund the IMPROVE initiative through the Eunice Kennedy Shriver National Institute of Child Health and Human Development. This initiative reflects our shared bipartisan interests in improving maternal health by advancing research that reduces maternal mortality and morbidity, addresses disparities in maternal health outcomes, and improves health for pregnant and postpartum women before, during, and after pregnancy.

And we have legislation that will support and expand research and awareness of uterine fibroids, a condition that impacts as many as 80 percent of women.

Now, shortcomings in clinical trial diversity have

created knowledge gaps in our understanding of diseases, conditions, treatments, and prevention. And these gaps impact health care decision-making, risk reduction, our knowledge of treatment outcomes, and the development of interventions and medications. So we will also discuss bipartisan legislation that will address these shortcomings by supporting and increasing diversity in NIH-funded clinical trials.

Another bipartisan bill supports pediatric research awards for early career pediatric researchers, and prioritizes researchers who have been historically under-represented in the field of pediatric medical research.

And we have three bills focused on security in biomedical research. As we look to secure the integrity of our research enterprise, we have to do so in a way that does not impede global collaboration and scientific discovery. But many of us will agree that the United States cannot and will not remain a leader in medical research without attracting the brightest minds across the world and working with the best institutions. And we can both protect our national interests and remain a world leader in biomedical research, in my opinion.

And I look forward to working with my Republican colleagues on these bills.

So to the witnesses, thank you for joining us. A bunch

of bills, but these are all very important.

[The prepared statement of The Chairman follows:]

**********COMMITTEE INSERT**********

*The Chairman. And I appreciate, Chairwoman Eshoo, the fact that we are having this legislative hearing today, and then can move these because they are bipartisan. So I yield back. Thank you.

*Ms. Eshoo. The gentleman yields back.

The chair is now pleased to recognize the ranking member of the full committee, Representative Cathy McMorris Rodgers, for your five minutes of -- for an opening statement.

*Mrs. Rodgers. Thank you, Madam Chair. The bills before us today reflect the importance of the committee's authorizing responsibilities over key public health programs.

We are discussing today about the threat to biomedical research posed by our adversaries, and examining a few steps we could take to address those threats. In the last few years there has been numerous reports of FBI investigations into researchers taking U.S. taxpayer-supported intellectual property to China, not disclosing foreign connections, or tampering with peer review process. We must address those concerns and hold China accountable.

Mr. Curtis's bill, H.R. 5442, the Fix Non-Disclosure of Influence in Health Research Act, which requires HHS to report on how they address non-compliance with disclosure requirements or research misconduct related to foreign influence.

Mr. Hudson's H.R. 6305, the Protect America's Biomedical

Research Enterprise Act, requires the Administration to identify ways to improve intellectual property protection, and develops strategies to prevent national security threats in biomedical research.

Mr. Bilirakis's H.R. 5478, the Protecting the Integrity of our Biomedical Research Act, requires NIH grantees to disclose their participation in foreign talent programs.

I look forward to examining these bills to address and understand what more NIH can be doing to address these threats, and who has the responsibility -- NIH or the grantees -- for protecting this information. These are common-sense bills, and critical to protecting our national security. They also complement work done in ARPA-H related to research security, which just passed the House, to stop the Chinese Communist Party's influence in our biomedical research.

If we don't do a better job of safeguarding our research, both America's national security and our global leadership will be at risk.

The pandemic has only made the need for action more urgent, and I want to thank my colleagues on the Energy and Commerce Committee for solutions to hold NIH and HHS accountable for their responsibilities to protect national security.

In addition to provisions related to research integrity,

there are a number of other NIH bills we are considering today.

I have not been shy about my concerns with NIH. I am concerned about a lack of accountability and response to congressional oversight. Their authorization has expired. There is no permanent director. And I think we need to have NIH testify to do more of our oversight of how NIH is functioning as a whole, before providing new authorizations for -- of funding of NIH. I have spoken with the chair of the subcommittee about that, and hope we can work in a bipartisan way to look at NIH and rebuild trust that the NIH has broken.

And in addition to NIH, we will also be considering solutions that increase access to health care services in under-served and rural communities like my district.

Mr. Pence's Rural Telehealth Access Task Force Act will help identify barriers to telehealth services in rural areas, and better understand how to make telehealth more widely available.

We are also considering the Mobile Health Care Act, which allows community health centers to use their funding to purchase mobile health clinics, as well as conduct facility renovations and construction projects.

I understand the need for increased access to health services, and appreciate how helpful mobile units have proven

to be in rural areas. However, I want to note that I am concerned about permanently allowing funds to be used for construction, instead of health care delivery. Community health centers are an integral part of the health care safety net and have received almost $38 billion over the last 5 years. This includes supplemental funding provided through the public health emergency. I am hopeful that we can come to a consensus on this legislation, and work together to conduct oversight in advance of the funding expiring next year.

I want to thank our witnesses for testifying. A special thanks goes out to Desiree Sweeney. She is the CEO of NEW Health in my district, based in Colville, Washington. It is great to have her join us today.

I also want to emphasize the importance of oversight and the topical hearings before legislating, including having Federal agencies come before this committee to comment, discuss programs and other related initiatives. I look forward to that happening.

Just a big thank you to all the members for putting forward such thoughtful solutions to these important public health issues. Thank you, and I yield back.

[The prepared statement of Mrs. Rodgers follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. The gentlewoman yields back.

Pursuant to committee rules, all members' written opening statements shall be made part of the record.

I now would like to introduce our witnesses. We have a superb panel of witnesses.

Dr. Kirsten Bibbins-Domingo is a professor of epidemiology and biostatistics and the Lee Goldman, M.D. endowed professor of medicine at the University of California, San Francisco.

Welcome to you.

Dr. Kevin Croston is the chief executive officer of North Memorial Health. He is testifying today on behalf of the Trauma Center Association of America.

Ms. Tanika Gray Valbrun is the founder and president of the White Dress Project.

Mr. Michael Shannon is the executive and president of the Government Solutions at IP Talents, Incorporated. He is also the former director of the Office of Management Assessment for the National Institutes of Health.

Ms. Desiree Sweeney is the chief executive officer of NEW Health.

Dr. Leslie Walker-Harding is the Ford/Morgan endowed professor and chair of the department of pediatrics at the University of Washington. She is also the chief academic officer and senior vice president at Seattle Children's

Hospital.

Thank you to each one of you. It is an honor to have you with us today, and we look forward to your testimony.

For witnesses testifying in person, you are probably familiar with the lights in front of you. You have one minute remaining when the light turns yellow. Please stop when the light turns red.

Dr. Bibbins-Domingo, you are now recognized for five minutes, and thank you again for joining us.

STATEMENT OF KIRSTEN BIBBINS-DOMINGO, PH.D., M.D., M.A.S., PROFESSOR OF EPIDEMIOLOGY AND BIOSTATISTICS AND THE LEE GOLDMAN, M.D. PROFESSOR OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO; KEVIN CROSTON, M.D., CEO, NORTH MEMORIAL HEALTH; TANIKA GRAY VALBRUN, FOUNDER AND PRESIDENT, THE WHITE DRESS PROJECT; MICHAEL D. SHANNON, EXECUTIVE/PRESIDENT OF GOVERNMENT SOLUTIONS, IPTALONS, INC.; DESIREE SWEENEY, CEO, NEW HEALTH; AND LESLIE R. WALKER-HARDING, M.D., F.A.A.P., F.S.A.H.M., FORD/MORGAN ENDOWED PROFESSOR, CHAIR DEPARTMENT OF PEDIATRICS/ASSOCIATE DEAN, UNIVERSITY OF WASHINGTON, CHIEF ACADEMIC OFFICER/SENIOR VICE PRESIDENT, SEATTLE CHILDREN'S HOSPITAL

STATEMENT OF KIRSTEN BIBBINS-DOMINGO

*Dr. Bibbins-Domingo. Thank you very much. Chairwoman Eshoo, Ranking Member Guthrie, and members of the committee, thank you for the opportunity to testify today.

I am a general internist and a professor at the University of California, San Francisco. I am here today speaking in my capacity as a physician scientist, and as someone who has personally faced the importance of diversifying clinical research.

Two thousand seventeen was the year that the issues before this committee became urgent for me. I was then the

chair of the U.S. Preventive Services Task Force, an independent body charged by Congress with generating evidence-based guidelines on the use of preventive services. During my tenure we issued recommendations on diabetes, breast cancer, colorectal cancer, lung and prostate cancer.

In my discussion with patients and clinicians on our recommendations, I inevitably encountered a similar pattern of questions: How confident are you that these recommendations apply to me and to patients like me? Were these studies conducted in clinics like mine? You are recommending screening for diabetes and those who are overweight and obese, but my Asian patients seem to develop diabetes at lower weight. What about them? What about my Latino patients who develop diabetes at younger ages, or my Black patients, who develop colorectal cancer at younger ages? Shouldn't we start screening them earlier?

My recurring response was, unfortunately, we just don't have the studies in these populations that allow us to say with certainty whether or how to adapt our guidelines.

In 2017, this was also the year my father lost his battle with prostate cancer. My father was a career Army officer, a veteran, and a strong supporter of science and medicine. He had even served as a lay reviewer for a committee on Federal funding for prostate cancer research.

He had had excellent medical care, but as his journey with prostate cancer came to an end, the stark absence of Black men like my father in prostate cancer research became acutely distressing to me.

Prostate cancer is the most common cancer in all men in the U.S. Black men, who make up 13 percent of the population of men, are nearly twice as likely to get prostate cancer, and are more than twice as likely to die once diagnosed. Yet Black men make up only 5 percent of the participants in prevention studies, and a strikingly low 2.4 percent of participants in late-stage treatment studies.

I recently chaired a National Academies report on improving representation in clinical trials and clinical research. I would like to leave this committee with the three main takeaways from that report.

Number one, failing to achieve a more diverse clinical research ecosystem is costly. It costs us in terms of scientific innovation and the generalizability of our research. It costs us because it deprives patients of state-of-the-art treatments that are often only available through clinical trials. It costs us in the trust we seek to build in the medical and scientific enterprise across all communities in the U.S.

The data is clear that many want to participate in clinical studies but are simply never asked. And it costs us

in dollars. Our economic analysis demonstrated that the financial and social costs of health disparities in the U.S. are in the range of hundreds of billions of dollars over the next three decades. Addressing health disparities is complex, but better representation in clinical studies may help address this issue. And if only modestly so, the value would be worth billions.

Number two, despite more than three decades of stated commitment to this issue across Federal agencies, very little progress has been made. This is an issue that seemingly everyone supports, but no one is held accountable for its progress. And yet Federal agencies operating in a coordinated fashion could have immense power to improve representation. The Federal Government is the largest funder of research. It is the regulator of processes of scientific research. It is the gatekeeper to monetizing scientific discovery. And it is the purchaser of new drugs and devices. More coherence in Federal policy to align investment and accountability could achieve the goals of inclusive science.

Number three, Congress has a particularly important role right now to move us beyond the status quo, to ensure a coordinated Federal response to this issue across Federal agencies, to increase accountability towards stated goals, to ensure that we have adequate data collection so that we can mark our progress in a transparent and open manner, and to

align incentives for all in the research ecosystem to enable progress be made more quickly.

Whether you are motivated by the goal of producing the highest quality science, or by pursuit of fairness and equity in how science translates to better health for our patients, or by the enormous economic toll of health disparities in the U.S., I urge the committee to approach the issue of improving representation and inclusion in clinical research with the urgency it deserves.

Thank you very much.

[The prepared statement of Dr. Bibbins-Domingo follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. The -- thank you, Dr. Bibbins-Domingo.

The chair now recognizes Dr. Croston for five minutes.

STATEMENT OF KEVIN CROSTON

*Dr. Croston. Chairman Pallone, Ranking Member McMorris Rodgers, Chairwoman Eshoo, Ranking Member Guthrie, members of the subcommittee, thank you for holding this hearing on the Improving Trauma Systems and Emergency Care Act, H.R. 8163.

My name is Dr. Kevin Croston, I am the chair-elect of the Trauma Center Association of America, also called TCAA. I am the chief executive officer of North Memorial Health, a health system in the Minneapolis/St. Paul area of Minnesota, and a practicing general surgeon. Thank you for inviting me to speak.

TCAA is a non-profit, 501(c)(6) association representing trauma centers and systems across the country, and is committed to ensuring access to lifesaving trauma services and the financial health of our trauma centers.

For a little background, let me walk through a couple of quick definitions.

Traumatic injury is the leading cause of death for people under the age of 44, and the fourth leading cause of death of all age groups in the United States, claiming more than 270,000 lives annually. And in 1920 and 1921 [sic], incidentally, COVID-19 surpassed traumatic injury as the third leading cause of death.

According to the World Health Organization, the leading

causes of traumatic injury and death, including traffic accidents, murder, and suicide, are expected to increase substantially in the coming years, placing all three among the top 20 causes of death in the world by 2030.

Trauma centers play a key role in reducing these numbers. Care at a level 1 trauma center lowers by 25 percent the risk of death for injured patients, compared to treatment received at non-traumatic centers. In other words, the routine hospital emergency departments. This is because trauma centers are uniquely qualified to provide comprehensive, high-level acute care for patients with the most extreme injuries, regardless of the -- a patient's ability to pay. We have people waiting for their arrival, and we have specialists, a panel of specialists, available at all times.

Trauma systems are -- by contrast, they represent comprehensive networks and infrastructure to provide optimal care for injured patients, encompassing a wide spectrum, from injury prevention efforts, coordinated pre-hospital care, integrated networks of trauma centers for acute and rehabilitative care, to a concerted research agenda.

Regarding patient access and trauma center financing, there remains a significant geographic variation in the availability and accessibility of trauma care. A little over 46 million Americans lacked access to a level 1 trauma center

within the golden hour, the 60-minute period following traumatic injury during which there is the highest likelihood that prompt medical procedures will prevent death.

This deficiency is particularly acute in our nation's rural areas, as well as among some traditionally vulnerable populations -- for example, minorities, recent immigrants, et cetera, and trauma center closures disproportionately affect communities with higher proportions of minorities, the uninsured, and people living in poverty.

According to the -- an Avalere study commissioned by the Trauma Center Association of America, trauma centers report numerous financial pressures, including Federal payment reductions; increased trauma care demands, particularly among the geriatric population and from opioid-related trauma cases; the need to cover vast geographic regions; difficulty attracting and maintaining high-quality trauma physicians and other staff due to the strains of the 24-hour trauma service availability and the staffing crisis that resulted from COVID-19.

The Improving Trauma Systems and Emergency Care Act, H.R. 8163 -- in history, in 2010 Congress authorized hundreds of millions of dollars per year in Federal grants to support and sustain trauma care and systems nationwide. However, Congress has not appropriated any of the funding authorized for these programs. The Improving Trauma Systems and

Emergency Care Act would reauthorize, reorganize, and modernize Federal grant programs for the purposes of awarding pilot grants for trauma centers, supporting trauma care readiness and coordination, and awarding grants to improve trauma care in rural areas.

There are three areas of the Act. The pilot grants for trauma centers requires the Assistant Secretary for Preparedness and Response to award 10 multi-year contracts or competitive grants to states, tribes, or tribal organizations, or level 1, 2, or 3 trauma centers, or other eligible entities or consortia. These strengthen the trauma system coordination and communication. They improve situational awareness, develop and disseminate evidence-based practices across facilities, and conduct activities to facilitate research.

It also lowers the barrier for entry by providing -- by lowering awardees the current requirement in -- statutory for Federal -- non-Federal matches from 1 for each $3 of Federal funds to 1 for every 5.

Grants to improve trauma care in rural areas reauthorizes the Secretary of Health and Human Services to improve trauma care in rural areas, and by supporting research and demonstration projects.

And lastly, the trauma care readiness and coordination piece of this legislation requires ASPR again to support

states and consortia to coordinate and improve emergency services and trauma care during a public health emergency by disseminating information in a more friendly way.

*Ms. Eshoo. Doctor --

*Dr. Croston. So, in conclusion --

*Ms. Eshoo. Your time has expired. You want to just offer another sentence to close?

*Dr. Croston. Yes, thank you. Sorry about that.

Thank you again for your consideration of this important legislation, and for the opportunity to testify before you today. I am happy to answer any questions the subcommittee may have. Thank you for your time.

[The prepared statement of Dr. Croston follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Thank you.

The chair now recognizes Ms. Gray Valbrun for your five minutes of testimony.

STATEMENT OF TANIKA GRAY VALBRUN

*Ms. Valbrun. Chairman Pallone, Ranking Member McMorris Rodgers, Subcommittee Chairwoman Eshoo, Subcommittee Ranking Member Guthrie, and members of the committee, my name is Tanika Gray Valbrun, president and founder of the White Dress Project.

The mission of the White Dress Project is to raise global awareness about the uterine fibroid epidemic through education, research, community, and advocacy. It is my absolute honor to testify in support of H.R. 2007, the Stephanie Tubbs Jones Uterine Fibroids Research and Education Act of 2021.

H.R. 2007 is named in honor of the late Congresswoman Tubbs Jones, who not only championed women's health issues, but also suffered from uterine fibroids herself. I am proud to call her son, Mervyn Jones, who is here with us today, a dear friend and supporter of the White Dress Project.

H.R. 2007 is a critical step to improve research into this public health crisis, to garner data, and improve health outcomes for those living with fibroids. The critical need to address fibroids is neither a Democratic or Republican issue, as demonstrated by the Senate companion bill, but it is a health issue that impacts many women, whether they live in rural or urban America.

According to NIH, the U.S. economic burden of fibroids is estimated at $34 billion annually. Yet scientists know very little about the genomics that underlie uterine fibroids.

As the only surviving child of a mother who lost twins due to fibroids, my personal struggle with fibroids has been debilitating, and gravely impacted my quality of life. Since age 14, I have experienced heavy menstrual bleeding. I have had more than six blood transfusions due to severe anemia. I have had excessive cramping and bloating for much of my life, and many times appearing to be more than four months pregnant. I have missed out on social functions, time with my family, days off work. I was nicknamed Bag Lady because I would always have a bag of clothes with me, just in case I had an accident. I have never bought a car with cloth seats, only leather to easily remove stains; multiple days in the month calling out sick from work because I was just too tired to go; and never, ever wearing white.

I decided to seek treatment for my fibroids, and I was told that I needed a hysterectomy the first time I saw a doctor. I had to find more options, because I knew I wanted to be a mother. In July of 2013 I had 27 grapefruit-sized fibroids removed in an emergency surgery. In 2018 I had to have another surgery for fibroids. And today, as I speak before you, I still have fibroids. And it has impacted my

journey to be a mother.

After my surgery I knew that I wanted to be a champion, so I started the White Dress Project. In research conducted by our organization and Healthy Women, we found that race plays a significant role in fibroid outcomes and quality of life among women living with fibroids. They are more common in Black women than White, Hispanic, or Asian women. And fibroids typically develop in Black women at a younger age, grow larger, and cause more severe symptoms than for women of all other races.

Black women are more likely to be hospitalized, more likely to have fibroids surgically removed, seven times more likely to have a myomectomy, and two-and-one-half times more likely to have a hysterectomy, compared to White women.

Fibroids also tend to have a disproportionate impact on women living in rural areas. Typically in rural areas, access to trained OB-GYNs who feel comfortable performing certain procedures and appropriate testing is severely limited.

I would also like to address the lack of diversity in clinical trials. Genetic studies on fibroids, particularly for Black women, have been limited for a variety of factors, leaning toward a mistrust of the medical community as a result of Tuskegee syphilis studies and the Henrietta Lacks cancer cells processing. Thus I fully support H.R. 7845.

In conclusion, almost 20 years ago, in a 2007 op ed, the late Congresswoman Tubbs Jones wrote, "Women deserve better,'' and I absolutely believe they still do. By passing H.R. 2007, Congress would be taking a step toward prioritizing the health care and quality of life for women across the United States.

A special, special thank you to Congresswoman Yvette D. Clarke for her unwavering advocacy of this issue, and for serving as a congressional champion.

To the committee, I sincerely thank you for listening to my testimony today and your support of H.R. 2007 to improve the lives of millions of women who are dealing with uterine fibroids.

And thank you to everyone who has shared their story. We must continue to share.

[The prepared statement of Ms. Valbrun follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Ms. Valbrun, thank you for your superb testimony. You really honor our late colleague, Tubbs Jones, and I want to welcome her son to our hearing today, as well. So a very special thanks to you.

Mr. Shannon, you are recognized for your five minutes of testimony.

STATEMENT OF MICHAEL D. SHANNON

*Mr. Shannon. Good morning, Chairman Pallone, Ranking Member McMorris Rodgers, Ranking Member Guthrie, and Chairwoman Eshoo, and members of the subcommittee. I am speaking today as an expert witness on oversight and internal controls reinforcing research security associated with federally-funded research and development.

I am president of the Government Solutions for IPTalons, Inc., which is a managed service risk and research security company. I am formerly a member of the Senior Executive Service and Director of the Office of Management Assessment for the National Institutes of Health. I thank you for the opportunity to appear before you, and discuss three pieces of legislation related to disclosure requirements, participation in foreign talent programs, and protecting America's biomedical research enterprise.

I am not representing the NIH or the Federal Government, but rather appear before you as a citizen with unique knowledge of government oversight and expertise in the subject matter at hand. Any comments I may make related to operations in my statement here or during questions are limited to my experience up to the time that I left my position in January of 2021.

I left Federal service to engage more directly in the

protection of the U.S. research enterprise from risk associated with non-compliant actions and malign foreign activity intended to take advantage of those actions. I joined my business partner, Allen Phelps, in building IPTalons to provide specialized research security services, training, and tools in support of this aim, as recognized thought leaders in this area were regularly asked to assist in identifying solutions balancing the burden on awardees with the need for stewardship and accountable due diligence.

International collaboration is absolutely essential for innovation, discovery, and the benefit of science to all humankind. Transparency and reciprocity are the glue holding mutually beneficial research relationships together. As with any endeavor, trust and due diligence protects efforts and promotes best outcomes.

I have provided an extended review of the legislation in my written response, but would like to speak to some specific points here.

We have all heard FBI Director Wray correctly say we cannot arrest our way out of this issue. The rest of that statement could be because the issue of conflicts of interest, commitment, and foreign influence are often primarily compliance issues. Early emphasis on criminality rather than compliance resulted in many missed opportunities and -- to remediate risk, and contributed to an inaccurate

perception of the actual scope and scale of the problem, by pointing to just a few high profile events as indicia of a smaller problem.

We have heard some tout resignations and terminations as a sign of activity and success. However, a loss of a researcher is not a win for anyone. Focus on terminations and resignations often fails to address compliance, can lead to a lost opportunity to understand the full impact of the risk, and foments distrust among researchers and research administrations. We advise a restorative approach. Focus should be on restoring and maintaining compliance whenever possible and appropriate among federally-funded research programs and persons.

Unreported affiliations and support have been a persistent problem for over two decades because of a lack of consistent oversight and internal controls. Individuals and nation state actors have exploited the open and collaborative environment. The issue is one of individuals making decisions, wittingly or unwittingly, influenced or independently, leading to non-compliance.

Research security programs must be a part of the pre-award process and periodic reporting cycle to identify potential risk of unreported affiliations and support. Applicant organizations and awarding agencies must better validate certifications of complete and accurate submissions

at the application and throughout the life of the award.

There is concern about discriminatory activity targeting specific persons and ethnicities. Avoiding prejudice is essential, and focus on conduct is the only valid indicator of misconduct. Unfortunately, these allegations have also been used to deflect attention from exploitive activity. It is important to understand that this issue is about conduct, not culture. Allen and I have conducted thousands of investigations on these issues. And although one state is, by far -- nation state is, by far, the most prolific offender, offenders are of all stripes.

Legislation, policy, and guidelines should focus on requiring and enabling authorities to fix and find issues -- find and fix issues. Where violations of law is found, proper referral is made. However, in most cases, restoration to a compliant posture is possible.

As much as possible we must focus on the elimination of risk, rather than people, because it is more appropriate to the threat and essential to U.S. research, innovation to retain those persons and their contributions mindfully and accountably. Congress should demand stewardship and due diligence on behalf of the U.S. taxpayer as a requirement for an awarding agency and a condition for award recipients. The bills before you take steps in the right direction.

I thank you for the opportunity to appear before you,

and I am happy to answer any questions you may have.

[The prepared statement of Mr. Shannon follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Thank you, Mr. Shannon.

I am now pleased to recognize Ms. Sweeney for your five minutes of testimony.

STATEMENT OF DESIREE SWEENEY

*Ms. Sweeney. Thank you. First of all, I want to say thank you, Chairman Eshoo, Ranking Member Guthrie, Chairman Pallone, Ranking Member McMorris Rodgers, and members of the committee. Thank you for the opportunity to testify today.

My name is Desiree Sweeney, and I am the chief executive officer at NEW Health. We are a community health center serving rural northeast Washington State. We were founded in 1978, and today we provide primary medical, dental, behavioral health, and pharmacy services to more than 16,000 patients annually, and employ over 150 staff members. Three-quarters of our patients are insured through Medicaid and Medicare, or are uninsured. With -- 80 percent of our total patients are low income. We operate seven medical and three dental locations within our three rural counties, which are connected by three mountain passes. One of our counties we serve meets the frontier definition of fewer than seven people per square mile.

NEW Health is part of a system of 1,400 community health centers that make up the largest primary care network in the nation, serving nearly 29 million patients.

Health centers have been able to thrive because of the incredible support this committee has shown over the 50-year history of the program. In the spring of 2020, NEW Health

purchased a mobile clinic that is equipped to provide both medical and dental services. While we are rural, our population is rapidly increasing, and we are at capacity and utilizing the space of all of our locations, and are quickly working to expand physical space.

As a health center serving communities in rural and frontier communities, we have to also recognize that not all of these communities can support a full time brick-and-mortar site. Our new mobile clinic is a cost-effective alternative that breaks down transportation and access barriers for our patients by going beyond the traditional four walls of the clinic. The communities that we serve are home to a high number of older adults. Bringing health care services closer to our patients' homes is essential to help patients gain access to care.

While some of our communities have access to fiber internet, the vast majority of our service area have historically lacked internet and adequate cell phone signal. Broadband infrastructure development is a high priority in northeast Washington, but until we have better infrastructure many residents have limited access to telehealth and must access health care services in person. The mobile clinic expands our ability to connect patients with health care.

Importantly, the mobile clinic allows for services to be tailored to specific populations. When we evaluated our

community gathering locations in our rural communities to evaluate where to -- we could take the mobile clinic, the most common public locations included our K through 12 schools, our libraries, and our VFW halls.

With nearly 10 percent of our population residing in our service area being veterans, some individuals are mistrustful of a brick-and-mortar clinic, and we are hoping to reach these patients through the mobile clinic when it is parked at their local VFW.

Every year our region in Washington State is impacted by wildfires. These camps are often set up in remote locations. And if we could have that mobile clinic closer to that, then we could ensure the safety of the firefighters.

I want to thank the committee for considering H.R. 5141, the Mobile Health Care Act. I, along with National Health Service, National Association and Community Health Centers support this bill because it will authorize mobile units specifically as part of HRSA's New Access Points Grant authority. The bill will facilitate more mobile units and provide greater care in the community.

I would also like to speak to the Building a Sustainable Workforce for Healthy Communities Act. In 2023 we will bring in community health workers in the role of a patient navigator. Our navigators will focus on social determinants of health by connecting patients with food, housing, and

other resources. It is important for these positions to understand local needs and be a trusted resource.

Many of our patients rely on firewood in the winter months, and we have even had patients who have run out of firewood, and we were able to connect them to local resources. Developing funding mechanisms to increase the utilization of community health workers would help health centers and other organizations in serving low-income and vulnerable patients.

H.R. 8151 will ensure continued resources for the important work of community health workers and support primary care at 1,400 health centers across the country.

Again, I appreciate the opportunity to share my thoughts and experiences from NEW Health as the committee debates these pieces of legislation. I know our patients will benefit from the new mobile clinic, and believe health centers across the nation will also benefit with the mobile act passed.

Additionally, H. 151 [sic] would able increased utilization of community health workers.

Thank you, and I welcome any questions.

[The prepared statement of Ms. Sweeney follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Thank you, Ms. Sweeney.

The chair is now pleased to recognize Dr. Walker-Harding for your five minutes of testimony.

STATEMENT OF LESLIE R. WALKER-HARDING

*Dr. Walker-Harding. Wonderful. Good morning, Chairman Eshoo, Ranking Member Guthrie, and members of the subcommittee. And thank you for convening this hearing on this most important topic, and for inviting me as a witness.

My name is Leslie Walker-Harding, and I serve as chair of pediatrics at the University of Washington School of Medicine, and as senior vice president and chief academic officer at Seattle Children's Hospital. I am a practicing adolescent medicine pediatrician. I serve as an executive committee member of the Pediatric Scientists Development Program, run by the Association of Medical School Pediatric Department Chairs. And I serve as a member of the Steering Committee on the Coalition of Pediatric Medical Research.

I will focus my testimony primarily on H.R. 3773, the Pediatricians Accelerate Childhood Therapies Act, which is led by Dr. John Joyce and my good friend -- and the only pediatrician serving in Congress today -- Dr. Kim Schrier. And that was co-led by another health policy leader from Washington State's delegation, Ranking Member McMorris Rodgers in the last Congress.

The PACT act, as well as the NIH Clinical Trial Diversity Act, which is also on the agenda, focuses on three core principles that are needed to achieve more research

breakthroughs for children and other populations.

First, the PACT Act recognizes that a robust pediatric research workforce, including a pipeline that produces early career researchers, is fundamental to achieving breakthroughs that will lead us to new therapies and cures for children. Simply put, if we don't attract and retain the next generation of pediatric scientists to the field, children and adolescents will continue to suffer the effects of diseases and syndromes that impact them through adulthood.

The PACT Act also recognizes that our pediatric research workforce needs to better reflect the diversity of our nation's children. The lack of diverse representation in pediatric researchers limits the diversity of questions asked and studied, resulting in fewer solutions to be applied to improve the health of all children.

And the NIH Clinical Trial Diversity Act recognizes that our clinical trials need to better reflect our nation's population, particularly when it comes to the very patients that candidate therapies are intended to treat. The core of the PACT Act would authorize the National Institutes of Health to create a career development award that focuses on developing early career researchers who are focused on pediatrics, particularly those researchers from populations that have been historically under-represented in the field.

Supported by the American Academy of Pediatrics and the

Children's Hospital Association, let me briefly describe the challenges that we are navigating. Developing our next generation of researchers is a top priority of my institution. We have several programs focused on this initiative.

To attract a wide range of early career scientists with diverse lived experience at Seattle Children's, we created three-year awards to support MDs and PhDs just after the completion of their post-graduate training, so they can benefit from mentorship and funded needing -- needed to be successful in acquiring NIH funding. Unfortunately, programs developing promising pediatric researchers into impactful scientists are not sustainable or feasible for most academic or children's hospital programs to fund indefinitely. We need the PACT Act to supplement what our institution and others are doing.

Pediatric research faces a number of particular challenges that are unique or more pronounced compared to other fields. Children are a smaller proportion of the overall population, and thus pediatrics has a more challenging time competing against fields focused on adults. Children's hospitals are more heavily reliant on public programs, notably Medicaid and CHIP, which pay less than commercial payers and Medicare, and often do not cover the full cost of clinical care, leaving less revenue to devote to

research activities.

To fix these challenges, I urge Congress to enact the PACT Act, which would create a career development award program to support outstanding early career researchers focusing on pediatric research. Awards would go to individual researchers, and could also support training programs involved -- involving research entities and minority-serving institutions to help develop more researchers from under-represented populations. By focusing awards on individual researchers, the program would favor -- not favor only those in largest institutions, but cast a broad net for talent.

You might ask, "Why now?'' Not acting now to create this opportunity that builds upon the 21st Centuries Act [sic] would only set us further back in the overall health of the nation. Science is at a crossroads with technological advances and with ARPA-H passing the House last week. The country is poised to leap ahead with biomedical innovation, as we did in technology with DARPA. A shortage of pediatric researchers to engage in this scientific renaissance will prevent us from realizing our potential to discover major breakthroughs and cures for children that result in advances over the lifespan.

I thank you for including the PACT Act on this agenda, and I look forward to answering any questions on the bill.

[The prepared statement of Dr. Walker-Harding follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Thank you, Dr. Walker-Harding.

And to each of our witnesses today, you have more than enhanced this hearing with your expertise.

We will now move to members' questions. I recognize myself for five minutes, first to Dr. Bibbins-Domingo on clinical trial diversity.

Doctor, the House recently passed the DEPICT Act legislation that I wrote to increase clinical trials diversity by requiring drug sponsors to submit to the FDA a diversity action plan for later-stage pivotal trials. Would you share for a moment why it is important for researchers to also consider and plan for diverse participants in earlier trials, including trials funded by the NIH?

And do you support 7845 and 6586 becoming law? And if you don't, why?

*Dr. Bibbins-Domingo. Thank you very much for those questions.

I am really pleased that there -- at the efforts to spur the type of diversity and inclusion in trials from the drug companies that are seeking approval from the FDA. To really achieve our goal, though, we have to have diversity and inclusion at all phases of research. And that is why it is very important that there be a focus on the NIH. The NIH is the largest funder of the research that really underlies all of our drug discovery. It is the basis on which we know

information that goes into how we develop drug trials.

Quite simply, we need to have studies in the populations for whom our drugs, our devices, all of our innovations are intended. And so from purely a standpoint of generalizability, we should be including the populations who are affected by the diseases and the conditions that we are seeking to try to understand, and then develop drugs, devices, other interventions to be able to do. So a focus on the NIH is very appropriate.

Simple things like genetic diversity, which one of the speakers talked about, our genetic studies are mostly in White populations. And so just on that basis alone, we are often times not considering the full diversity and heterogeneity that might underlie genetic basis for some types of conditions --

*Ms. Eshoo. Great, thank you very much.

To Dr. Walker-Harding on pediatric research, I was really taken aback to learn from your testimony that, despite being several years into recruitment of the NIH's precision medicine All of Us program, that the program has yet to implement a child recruitment strategy. After the delay of the COVID vaccine for the pediatric population, I think that there are many Americans that are fed up with kids being a second thought when it comes to medical research.

What should the NIH be doing to include more children in

All of Us?

And how will the PACT Act improve pediatric research?

*Dr. Walker-Harding. Wonderful. Thank you. Yes, I share some of the same feelings.

I think one of the things is to think about kids. A lot of times, as I mentioned, there are so many more adult illnesses and people working in adult medicine that pediatrics sometimes is thought of second, and especially in research. Even in the IRB, people worry, should we be looking at kids first? Shouldn't we look at adults? It is safer. It -- you know, it is just different. It is not safer.

*Ms. Eshoo. But what should the --

*Dr. Walker-Harding. And I --

*Ms. Eshoo. -- NIH -- excuse me --

*Dr. Walker-Harding. Yes.

*Ms. Eshoo. What should the NIH be doing to include more children in this program, which is called All of Us?

*Dr. Walker-Harding. I think we have to start putting the plans together to actually have them start being recruited, doing the actual work.

I think there has been a lot of time in planning, and less in doing -- actually just signing people up and getting them there. The people are there. People want to enroll their kids. We just have to start doing it.

*Ms. Eshoo. Okay, well --

*Dr. Walker-Harding. And I think the PACT Act -- what I would say, too -- the PACT Act is important because we need the researchers who are interested in pediatric research ready, and standing ready to interpret and make sense out of the data that is collected.

*Ms. Eshoo. Okay. Thank you very much.

I will yield back and recognize the ranking member of the -- of our health subcommittee, Mr. Guthrie, for your five minutes of questions.

*Mr. Guthrie. Thank you, Madam Chair. What a great hearing, and what wonderful testimony: pediatric research; focusing on women's health; diversity in our studies to make sure we get our studies that reflect the makeup of America is absolutely important. So thanks for doing that.

I am going to focus on the security of our intellectual property and NIH in my questions. And these are to Mr. Shannon.

You know, there was an IG study that looked at 770 grantees, 617 responded. Two-thirds of the respondents found certain issues with disclosure about investment in foreign -- of the proper disclosures. That means 153 didn't even respond. And I think, being a statistics person myself, you can probably figure that population is biased by people who, if you didn't respond, either you just didn't make the effort

or you have something to hide for not responding. So I think we could even assume it is a higher number than two-thirds.

So the question is, why isn't the NIH taking this more important -- making it more important to them? It just -- are they willfully turning their eye? Is it -- or are they just indifferent, and why is this such an issue that we [inaudible] before?

And also, I think, as we move these bills forward, if 153 grantees just don't respond to the IG, maybe we should look at banning them from future research if they don't respond to the IG as we move forward.

But -- so Mr. Shannon, why is the NIH so lax in this area?

*Mr. Shannon. Well, there are a couple of thoughts to that.

I don't think it is a willful -- necessarily, in all cases, a willful desire to avoid answering the question. I think, first, the question has not been asked for quite some time.

I also think that it is difficult to have a cohesive plan when there is no specific cohesive strategy to address this.

Awardee compliance absolutely should be -- they should be held accountable for compliance. And they have requirements under the grants policy statement and the grant

agreement that they have signed to receive those funds. And the --

*Mr. Guthrie. Well, let me just -- I am going to interrupt.

*Mr. Shannon. Yes, sir.

*Mr. Guthrie. But you said that this question hasn't been asked in quite some time. It is asked in every grant, isn't it?

*Mr. Shannon. Oh, that is correct.

*Mr. Guthrie. Okay.

*Mr. Shannon. I was specifically thinking of the question of conflicts of interest and the like that -- those questions are asked in general in every grant. And some of the legislative efforts here today get more specific, although I caution against specific titles for various programs, because, on a wider perspective, to avoid that, you just change the title.

But awardees struggle from everything from the increased burden of being able to provide this oversight. Their sense that I am hearing from them often times is, well, this hasn't been something that has been paid attention to. And that is, quite frankly, true. There has not been an initiative to provide the type of in-depth oversight or accountable process to audit whether or not -- and validate and verify whether or not those certifications are complete and accurate when they

are answering that question.

So -- and we see the numbers even larger, perhaps, that -- based on our company's investigative research, just our data alone, indicate that up to 85 percent of U.S.-based researchers with federally-funded research have some type of foreign affiliation that is -- may not be reported. Now, not all of those are -- that is not an indictment of anyone. Not all of those are bad. But those all indicate the potential for non-compliance. And that is why my emphasis was on compliance.

*Mr. Guthrie. Thank you. I think -- yes, I was going to ask you that next. Just because it has foreign connections doesn't make it necessarily bad research.

What do you think the risk is of -- out there, since we are not getting the disclosure we are supposed to be receiving? And hopefully these bills will actually force NIH to do that.

What do you think the risk is out there that, if researcher A is working with researcher B that has -- in a common interest to solve a problem for humanity that is -- from a foreign country, that is fine. But if researcher A is working with researcher B, who is from an antagonistic country, or a country that is an adversary for ours, that is an issue and risk. What do you think is the actual risk out there?

I have about a minute left, less than a minute. If you would just talk about the actual risk that we are facing, and I will yield back after you finish.

*Mr. Shannon. Certainly. The risk is substantial, particularly from non-compliance. The key is transparent and reciprocal relationships. Everybody wants international collaborations. We all benefit from that, and that is the way it should be. But when that relationship is not transparent or reciprocal, or an individual is seeking to benefit themselves as a result of that, that is where you fall into problems. So the risk is --

*Mr. Guthrie. And how common do you think that is? I am sorry. How common do you think that is -- the second version you just said.

*Mr. Shannon. As I said, our data suggests 85 percent have some type of foreign affiliation. The percentage of those who are doing that intentionally to enrich themselves is probably at about five percent, based on our investigative data.

*Mr. Guthrie. Okay. Thank you. Thank you, you finished right on time.

My time is up and I yield back. Thank you, Madam Chair.

Thanks for your testimony, and all of the other witnesses, as well.

*Ms. Eshoo. The gentleman yields back. The chair is

now pleased to recognize the chairman of the full committee, Mr. Pallone, for your five minutes of questions.

*The Chairman. Thank you, Chairwoman Eshoo. My questions are related to the NIH Clinical Trial Diversity Act of 2022.

Earlier this year we considered clinical trial diversity policies in the FDA user fee package. And without clinical trial diversity, we lack robust data on the very groups that the drug device or biological product was intended to help, and the populations most impacted by certain diseases. So I wanted to ask Dr. Bibbins-Domingo.

In your testimony you say that Congress has a particular role right now to move us beyond the status quo. And I wanted to ask, what is the role that Congress has, in your opinion?

And then what is the cost of not improving diversity in clinical trials, economically and otherwise, if you would?

*Dr. Bibbins-Domingo. Yes, thanks for that question. I think what is lacking is coordination across the various agencies, Federal agencies, that have a responsibility for funding, for regulating, and for oversight of our clinical research enterprise.

Right now, one of the most shocking things in our report was that we couldn't find the information. You can't find the information right now today on how many -- on the

demographics of people who participate in clinical research in the U.S. You can find from the FDA those drugs that have been approved, and the demographics of those, but we don't know anything about all of the studies that are out there. It is very hard to find those things, even with clinicaltrials.gov reporting.

And so I would urge there be an annual report to Congress. That is one of the recommendations in our report that has -- across these agencies can really highlight across various characteristics, demographic characteristics, regional characteristics, participation in the clinical research enterprise, the progress that is made over time because that is what is needed. The data, the accountability, and the reporting is needed in order for these Federal agencies to work together to achieve these goals.

*The Chairman. All right. Thanks a lot. I wanted to shift gears and speak briefly about some of the barriers to care that low-income populations face, and how H.R. 5141 -- that is Representative Lee's Mobile Health Care Act -- may help to improve access.

So, Ms. Sweeney, in your testimony you mentioned that NEW Health serves -- or N-E-W Health service -- serves a rural area where transportation is a problem. And given the low-income population you serve, I assume a lot of your

clients don't have access to reliable transportation. Is that right?

I mean, you can just say yes or no, but is that correct?

*Ms. Sweeney. Yes, that is correct.

*The Chairman. Okay.

*Ms. Sweeney. We do not have public transportation.

*The Chairman. All right. So can you describe how you have been able to use your new mobile health unit to increase access to care?

*Ms. Sweeney. So we received our mobile unit. We ordered it in 2020. And because of manufacturing we received it just recently this year. And so we are currently using that programing. So we haven't rolled it out to date, but when we do that programing, then we will definitely address that. So we have already done the planning and the conversations.

And you know, food banks are one area that we have really identified that patients can access. And so we have already talked to our stakeholders and partners at food banks, the K-through-12 schools, and the VFWs to get that programing. So that will be one way that we have -- you know, we will be able to address those barriers.

And then the second way, as we learned during the pandemic, when we really needed to get out into hot spots and hot zones, we can definitely deploy that out into our units.

And so we have already worked with our local health district to identify future opportunities to support health needs as they arrive.

*The Chairman. All right, then. Let me ask you one more -- one last question.

Your clinic used Federal COVID funds to set up the mobile clinic, but the Mobile Health Care Act, you know, Representative Lee's bill, would allow the New Access Points funds to be used to establish similar mobile clinics.

So how important was this Federal funding in helping NEW Health to set up a mobile clinic? I mean, would you have been able to do it without it?

*Ms. Sweeney. We would not. We had been watching and had internal strategy conversations to how would we be able to afford a mobile unit. We identified a need, but we just weren't able to bring it on with the funding that we had.

And so, with the opportunity of the COVID funding, we were actually able to bring that need and that service line into our communities.

*The Chairman. I am just asking you, because I think, you know, we want to highlight that, you know, Federal support is critical to help, you know, that that is really important, you know, in order for you to get up and running, and others that would be similarly affected. So thanks again.

Thank you, Madam Chair.

*Ms. Sweeney. Thank you.

*Ms. Eshoo. The gentleman yields back.

The chair now recognizes the ranking member of the full committee, Mrs. McMorris Rodgers, for your five minutes of questions.

*Mrs. Rodgers. Thank you, Madam Chair. I join in thanking all the witnesses for your testimony today. Very helpful and insightful. I wanted to start with Mr. Shannon.

The Protect America's Biomedical Research Enterprise Act requires the Department of Health and Human Services to evaluate ways to better protect intellectual property and sensitive medical information used in biomedical research from national security risk and related threats. Would you explain the differences between compliance research and security and research as it relates to foreign influence and other conflicts?

And do you think that there needs to be more awareness in the research community about these differences?

And what are the roles of the individual research institutions and academia versus the role of Federal agencies in these matters?

*Mr. Shannon. Certainly. Thank you for the question.

So there is a difference between research integrity and research security, and that is kind of a distinction that I

think your question gets after.

Research integrity. I had a conversation with Dr. Nakamura when I first joined NIH. He was the director of the Center for Scientific Review, and he was concerned about misconduct among scientists. And I said, "What kind of misconduct, like data manipulation or plagiarism?'‘

He said, "No, that is research integrity.'‘ And so he explained that we were talking about scientist -- non-scientific misconduct.

Well, fortunately, we came up with a much easier way to say that: research security. Research security focuses on the protection of the information, the -- ensuring that the access to information is not abused, and that the process has integrity, but for the purpose of ensuring that it is a closed system.

So when you -- when an awardee or an applicant submits a grant application to the peer review, for example, that they know that their intellectual property is going to be protected by the agency they have submitted it to, and trusts that they will get a fair hearing, and there will be a fair playing field. We know that that has not always been the case. Peer review is an amazing process, but it has some vulnerabilities.

Similarly, at the university level or at the awardee level, whether it is lab or university, the integration of a

security review into the pre-award process is almost never done. It is starting to be done. But prior to recent events, it has not been.

And so why is that important? Well, there are implications when you receive certain types of awards that can affect the cost on that award. And research security is one of those, depending on the level and sensitivity of the award to be granted.

So it also encompasses things like ITARs and CFIUS protection of information that might be limited or restricted by Commerce or the State Department.

*Mrs. Rodgers. Okay.

*Mr. Shannon. So all of those things, rolled in, contribute to the security posture.

*Mrs. Rodgers. Thank you. I -- as you know, the Fix Nondisclosure of Influence in Health Research Act, H.R. 5442, requires NIH to report actions taken to ensure compliance with foreign influence disclosure requirements. However, there are many non-compliance cases which do not include questions of undisclosed conflicts.

Are there other areas vulnerable to conflicts that would benefit from increased transparency and disclosure, such as the peer review process?

*Mr. Shannon. Definitely the peer review process, and certainly, at the awardee level, those persons submitting

those applications need to -- there needs to be a way -- and there is -- to vet and identify or verify what is disclosed. Right now it is an honor system. And most people are honorable within that system. However, when it is purely an honor system, those who are dishonorable tend to be able to take advantage of that.

I would also say it is important that not just at the award level do you need to have that kind of protection, but also intramural programs. NIH, for example, has a very large intramural program. They are faced with the same challenges as the research awardee community. So that is --

*Mrs. Rodgers. Thank you.

*Mr. Shannon. -- another area that I would point out.

*Mrs. Rodgers. Good, good. I appreciate your insights there. I just have some other questions I want to ask, too.

*Mr. Shannon. Certainly.

*Mrs. Rodgers. Ms. Sweeney from my district, the Rural Telehealth Access Task Force Act will create an inter-agency task force to help identify barriers to telehealth services in rural areas. I wanted to ask if you would speak to how NEW Health has utilized telehealth, and any barriers that you have faced along the way.

*Ms. Sweeney. Yes. I think one of the most important things is to recognize, as you know, being in our district, many of our constituents still have dial-up internet and cell

phone service is not 5G, it is 3G at best, if we have service. So thank you for that question.

Broadband investments are critically needed for how -- for our service area. And I support this bill because it would look at how we address barriers to adoption of telehealth. So even at the height of our pandemic, our telehealth was about four percent of our patient population, at best, and the majority of those were telephonic because our patients just did not have access to that. And so, you know, we really understand those challenges, and broadband is just such a challenge.

One thing I want to address, too, is the lack of infrastructure. And so --

*Ms. Eshoo. The gentlewoman's time has expired. This is an important area. Maybe someone else can continue pulling this thread. So we need --

*Mrs. Rodgers. Thank you.

*Ms. Eshoo. -- to go to -- yes.

*Mrs. Rodgers. I yield back.

*Ms. Eshoo. The gentlewoman yields back to -- the chair recognizes the gentleman from North Carolina, Mr. Butterfield, for your five minutes of questions.

*Mr. Butterfield. Thank you, and good morning, Madam Chair. It is good to see all of you this morning. And thank you to the chair for your leadership. And thank you for

convening us, and just leading this subcommittee into great, great destinations. You have done great work during this session, and we thank you so very much.

And to the chairman of the full committee, and to both of the ranking members, thank you as well for your service.

This committee -- let me just say to the witnesses -- and thank you for your testimony. I heard all of your testimonies, and they were very powerful and very relevant. And just thank you for your resource and for your intellect.

Let me just start with Dr. Bibbins-Domingo.

Dr. Domingo, this committee has a very, very strong record of supporting clinical trial diversity measures. And I am so glad to see the NIH Clinical Trial Diversity Act's inclusion in today's hearing is now before us.

I have worked with Dr. Francis Collins over the years, and we are going to miss him dearly. But every time we met with Dr. Collins he would always stress the importance of including minorities -- African Americans, if you will -- in clinical trials. And so this bill that we have today will help move the needle on health disparities by building on NIH's current work to strengthen participation in clinical trials by unrepresented populations.

And so my question to you is, in your testimony you stated that lack of representation may compound low accrual that causes many trials to fail. You also stated that under-

represented populations are just as likely to want to participate in clinical trials as other groups, if they are given that opportunity. And so I am interested in the connection, if you will, between these two statements.

*Dr. Bibbins-Domingo. Yes, thank you very much. It is often times a misunderstanding to say that we face the state of under-representation because these communities and these populations don't want to participate in studies. And we often talk about the past wrongs. Those are really important issues, and we have to do everything to build trust.

But the data on this is quite clear, that when people are asked, minority populations are no more likely or less likely to want to participate in studies. And in fact, in many cases for conditions that they are affected by, they are more likely to want to participate. We do --

*Mr. Butterfield. Well, can you explain --

*Dr. Bibbins-Domingo. -- have to address many of the barriers --

*Mr. Butterfield. Yes, that is --

*Dr. Bibbins-Domingo. Go ahead.

*Mr. Butterfield. Yes. Can you explain how NIH Clinical Trials Diversity Act will encourage participation in early-stage clinical trials, and how that participation will help solve the problem?

*Dr. Bibbins-Domingo. Yes. I think that we have to

basically not put the burden on the communities that are not participating, but rather put those processes in place at the funding level at the NIH, and then with the investigators to say this is a priority, and therefore we need to invest and enroll these populations and, as funders, need to hold those accountable who have received NIH funding.

And I think, by --

*Mr. Butterfield. Thank you.

*Dr. Bibbins-Domingo. -- setting the clear targets, this will achieve those goals.

And I do think this is also an issue of accrual for trials. As you probably know, many trials don't reach their accrual targets. And it is important that, if we build the infrastructure to enroll the populations that should be represented, we likely will have more of an opportunity to actually reach those targets.

*Mr. Butterfield. Thank you. Let me now move over to Dr. Walker-Harding.

Dr. Harding, I would like to pivot, if I can, to the research security policies before us today. Research security. The contributions of immigrants to the American scientific landscape cannot be understated. Since the year 2000, American immigrants have won 39 percent of U.S. Nobel Prizes in physics and chemistry and medicine. It is clear that our nation's institutions and universities benefit

greatly from foreign biomedical workers.

And so the bills before us seek to promote the security of federally-funded biomedical research by evaluating better ways to protect intellectual property and sensitive medical information and other biomedical research and development of products from national security risk and threats. And so I agree that we must protect our research enterprise, but we must do so with a balanced approach that does not impede America's position as a trustworthy global partner and leader.

It looks like I am running out of time. I am not going to be able to get through my question, Madam Chair. I am very respectful of time, and so thank you so very much. I yield back.

*Ms. Eshoo. The gentleman yields back. And thank you, Mr. Butterfield. We are just going to so miss you. I don't know how else to say it. You are such a --

*Mr. Butterfield. Thank you.

*Ms. Eshoo. -- really a high-value member of our subcommittee. Thank you to you.

*Mr. Butterfield. Thank you so much.

*Ms. Eshoo. The chair is pleased to recognize one of the doctors on our subcommittee, Dr. Burgess of Texas, for your five minutes of questions.

*Mr. Burgess. Thank you, Chair Eshoo. Thank you for

having this hearing today.

Every one of these witnesses today is fascinating. There won't be enough time to get to all the questions that I have in front of me. And I would just tell each of you, you can expect questions for the record to be coming your way.

I just want to underscore something that our ranking member, Cathy McMorris Rodgers, said at the outset of this hearing. We are -- we have got 11 public health bills in front of us. Most of them will concern the Department of Health and Human Services, the National Institute of Health, and we have no Administration witnesses in front of us. And in fact, over the term of this Congress we have had very little in the way of participation of Administration witnesses at a time when we are in a once-in-a-century pandemic.

And Chairman Pallone, I have written to you several times about what appears to be the passivity of this committee -- which is unfortunate, because we are one of the premiere research committees in the United States House of Representatives. But we -- I don't feel we have done our work.

Today we had an opportunity to perhaps hear from some of those agencies. But again, we are not. We do have good witnesses, and I don't want to diminish what they are bringing to the discussion, but there is a lot of work that

is left undone.

And so let me just point out that Chairwoman DeGette, in an Oversight and Investigations Subcommittee hearing a year ago promised a hearing -- promised to me, individually -- a hearing on the originations of the coronavirus, the COVID origination hearing. And to the best of my knowledge, we have not had such a hearing. And again, we desperately need it.

Mr. Shannon, who is with us here today, certainly your expertise is one that we value. I think you bring a lot to the discussion. Let me just ask you, since you worked at the NIH until January of 2021, do you think the NIH considers itself to be a leader in global health research?

*Mr. Shannon. I do. NIH is a global collaborator, and rightfully so.

I think the -- although I think the U.S. is more innovative than most, it doesn't have a corner on the market of good ideas. So I think that is an important consideration, that we must have international collaboration. But we have got to do our due diligence to protect that collaborative relationship, and make sure that it is transparent and reciprocal.

And there are some -- there are solutions. You know, a national research security standard, for example, would be very helpful to help NIH have a cohesive strategy, and even

consideration of expansion of the IG opportunity. So there are things that can be done to help NIH be even more diligent in their global activities, which are absolutely necessary to the benefit of our research and development enterprise.

*Mr. Burgess. Well, thank you. You actually anticipated and answered my next question, but it just underscores the point: the NIH is going to be collaborating with foreign entities and researchers, and we have to have the proper measures and procedures in place to -- certainly to protect Americans. But as we have seen in the global pandemic, we want to be certain we protect the world at large.

Let me just ask you this. To your knowledge -- and I realize that you concluded your term in January 2021 with the NIH, but did the United States federally fund gain of function research?

*Mr. Shannon. I -- sir, I have no idea. I am not -- I wasn't privy to any of the discussions on the scientific side of things. I was oversight and compliance.

A question on whether or not a grant was appropriately used on any type of deliberative research would be brought through the extramural research compliance arena.

*Mr. Burgess. Well, let me -- my time is going to run out, so let me ask you this question. Would it have been appropriate to engage in this type of research in an

adversarial country?

And I think we have to agree that China, Russia, and Iran would be adversarial countries. Would that be problematic, if research was conducted in one of those labs?

*Mr. Shannon. Again, sir, I think there are circumstances where international collaboration may include countries that are adversarial or not.

You know, again, the decision and discussion process through the peer review and the laws and requirements that allow what type of research to be done, I don't have knowledge on whether or not --

*Mr. Burgess. Let me --

*Mr. Shannon. -- that grant in particular, the focus --

*Mr. Burgess. -- because it was two years ago the city of Houston, where the Chinese consulate -- they had to call the fire department, because they were burning records in open trash barrels. And apparently, the fire was so large that it attracted attention.

*Ms. Eshoo. The gentleman's time has expired.

*Mr. Burgess. Well, I will follow up, Mr. Shannon, in writing.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Burgess. But I mean, it is this type of activity that leads the casual observer to be suspicious of some of these actions.

And I thank our witnesses, all of our witnesses.

*Ms. Eshoo. The gentleman yields back.

It is a pleasure to recognize the gentlewoman from California, Ms. Matsui, for your five minutes of questions.

*Ms. Matsui. Thank you very much, Madam Chair, for holding this hearing. And thank you for the witnesses for your testimonies today. I know five minutes goes quite quickly, so I will just jump into the questions.

Ms. Sweeney, this is for you. A growing number of health care organizations have hired community health workers to provide social support, care coordination, and advocacy for high-risk patients. These workers are often trusted individuals from local communities who understand how people live and work.

Ms. Sweeney, why is this local perspective important for the work of your patient navigators?

And does having a workforce that reflects the community impact your health center's ability to provide whole-person care?

*Ms. Sweeney. Yes. So I do believe that the community health workers can better facilitate improved health outcomes because it is a natural trust within many of our communities,

whether they are rural patients -- you know, we talk about equity for our immigrant patients, people of color. Everyone can really talk about their journey.

And so helping them support and identify resources -- because sometimes it is really challenging. People are prideful, and they don't want to say, "I need help with food, I don't need -- I need help with resources.'' And so someone that can be in that role that is not telling them take their medications for their A1C, but just saying, you know, "How can I help you with things that are outside of health care,'' is really going to be a very important component.

Some of our patient navigator work will also be to support patients in navigating the health exchanges and understanding things, whether it is identifying -- literacy is a barrier to it, whether it is digital literacy -- that is a big thing in our area. So our geriatric population doesn't know how to use a computer.

*Ms. Matsui. Thank you very much. Health centers in my district also continue to really face workforce challenges. Can you describe the shortcomings in reimbursement for community health workers, and how Congress might help address these obstacles?

*Ms. Sweeney. Yes, I think that is a great question. Currently, to my knowledge, in Washington State we don't have a reimbursement mechanism for that. So it is something that,

you know, we are having to self-fund.

*Ms. Matsui. Okay.

*Ms. Sweeney. And so those gaps are always challenging to try to fill.

*Ms. Matsui. Okay --

*Ms. Sweeney. So you can recognize the need, but you need to figure out how to sustain the program financially.

*Ms. Matsui. Sure. Thank you very much. This question is for Dr. Bibbins-Domingo.

I am pleased that today's hearing continues this committee's work to promote clinical trial diversity. You know, clinical research is no exception to the rapid pace of health care innovation, as trial sponsors look for new ways to improve the speed and experience of clinical trials for patients and providers.

During the pandemic we have seen an uptick in adoption of decentralized clinical trials, as longstanding regulatory barriers to telehealth and conducting trial activities remotely [inaudible] way for the duration of the public health emergency.

Dr. Bibbins-Domingo, in your view, how might telehealth fit into the conversation around what Congress can do to better coordinate Federal efforts that promote equitable clinical research?

Post-pandemic, do you see telehealth continuing to play

an increasingly important role in recruiting and retaining diverse participants for clinical trials?

*Dr. Bibbins-Domingo. Thank you very much for that question. I actually think that the pandemic, in its way that it was disruptive, allowed new innovations to actually flourish, and telehealth is certainly one of them.

I can -- speaking as a clinician, I can say telehealth has been remarkable in allowing us to increase our access.

I will also say that new technologies also have to be adapted to the goals that we are trying to achieve. For me and my population -- I serve in an urban safety net setting -- we don't -- most of my patients don't use telehealth. They use the telephone, unfortunately. And so we always have to be ensuring that our new technologies also work for all of the populations that we are trying to have them achieve. They increase access. We can reach rural populations, people who can't come in, in much better ways. That is remarkable. But then also making -- we have to build in the types of investment that ensures that new technologies are actually available to all of those that we want to include in care and in our studies.

So I am all in favor of technologies. I think that they are remarkable and increase access, but we also have to make them equitable, as well.

*Ms. Matsui. Well, absolutely. And that is part of the

challenge, because, as we have more access, we know that there are disparities in all of the access, too. So thank you very much. I do look forward to Congress advancing legislation that really supports leveraging telehealth in an equitable manner as a tool across the health care sector.

Thank you, Madam Chair. My time has disappeared. I yield back.

*Ms. Eshoo. It goes by quickly. The gentlewoman yields back.

The chair is pleased to recognize the gentleman from Virginia, Mr. Griffith, for your five minutes of questions.

*Mr. Griffith. Thank you, Madam Chair. And I just want to say I agree with the questions and the answers just given to -- by Ms. Matsui, and then the answers that were given. Both Ms. Bibbins-Domingo and Ms. Sweeney have mentioned that a lot of folks in their areas -- and in my area, as well -- use telephonic forms of telehealth. And we have to figure out how to make reimbursement for both the computer version and continue to reimburse or do better ways of reimbursing for telephonic.

All right, let me move on to Mr. Shannon.

Mr. Shannon, EcoHealth Alliance, an NIH grantee during the time that you were there -- at least it started then -- recently acknowledged that it is waiting for its sub-grantee, the Wuhan Institute of Virology, to release electronic files

and lab notebooks associated with a key experiment on coronavirus and doing coronavirus research prior to 2020, which was supported by the NIH grant. It seems weird and perverse to me that an NIH grantee cannot or will not produce the substantiating materials from an experiment paid for by the United States. Wouldn't you agree, yes or no?

*Mr. Shannon. Yes, I would agree.

*Mr. Griffith. Shouldn't NIH grantees be required to retain a copy of all research records? And when I say "grantees,'' I mean grantees and sub-grantees. Shouldn't they be required to retain a copy of all research records, electronic files, and laboratory notebooks generated by a foreign sub-grantee, and be required to make such data available upon request to the NIH and/or from Congress, yes or no?

*Mr. Shannon. Yes, and the requirement exists.

*Mr. Griffith. Then how come we can't get these records from the Wuhan lab?

*Mr. Shannon. I don't know the answer to that, sir. I can tell you that the NIH grants policy statement -- section 8.4.2, specifically -- requires that any record reasonably considered to be pertinent to the grant must be retained and available.

And in fact, the grantee and -- or the awarding recipient and -- is responsible for compliance across the

board. They have -- they actually have to --

*Mr. Griffith. Okay.

*Mr. Shannon. -- keep their people available [inaudible] --

*Mr. Griffith. Let me move on. We have had a number of issues with this type of thing with EcoHealth Alliance. And at one point they were banned from getting new money on that grant, but then the NIH gave them a grant for something else.

When we have somebody who is not complying or not making their sub-grantees comply, shouldn't we ban them from getting new grants in the future?

*Mr. Shannon. Well, I think there is absolutely a case to be made that stewardship should be a --

*Mr. Griffith. I take that as a yes, and I apologize.

*Mr. Shannon. Okay.

*Mr. Griffith. I would love to talk to you for hours, but I only have five minutes.

Also, as a former director at the NIH, and an NIH advisor to the FBI, how big of a problem is non-disclosure of foreign interests?

Under current requirements, should it have been disclosed when EcoHealth Alliance received their NIH grant that they had a partnership with the Wuhan Institute of Virology?

*Mr. Shannon. Generally, all disclosures of support or

activity and location of performance are supposed to be disclosed. That is a requirement of the grant in the grant's policy --

*Mr. Griffith. Since you were there at that time -- and I know you may not remember, but do you know if that was disclosed at the time of the grant on coronavirus to EcoHealth Alliance?

*Mr. Shannon. I do not. Those grant compliance areas fall under the auspices of [inaudible] --

*Mr. Griffith. Yes, I heard your answer to Dr. Burgess, and I thought that was fine. Again, I hate to cut you off, but I have got to move on.

What is the China military civil fusion strategy, and how is it relevant to the threats facing biomedical research by the U.S. in China?

*Mr. Shannon. It is a -- the MCF for military civil fusion strategy is a major driver of the Chinese Communist Party in their efforts to create a technologically advanced military to promote economic benefit beyond, and replace the U.S. as a premier economic powerhouse. So the focus is on targeting critical infrastructure, including biomedical, and there is a purposeful attempt to do that, to gather information that way.

And the focus is also recognizing that the way we look at the right and wrong of it is probably not the way they do.

They don't see it as their job to comply --

*Mr. Griffith. Yes, I mean, let me --

*Mr. Shannon. -- but for us to --

*Mr. Griffith. Let me -- hang on. Let me finish up, and I do apologize. I could talk to you for hours.

But do you think, looking at Wuhan Institute of Virology, that they are, in fact, a part of this strategy? I do. Do you?

*Mr. Shannon. I don't have any knowledge to demonstrate that that is the case. But I know, if you --

*Mr. Griffith. But you would -- yes or no, you would be surprised if they were not a part of it, wouldn't you?

*Mr. Shannon. I would be surprised if they were not part of the -- both the military and party.

*Ms. Eshoo. The gentleman's time has expired.

*Mr. Griffith. Thank you.

*Mr. Shannon. Yes.

*Mr. Griffith. I appreciate it.

*Ms. Eshoo. The gentleman's time has expired.

The chair is pleased to recognize the gentleman from California, Mr. Cardenas, for your five minutes of questions.

*Mr. Cardenas. Thank you very much, Chairwoman Eshoo, and also Ranking Member Guthrie, for holding this important hearing, and I really appreciate this opportunity to discuss these matters with these experts on their expert opinions and

their experience that collectively goes far beyond many, many communities.

So we are very fortunate to have all of you witnesses. So thank you so much.

I am thrilled to see that the NIH Clinical Trial Diversity Act is being considered today. And I want to thank committee leadership, as well as the bill's lead author, Representative Robin Kelly, for ensuring this bill's inclusion at today's hearing.

If we are serious about demanding that clinical trials are reflective of all communities served, we need to implement policy that impacts each of the relevant agencies, including those that provide resource for trials. The NIH funds clinical trials, including those in phase one, as well as those that will not apply for FDA approval, which would include studies on potential behavioral health interventions, for example.

As a clinical cog in the broader clinical trial system, NIH must also hold to certain standards to ensure diversity and representation for all. Not only would the bill require NIH to develop measurable recruitment and retention goals based on disease prevalence, it would also ensure less burdensome follow-ups and launch a public awareness campaign across Federal agencies related to research participation opportunities.

I am going to be asking my first question to Dr. Bibbins-Domingo.

Given that context, I want to ask you, as a witness, as -- a bit about the importance of clinical trial diversity broadly, and the focus on NIH specifically. Dr. Bibbins-Domingo, thank you for joining us today. I understand that clinical trial diversity is a personal issue with you, as we heard in your testimony. And I am grateful that you are willing to share the story with us and all of America.

Failing to diversify clinical trials has a serious cost, both in terms of people, in livelihoods, and in dollars and cents. In your testimony you note that an economic analysis by the National Academies found that "lack of representation may cost the U.S. hundreds of billions'' -- that is billions, with a B -- "of dollars over the next three decades as a consequence of U.S. health disparities.''

My question to you is, can you explain this connection between clinical trial diversity and cost?

And why is the NIH a key player in addressing the shortfalls in the diversity of clinical trials?

*Dr. Bibbins-Domingo. Thank you very much. Yes. So our analysis that we commissioned for this report examined the three common conditions -- heart disease, hypertension, diabetes -- and asked what does the disparities, the big gaps

that we have in the U.S. across White, Black, and Latino populations for these conditions, and how much does it cost us in terms of life years lost, people with disability, and work loss -- people who are not productive members of society? These are now costs that, over a 30-year period, approach $1 trillion, frankly.

Now, disparities in health outcomes like that are actually multi-factorial. They are not all going to be addressed by improving diversity in clinical trials. But if clinical trials and clinical research, which is important, only addressed a small fraction, let's say one percent, the benefits to society in terms of life years gained, productive life years gained, would be on the order of hundreds of billions of dollars. This is an analysis restricted to a few conditions and a few disparities, but it does highlight how big an economic toll that is, and does suggest that research, which we do think is important in this country -- that is why we fund it -- for improving health is important for addressing this, even if it only plays a small role in that.

*Mr. Cardenas. What are the dangers of prolonged mistrust in our scientific processes?

And how can proposals like the NIH Clinical Trial Diversity Act help to close that gap?

*Dr. Bibbins-Domingo. Yes. We have a very important gap in trust, mistrust, distrust that we have seen really

highlighted through the pandemic.

A lot -- this is actually reinforced by the fact that we are not engaging communities in the participation in our scientific and medical enterprise. People don't accept a new vaccine because it really hasn't been studied in people like them. And I think that we -- often times we miss the opportunity to reinforce trust by engaging communities in all aspects of our medical and scientific enterprise. And this is just one aspect that I think is -- and an important feature of why representation is important.

*Mr. Cardenas. Thank you. It is clear that we need to take a holistic approach in making clinical trials more diverse. It is an urgent issue, and I appreciate all of your thoughtful responses.

Madam Chair, my time has expired, and I yield back.

*Ms. Eshoo. The gentleman yields back.

The chair is pleased to recognize the gentleman from Florida, Mr. Bilirakis, for your five minutes of questions.

*Mr. Bilirakis. Thank you, Madam Chair. I appreciate it very much. This is a great hearing, as always. And I really do want to talk about this particular issue, and I thank the witnesses for their testimony today. So this is a bipartisan hearing, and I appreciate the witnesses again being here today. In particular, Madam Chair, I want to thank you for putting up for consideration my bill, H.R.

5478, the Protecting the Integrity of our Biomedical Research Act, which will provide transparency and accountability at the NIH -- so very important.

American taxpayers deserve to know when their money is being used improperly, when it is being used to benefit foreign governments. My legislation would provide an extra layer of protection and increased transparency for our Federal research grants by requiring full disclosure of foreign talent programs as a condition of receiving extramural biomedical research grant funds.

In fact, GAO has been warning research institutions over the past few years with the concerns about inappropriate influence of foreign entities on NIH researchers. That is why I am grateful to have Mr. Mike Shannon, an expert in this field who previously worked as a senior executive at NIH.

And thank you for being here, Mike, today. I have a couple of questions for you, Mr. Shannon. Thank you for your testimony, again, and for providing specific feedback on how to better improve the three bills who have -- who were on the docket today. So we really appreciate it with regard to research integrity.

Can you expand more on the need to ensure we are capturing the full gambit of bad actors in this space, particularly those looking to subvert potential new requirements under the bill?

And that is why we have these hearings, to even improve our bills that were filed. So, please, if you can answer that question, Mike, I would appreciate it.

*Mr. Shannon. Certainly. There are a great many types of influence that can be wielded, and that can include financial remuneration, additional payments. And those are often understood that they need to be reported. What is not clear, and what has been not universally done is the complete and accurate reporting of all support.

So we know that the Health Education Act section 117 requires the reporting of gifts, and we know that my colleague there who heads that arena recognizes the vast under-reporting that has been happening there. But that is another indicator of where support can be used to influence.

We have also seen in investigations where individuals who are -- who may have family members in the foreign nation, they may be coerced. They may be encouraged, either with threats to that family or just an honor threat, that you are embarrassing our family, that sort of thing.

So it really spans the gamut of what is going to inspire and influence someone to be willing to take that step, and whether it is for self-enrichment or some type of reputational self-preservation, it is a large issue. Again, we see it as primarily a compliance issue. There are law enforcement instances. We have got to make sure we charge

the appropriate charges when there is a law enforcement incident. It is much more of an espionage kind of effort than it is, you know, the common criminal.

But on the compliance side there is a solution, and there is a mechanism to restore, rather than remove individuals and then put in place due diligence to observe and ensure that that conduct does not continue.

*Mr. Bilirakis. Thank you very much. I didn't want to interrupt you, because this is such good information for us.

You also rightly point out that this issue may be addressed in the American -- the America COMPETES Act. And I want to reiterate that H.R. 5478 builds on bipartisan provisions included in the original USICA bill sponsored by Senator Schumer.

I also helped lead a bipartisan letter to NIH, with some of my fellow colleagues on this committee, addressing this topic in response to specific incidents regarding inappropriate influence. You addressed that to a certain extent, inappropriate influence from the Chinese Communist Party within our biomedical research grants. We must better address this.

I am not sure if we have time for this, but I am going to give you the question.

And then, Madam Chair, if you want to cut me off, that is okay, because he will respond to me.

Can you discuss the importance of internal buy-in within NIH and HHS, which we know is traditionally resistant to change?

And can you tell me how we can provide better oversight of compliance in this area?

*Ms. Eshoo. The gentleman's time --

*Mr. Bilirakis. Yes.

*Ms. Eshoo. -- has expired.

*Mr. Bilirakis. Yes, I will yield back --

*Ms. Eshoo. But I think that your question --

*Mr. Bilirakis. -- so we can get a response --

*Ms. Eshoo. -- can be submitted to the witness to --

*Mr. Bilirakis. Absolutely.

*Ms. Eshoo. -- respond in writing.

[The information follows:]

**********COMMITTEE INSERT**********

*Voice. Welch is back.

*Ms. Eshoo. Pardon me?

*Voice. Welch is back.

*Mr. Bilirakis. Thank you.

*Ms. Eshoo. The chair is now pleased to recognize the gentleman from Vermont, Mr. Welch, for your five minutes of questions.

[Pause.]

*Ms. Eshoo. Mr. Welch?

*Mr. Welch. I thank you very much, Madam Chair. I appreciate the hearing, but I actually do not have any additional questions. Thank you very much.

*Ms. Eshoo. Okay, then we -- the chair now recognizes the gentleman from California, Dr. Ruiz, for your five minutes of questions.

*Mr. Ruiz. Thank you for holding this important hearing. Just real quickly, I will take the personal privilege of sending a shout out to the multitude of interns in my office watching live on screen right now. Thanks for being here.

As we have seen throughout the pandemic, there are critical gaps in our public health infrastructure. We are presented with an opportunity at this moment, as we move forward, to learn from this experience. I truly believe that we are at a critical juncture as a country. If we don't

course correct now, even after everything we have seen and experienced throughout the past two years, then I fear we won't ever have the will to do it. And yes, to do it right, we will have to invest in our public health infrastructure.

But inaction costs more than action, and we end up with sicker communities. As a doctor and a public health expert, it is hard for me to even narrow down priorities in the public health space because there are so many critical issues to address, like the need for a better public health education system, especially for our harder-to-reach communities, to empower them to make better decisions to protect their health, or even the ever-worsening provider shortage, or generally the way our health care system focuses on curing severe, expensive sickness, but not preventing it, or how we balk at spending money on things that will prevent disease, even if it saves us money down the road.

What I would like to talk about today, the utilization of community health workers, or promotoras, helps address a number of these critical issues. Greater utilization of community health workers is not a silver bullet to solve our public's health system. There is no one silver bullet here, but they can go a long way to keeping our communities healthier.

As you know, community health workers understand local needs and can give people tools and resources to achieve

better health and well-being. This may include helping patients manage chronic diseases, connecting them with social services organizations, or making sure a patient has a proper storage for their medication.

Proactively addressing root causes of poor health is not only better for the health of our communities, but it actually saves money. In fact, research has shown that utilization of community health workers saves $2.47 for every dollar spent.

So if community health workers saves us money and improves health, I think that investing in policies that increase utilization of them is a no-brainer. My bill, H.R. 8151, the Building a Sustainable Workforce for Healthy Communities Act, will reauthorize a competitive grant program to support state and local governments, tribal organizations, and community-based organizations, and expanding community health worker programs in under-served areas. The grants are intended to serve communities that experience higher rates of chronic disease, infant mortality, maternal morbidity and mortality, and health professional shortage areas.

The bill also expands the services that community health workers can provide under this grant, such as using community health workers to educate, guide, and provide home visitation services for chronic diseases and postpartum care.

Under my bill, the community health workers will also be

able to conduct outreach and education to communities that require additional support during public health emergencies.

Ms. Sweeney, what are some services that you intend for the patient navigators, as described in your testimony, to provide into the future as NEW Health works to get their community health worker programs off the ground?

*Ms. Sweeney. Thank you. So I think, for us, really, you know, everyone's barriers are different, and they are all the same at the -- at many community health centers. So for us to identify those social determinants of health and what are the barriers to patient, whether it is compliance, comprehension, health care, access, trust -- and so we will really utilize these patient navigators to help build the trust within the community to eliminate barriers to care, whichever barrier that is.

And so I think, really, for them to identify those social determinants of health and non-compliance -- you, as a clinician, recognize non-compliance doesn't always mean obstinance. It could be financial barrier, or a comprehension barrier.

*Mr. Ruiz. Or a failure and non-compliance of a system that doesn't give -- take into consideration those barriers, which is their responsibility to do so.

*Ms. Sweeney. Right.

*Mr. Ruiz. So I -- you know, before we leave I would

also like to thank the committee for including H.R. 5141, the Mobile Health Care Act, in this hearing, and for my colleague, Congresswoman Lee, on her leadership on this important issue.

Giving health centers the ability to invest in mobile clinics will help them reach the most under-served areas by taking health care directly to the communities. I have participated multiple times in these mobile health clinics, and have even driven some of these RVs out into our most under-served areas in my district throughout my medical career.

And with that, I yield back.

*Ms. Eshoo. The gentleman's time has expired.

The chair is pleased to recognize the gentleman from Indiana, Dr. Bucshon, for your five minutes of questions.

*Mr. Bucshon. Well, thank you, Chairwoman Eshoo and Ranking Member Guthrie. Today's hearing covers a variety of important issues, many of which are particularly relevant, given that we have experienced and learned -- what we have experienced and learned over the last couple of years.

The COVID-19 pandemic has taught us a lot about what our public health agencies and our health care systems can do well. But it has also provided some startling examples of deficiencies Congress needs to address. The bills before us today represent just a small portion of that work.

I appreciate that my colleagues, Representatives Bilirakis, Curtis, and Hudson, have introduced bills to address some of the issues we are seeing with oversight of Federal funding for scientific research.

To be clear, I strongly support Federal funding for research. I learned in my early days of Congress, leading the Science, Space, and Technology Subcommittee responsible for the National Science Foundation, that we cannot rely on the private sector for all such work. But when taxpayer dollars are being used, we must pay close attention to the quality of the work being done, and we must have adequate and frequent oversight of all Federal agencies funding scientific research.

Mr. Shannon, your written testimony provides many solid observations about how we can improve that quality, particularly when it comes to foreign influence. Do you believe that, if we enact the proper guardrails, the United States can continue to safely and responsibly fund biomedical research projects, not only in the U.S., but internationally?

*Mr. Shannon. Yes, I do. I think, though, that the -- although the reporting requirements that are in the bills are absolutely essential and important for accountability and oversight, I think you also need to look at the IG axiom of what gets checked gets done. And so, if there aren't periodic audits for compliance and looking at all of those

conditions for award, then those will fall by the wayside, and we may find ourselves with a similar problem in the future.

*Mr. Bucshon. Yes. I mean, I, in general, have been, you know, shocked by the revelations of the lack of compliance and reporting that we have seen across the United States and academic institutions, particularly as some of those cases were mentioned, and the lack of oversight potentially that we have had.

And it does amaze me in Congress, I mean, how many things that in hearings like this you hear have happened, and you just can't understand why the law hasn't been followed. And primarily, I think a lot of that is, you know, it is Congress's responsibility to occasionally provide adequate oversight of basically everything that we do, particularly when taxpayer dollars are involved.

I am also grateful for the legislation like H.R. 7565, the IMPROVE Act, which provides authorization for a research initiative designed to mitigate preventable maternal morbidity and mortality. We have heard it, this subcommittee, the shocking data coming out across the country about the increasing maternal mortality, particularly in certain areas of our country, and the racial and ethnic disparities in that issue -- on that issue, and I know we are all trying to address that.

My state of Indiana has one of the highest rates of maternal mortality in the country, and it led me to advocate for the TRIUMPH for New Moms Act, a piece of legislation that Representative Barragan and I were able to pass in the House, that was included in the mental health package last week. That bill focused specifically on mental health challenges that often plague pregnant and postpartum women.

The IMPROVE Act would further build on efforts to support them.

Dr. Bibbins-Domingo, I don't have a specific question, but I want to comment on some things you have said. You have advocated for broader participation of women in clinical studies, and your testimony makes many critical points about the need for greater clinical trial diversity. Dr. Ruiz, who just recently asked questions, and I introduced H.R. 5030, the DIVERSE Trials Act, to improve diversity in clinical trials and a couple of other things. And the Senate actually has a companion bill, S. 2706, introduced by Senators Menendez and Tim Scott.

So I do agree also that telemedicine gives us a potential opportunity to increase the diversity in clinical trials, as you pointed out. And I know, as a medical doctor myself, different populations of people respond differently to medications, and they have different health issues that cannot be adequately assessed unless you actually study those

populations.

So with that, Madam Chairwoman, I yield back the balance of my time.

*Ms. Eshoo. The doctor yields back.

The chair is pleased to recognize the gentlewoman from Michigan, Mrs. Dingell, for your five minutes of questions.

*Mrs. Dingell. Thank you, Chairman Eshoo and Ranking Member Guthrie, for convening today's bipartisan legislative hearing, with so many important bills that support our nation's health care system, the workforce, and research enterprise.

The issues that today's witnesses and my colleagues on committee have discussed are so critical to addressing gaps in care and ensuring traditionally under-served groups are able to access quality, affordable health care in a timely manner. There are issues that are critically important to communities in my district, which has a very large Middle East and North African population. We have heard from concerned residents and community groups that the lack of such services are barriers to quality health and health equity for MENA residents.

Ms. Sweeney, community health centers play a critical role in addressing health equity, both in my district but across the country. Could you speak to the importance and effectiveness of culturally and linguistically appropriate

services, particularly for immigrants, refugees, and individuals with limited English proficiency?

*Ms. Sweeney. Yes, that is a great question, and I think that health centers have done a really great job of, you know, working towards that and addressing that by being community driven. And so we can better adapt to our patients' needs because you can't always understand what someone is going to need until they come and seek care with you. And so community health centers have really been known to build that trust within our patients, and to be community focused. And I think that is really a benefit to help support equity within our health center network, no matter where we are located in the U.S.

*Mrs. Dingell. Thank you for that. It is important to note that MENA Americans, like those in my district, are not currently recognized as a distinct community under the Public Health Service Act. This is why I have joined my colleagues, Representative Tlaib, Eshoo, and Kelly, to introduce the Health Equity in MENA Community Inclusion Act of 2022, which would amend the Public Health Service Act to address this issue.

But I would also like to highlight the 340B drug pricing program, which is critically important to ensuring community health centers in my district -- and again, across the country -- that they are able to provide quality health

access to be able to provide quality care to my constituents.

Ms. Sweeney, how has the 340B program helped NEW Health provide quality care to the beneficiary it serves?

And can you talk about the program's impact on under-served communities specifically?

*Ms. Sweeney. Yes, thank you. That is a great question.

The 340B program is incredibly important to health centers across the country. You know, by law and mission we must reinvest all savings of the 340B program back into the patient care.

So I think a couple of examples we could do is telehealth. When the pandemic first broke out, we just really didn't even know how it was going to be reimbursed, how that was going to be paid. And so having that opportunity to utilize that cost savings to do right by the patients in that time of need was essential.

And those needs for the under-served and vulnerable populations will always continue. And so being able to have that opportunity to reinvest that, and protect that savings for our most vulnerable patients is essential. And it is the mission of everything we do. And we -- it is really extremely important to the health center sustainability.

*Mrs. Dingell. I thank you, and I thank you for all that you do.

One thing that is important to note is that a number of major prescription drug manufacturers have arbitrarily decided to restrict their participation in the 340B program since the summer of 2020. It is an issue I am hearing about from my constituents who receive health care through the community health care centers, which have faced cutbacks in services as a result of the pharmaceutical companies overcharging these very, very, very critical safety net providers. It has a real impact on the access to care and pharmacy actions here need to be addressed moving forward.

Thank you, Madam Chair. And with that I yield back.

*Ms. Eshoo. The gentlewoman yields back.

The chair is pleased to recognize the pharmacist on our committee, the gentleman from Georgia, Mr. Carter, for your five minutes of questions.

[Pause.]

*Ms. Eshoo. Are you there, Mr. Carter?

*Voice. [Inaudible] Curtis.

*Ms. Eshoo. Pardon me?

*Voice. Curtis is next.

*Ms. Eshoo. Who?

[Pause.]

*Ms. Eshoo. Mr. Curtis of Utah, you are recognized for your five minutes of questions.

*Mr. Curtis. Thank you, Madam Chair.

*Ms. Eshoo. I don't know what happened to Carter.

*Mr. Curtis. Thank you, Madam Chair.

I am, like many of my colleagues here, deeply concerned by the foreign influence in our research institutions through China's Thousand Talents program. My bill before us today, which I am grateful that many have acknowledged, the Fix Nondisclosure of Influence in Health Research Act, or Fix NIH Research Act, would shine a light on these [inaudible] influence operations. The Fix NIH Research Act is currently in the China package, and I urge my colleagues on the conference to maintain its inclusion and pass it into law in the coming months.

I served on a GOP China task force in 2020. I lived in Asia. I have a great appreciation for the language, the culture, and the people. But that being said, the final report of the China task force found that the CCP has a coordinated global campaign to recruit overseas science and technology experts through talent programs like Thousand Talents and other efforts to obtain knowledge and IP through coercive and fraudulent means. The CCP's talent programs, rather, require participants to operate in secrecy and, in some cases, contractually obligate participants to legally -- illegally transfer information and property.

In 2019, a massive espionage campaign to steal advanced biomedical research was exposed at a prominent and cutting-

edge research facility in Houston. Multiple scientists were caught sending research back to the CCP's government, or plotting to do so. This brazen act is just the tip of the iceberg of the CCP's wide-scale espionage efforts here in the United States, especially through their talents -- Thousand Talents program.

In December 2021, the chair of Harvard's Department of Chemistry and Chemical Biology was convicted by a Federal jury in connection with lying to Federal authorities about his affiliation with the People's Republic of China's Thousand Talents program and the Wuhan University of Technology in Wuhan, as well as failing to report large sums of money he received from Wuhan University of Technology, while simultaneously receiving Federal grants from NIH and DoD.

Mr. Shannon, can you explain why it does matter that researchers who are working for Chinese-affiliated entities are also getting grants from the United States?

And why does this compromise the integrity of research, or how does it compromise national security?

*Mr. Shannon. Yes, it certainly matters. When scientific information is submitted for potential award to advance our research and development capabilities, the intent is for the benefit of all, from a U.S. perspective. When you have individuals who either work in a dual funding capacity,

or have a conflict of interest or a conflict of commitment, that can result in less effort being given to the U.S. research.

It can also cost in the way of the training and mentorship, where a scientist who may be deciding to work in this capacity and be -- enrich themselves, their effort is focused elsewhere, not on the primary effort here. And that is not the agreement that they entered into when they received that grant award.

From a national security perspective, it absolutely matters because not -- in most of these cases it is not a transparent or reciprocal arrangement. And so it is not to the benefit of the global health, or to the benefit of the U.S., who is funding the effort often times. It inures to the benefit of another nation. In many cases -- in our investigative statistics we see that is primarily the Communist Party in China. That effort directly impacts our ability to be innovative, our ability to be ahead of the curve, and to seek that innovation and commitment from the funds that we invest.

*Mr. Curtis. Thanks, Mr. Shannon.

I would also like to just re-emphasize my appreciation to my colleagues who have supported this bill. And, Madam Chair, I yield my time.

*Ms. Eshoo. The gentleman yields back.

The chair is pleased to recognize the gentlewoman from New Hampshire, Ms. Kuster, for your five minutes of questions.

*Ms. Kuster. Great. Thank you so much, Madam Chair.

Creative approaches to delivering care are essential to reach all communities and vulnerable populations, including those who are experiencing inconsistent housing, who may live far from medical facilities, and who don't have access to transportation, or may lack connection to a medical provider. That is why legislation such as the Mobile Health Care Act is so key to improving health.

As the founder and co-chair of the Bipartisan Addiction and Mental Health Task Force, I am proud to say that we included the Mobile Health Care Act as part of our legislative agenda for the 117th Congress. Providing financial support to health centers, establishing mobile health units in rural and under-served communities is an evidence-based approach to close significant gaps in physical and mental health care.

In my home district, Lamprey Health Care in Nashua, New Hampshire uses a mobile van to meet patients where they are, helping to remove barriers to establish primary care, provide behavioral health care, and respond to COVID-related concerns. Some days this means providing services to school children on site to ensure minimal disruption of their school

day, and other times this means leveraging the unit and expanded telehealth flexibilities to connect patients with substance use disorder to proper support.

At a time when workforce recruitment and retention is such a challenge, folks at Lamprey have expressed greater job satisfaction with the opportunity to work directly with patients through the mobile health unit. The Mobile Health Care Act will empower other health centers to follow organizations like Lamprey to expand their services.

Ms. Sweeney, what populations would benefit most from more health centers being able to use a mobile unit to deliver public health and health care services?

*Ms. Sweeney. Thank you. That is a great question.

So we are going to be able to provide dental exams, extractions, fillings, and sealants for patients perhaps who cannot access those. So when you talk about that K-through-12 group who have to miss school to go to a dental exam, or their parents have to take time away from work, so that is one specific population.

And then, when we really talk about 10 percent of our total population being veteran population, and their needs being in -- you know, where they are apprehensive to come into an institution or a brick and mortar, so we really think bridging that VFW with the veterans population are two very strong populations.

And then, of course, anyone that has transportation or mobility issues.

So also, we also talk about in our area we have wildfires. And so when those camps are deployed, they are often times not close to an urban area. And so those firefighters are charged to have to leave the area for health care. And so we will be able to target specific populations and respond to various needs, not just health care or pandemic, but also natural disasters or anything that could be impacting us.

And I think that is really going to be beneficial for all community health centers, to have access through a mobile unit, to really deploy resources to where it is most needed in the short term, and then long term for our youth and veterans.

*Ms. Kuster. Great. And could you speak to how mobile health units will improve mental health care in rural communities, as well as addiction treatment?

*Ms. Sweeney. Yes. So as we know in -- the increasing mental health needs and lack of resources, if we could deploy those to people where they are at on their journey -- and I think you had made that comment -- you know, we want to meet people where they are at in their journey in crisis, because it doesn't always happen Monday through Friday, 8:00 to 5:00. And so, if we can, deploy those resources where our patients

are.

And then addiction resources, if there is an area in our service area that has a higher-than-normal resource allocation needed, we could deploy that more cost effectively and more timely than trying to install a brick-and-mortar rapidly.

*Ms. Kuster. Do you use the medically-assisted treatment? Is that something that you have deployed for addiction, for substance use disorder?

*Ms. Sweeney. We have medication-assisted treatment support services, and we utilize our referral network in our critical access hospital in the county. So we participate in the substance use disorder health care system in our region with our health department, our critical access hospital, and our rural health clinics.

*Ms. Kuster. Great. Well, I will just say from personal experience here and elsewhere, that that would be really, really helpful. And I urge my colleagues to support the bill, and I thank the chair for including it in the package.

And with that I yield back.

*Ms. Eshoo. The gentlewoman yields back.

The chair is pleased to recognize the gentleman from Pennsylvania, Dr. Joyce, for your five minutes of questions.

*Mr. Joyce. Thank you for convening this important

legislative hearing, Chair Eshoo and Ranking Member Guthrie.

I would also like to thank the committee for including legislation that I introduced along with my colleague, Dr. Schrier, H.R. 3773, the Pediatricians Accelerated Childhood Therapies, or PACT. [Inaudible] legislation will codify efforts to coordinate pediatric research [inaudible] NIH research institutes, and will invest in supporting early career researchers to help ensure a health pipeline of new individuals working in this critical field.

As we saw during the debate of H.R. 7666 last week, pediatric populations have borne the brunt of the upheaval in our daily lives during the COVID-19 pandemic, and we will be dealing with the aftermath of this for years going forward. When speaking to hospitals in Philadelphia, specifically the Children's Hospital of Philadelphia, we hear this confirmed, particularly in the space of behavioral health.

Ensuring a strong supply of pediatric researchers, including physician scientists who focus on clinical, translational, pharmaceutical, these areas of research are so absolutely important.

[Audio malfunction.]

*Mr. Joyce. -- that emphasis at this point in time.

My first question is for Dr. Walker-Harding.

Would you please speak a bit more to the challenges that you are seeing in the field, particularly when it comes to

retaining researchers in pediatric academic research areas?

And what are the stressors that you are seeing from people that they are experiencing in this field that often force them to leave the field?

*Dr. Walker-Harding. Thank you so much for that question.

Yes, we are seeing a lot, especially -- some of the same things you are seeing in Children's Hospital, Philadelphia we see at the University of Washington and across the country.

It is -- first of all, less people go into pediatric research to begin with. And if they don't have the funding, if you are talking about a physician scientist who also wants to see patients, being able to balance seeing patients, trying to get funding -- and if you are a woman, trying to take care of your kids at home, especially during COVID -- this has been a stress. It is really hard to get that support.

Universities, children's hospitals don't have the same kind of funding to support early-career researchers. And so what happens is they start out with great ideas, trying to work on it, have difficulty finding funding for pediatric research, have difficulty supporting their time to do that work. And they slowly move out of that space, and we lose the critical people who are seeing patients who can answer the questions that they are seeing because they are trained

to do so. But without the funding --

*Mr. Joyce. Thank you for your insight --

*Dr. Walker-Harding. -- without -- we can't take care of them.

*Mr. Joyce. Thank you. I would now like to turn the issue to NIH research vulnerability, and what could be done to address the threats presented by the Chinese Communist Party.

In the last few years we have seen an alarming uptick in malign foreign influence in our nation's biomedical research. I am pleased to see that we are taking up bills related to fixing this problem today. And I would urge that we also look at legislation like H.R. 5626, the Safe Biomedical Research Act, which I introduced aimed at this issue, as well.

Mr. Shannon, in your experience, how important is it for the NIH to have strong standards on cyber and technology practices to safeguard sensitive information?

*Mr. Shannon. It is very important, and I think they have taken some great steps towards working in that direction on the cyber side.

But we are also -- you know, the large portion of this problem is behavioral-based. And so there is a nexus between cyber activity and behaviors, because a lot of those behaviors happen in the cyber space. So being able to

observe that and react to it is critically important.

*Mr. Joyce. [Inaudible] that the NIH has those strong standards on cyber and technology practices to safeguard the sensitive information?

And do you believe that those standards exist today, and are properly enforced?

*Mr. Shannon. I am not an expert in the NIH cyber policies. I worked very closely with them on investigations and audits. But I can tell you that they have a strong, committed team that does a great job in that regard. So I can't speak to the specifics of their cyber policies, but I know that they have been continually working to address that. And after the GAO audit that occurred a couple of years ago, I think they are in an even stronger position today.

*Mr. Joyce. I think we need that strong position.

Madam Chair, I see my time has expired, and I yield.

*Ms. Eshoo. The gentleman yields back.

The chair is pleased to recognize the gentlewoman from Illinois, Ms. Kelly, for your five minutes of questions.

*Ms. Kelly. Thank you, Madam Chair. I am so thankful for this committee's leadership in advancing important clinical trial diversity policy with the Food and Drug Administration of 2022. However, real progress on clinical trial diversity will require a multi-faceted approach across Federal agencies, as you know well.

While the DEPICT Act focuses on FDA policy to increase clinical trial diversity, there is a need for similar policies to be implemented at the NIH. The NIH is the largest funder of biomedical research in the world, investing $41.7 billion annually on biomedical research.

I am proud to have introduced the NIH Clinical Trial Diversity Act with Representative Fitzpatrick and my E&C colleagues, Representatives Cardenas, Butterfield, and Clarke. This bipartisan bill builds on current NIH policy, and provides a framework for NIH to work with sponsors so they can meet their clinical trial diversity goals. This bill would ensure that NIH-sponsored clinical research develops effective treatments for diseases and conditions across diverse populations.

Dr. Bibbins-Domingo, in your testimony you discuss the importance of including diverse populations at the outset of clinical trial research to ensure that all communities have access to innovative treatments. Could you please speak to the importance of including diverse populations in phases one and two of clinical trials?

*Dr. Bibbins-Domingo. Thank you for that question. It is important that we create an infrastructure that includes diverse populations at all phases of our research, including the formative phases and the -- all of the early phases of clinical trials for -- the reason is that this research

should be generalizable to the populations for whom it is intended.

Focusing on the earlier phases, especially by focusing on the NIH and the types of research that it funds, will actually reinforce the institutions that actually enroll individuals in research to create that types of infrastructure locally to make enrollment in studies easier.

It is true that in early phases of research, when the numbers are small, you don't -- they are not often powered to look for differences between groups. But looking for differences between groups is not the only reason we want to include diverse populations in research. We want to do them at the discovery phases, at the genetic phases, at the mechanistic phases, and at all phases to think about generalizability. And investing in the infrastructure at all phases actually will enhance our ability to recruit in those late-phase clinical trials, where we sometimes do want to explore differences in drug efficacy across populations.

So I really applaud the focus on FDA and NIH, and think that they can work in synergy.

*Ms. Kelly. Why is it important for NIH-funded trials investigating behavioral intervention for mental health and substance abuse use disorders will also be required to develop clear and measurable clinical trial diversity goals?

*Dr. Bibbins-Domingo. Thank you. For the same reason.

A focus simply on just the drugs and devices really ignores the fact that so much of what we do in clinical medicine to improve health is informed by funding that the NIH gives to investigators for things like mental health interventions, for things like implementation science, for things like substance use. All of those that may not have a pharmaceutical at the end of the pipeline, but are just as critically important that we use evidence-based practices to inform our care.

For those things that you mentioned -- mental health, behavioral health, substance use -- we know that there are huge disparities in those arenas, as well. And having research that addresses these issues in the populations that are affected are hugely important for addressing the health needs in those populations.

*Ms. Kelly. Thank you.

Dr. Walker-Harding, can you please elaborate on the need for alternative follow-ups to increase clinical trial participation of rural and linguistically diverse individuals?

*Dr. Walker-Harding. Sure, it -- different from adult medicine, pediatric specialists, pediatric researchers are not in rural areas. They have to travel sometimes for hours, especially where I am at, two to three hours a week for essential care. If you have to do that, you really need to

have other ways of having them engage in research, because it is an extraordinary burden to have to keep coming back and forth from rural and remote areas.

If you are linguistically diverse, you need to be able to understand in your own language and culturally what a research project --

*Ms. Eshoo. The gentlewoman's time has expired.

*Dr. Walker-Harding. -- would be doing to help your child.

*Ms. Eshoo. The gentlewoman's --

*Dr. Walker-Harding. So --

*Ms. Eshoo. -- time has expired.

*Ms. Kelly. Thank you.

*Ms. Eshoo. The chair now recognizes the gentleman from -- is Mr. Carter with us?

There you are. The gentleman from Georgia, Mr. Carter, for your five minutes of questions.

*Mr. Carter. Thank you, Madam Chair, and thank all of the witnesses for being here. We appreciate your participation.

Full disclosure, I am a pharmacist by profession. And as a health care professional, I know that accessibility and affordability in health care are extremely important to our country. If we are going to talk about public health, we have to make sure that patients continue to have access to

pharmacies.

You know, pharmacists are the most accessible health care professionals in America. Ninety-five percent of all Americans live within five miles of a pharmacy. And that is extremely important to make sure that we have accessibility to health care professionals. That is why I was happy and pleased to introduce H.R. 7213, the Equitable Community Access to Pharmacist Services Act, a bipartisan piece of legislation introduced in our committee. And I look forward to making sure that this legislation gets a hearing, and that it gets passed, because it will continue to give us access to pharmacies, and that is very important. And I am looking forward, as I say, to working with this committee to try to do that.

Mr. Shannon, I want to ask you. First of all, it was revealed in April that recently disclosed documents that the Wuhan Institute of Virology had an agreement with the University of Texas's Medical Branch's Galveston National Laboratory to collaborate on scientific research with the Chinese lab, and that it entitled the Chinese to ask the Texas lab to destroy any secret files.

It also -- in addition to that, EcoHealth disclosed to the NIH that the NIH-funded research files under their grant were in the custody of the Wuhan lab, and that EcoHealth would need to get permission from the Wuhan lab in order to

turn over the records to the NIH. Again, this is EcoHealth, who got a grant from NIH. NIH wants some information, and now EcoHealth tells them they got to get permission from Wuhan in order to get that information.

Mr. Shannon, my question for you is are you concerned about these side agreements between the NIH grantees -- that is, those who are getting money from the NIH, the National Institutes of Health, a federally-funded program -- are you concerned about those side agreements between them and the Chinese research partners that preclude the NIH from getting access to NIH-funded data?

*Mr. Shannon. Yes, that is in conflict with the regulations, the grants policy statement that requires that those records be available if they are considered pertinent to the grant. And so if there is a nexus between the grant funding that the one entity received, and they sub-award something out of that, then that requirement extends. That is -- so yes, I would be very concerned with that.

But it does go to the whole question of persons accepting risk at a level beyond their authorities, or unbeknownst to their organization, and not being able to account for those things. So that is part of the broader issue of these agreements, not only between organizations, but individuals, as well.

*Mr. Carter. Do you think there are any national

security concerns with an agreement like this?

And if there are, how can that be addressed?

*Mr. Shannon. Well, I think when you are talking about research that is funded for critical infrastructure technologies, that certainly falls into the realm of a national security concern.

The compliance aspect of this is absolutely something that needs to be addressed to ensure that there is compliance. And as I have said, the rules have been there for a long time. And NIH is not incorrect when they say, "Nothing has changed, the rules have been there,'' although they put out clarifying guidance to those rules, which is important to make sure it is clear.

But -- and you have got great people doing great things trying to get after this. But what gets checked gets done. And if it is not checked, it is not getting done. So periodic audits, periodic reviews, some type of stewardship score perhaps as consideration for an award, not to disrupt what science is awarded, but to perhaps result in additional conditions on award, would be helpful.

*Mr. Carter. Right. Well, let me ask you this. Shouldn't an NIH grantee -- that is, someone who has gotten a grant from the NIH -- the NIH, of course, being federally funded by taxpayers' money, shouldn't they be publicly accountable, especially to a congressional inquiry?

*Mr. Shannon. Well, I think it is -- they are accountable through their awarding agency. I think it would be difficult to have direct accountability for reporting from the vast number of awardees, and then being cognizant also of Congress's previous priorities of reducing burden on the grantee.

I think the appropriate mechanism is through the awarding agency, and that awarding agency being clear on what Congress wants to know, and making sure they get --

*Ms. Eshoo. The gentleman's time has expired. The chair is pleased to recognize, if she is available, Congresswoman Craig of Minnesota.

Are you on?

All right. I don't see or hear her. We will go to Congresswoman Schrier, Washington State, for your five minutes of questions.

*Ms. Schrier. Well, thank you, Chairwoman, and thank you to our witnesses for joining us today and for your excellent testimonies.

Today I would like to focus on the Pediatricians Accelerate Childhood Therapies Act of 2021, or the PACT Act, this bipartisan legislation that I was really happy to co-lead with my friend and colleague, Dr. Joyce, who you just heard from. And the PACT Act of 2021 would require NIH to make awards specifically to early career pediatric

researchers, creating a pipeline of research -- researchers, as you have heard, to advance childhood therapies.

This bill would also coordinate research at national health research institutions through the Trans-NIH Pediatric Research Consortium.

Dr. Walker-Harding. First, it is wonderful to see you again. Thank you for your devotion to children and families in Washington State. And thank you for highlighting the PACT Act in your testimony. You really highlighted how important it is to support research early in pediatric careers, especially given the tight timeline that researchers have to demonstrate that they can win independent research funding.

And in prior conversations, you have also made the case for supporting pediatric research at children's hospitals and universities so that we can keep research in academic institutions, and not lose all of that talent to the private industry.

Of course, you and I know pediatric research is vital to finding causes and treatments for conditions that affect children like pediatric cancer, autism, brain injury, infectious diseases, metabolic disorders. But even with this tremendous need and increased investment at NIH, there has been a decline in pediatric researcher slots at NIH.

Can you talk about how this has affected Seattle Children's?

*Dr. Walker-Harding. Yes, this has resulted in us having less ability to recruit people with great minds that are coming out wanting to do research without the funding. This is very much restricted, the spaces that people can do this research. I think that we have to be able to have what the PACT Act underscores: individual research, funding support. It gives security to the early researcher early on, when they are really in that tenuous point of can they do this work, especially for people who are coming from under-represented places where they haven't, you know, gotten the support that they needed to be successful.

*Ms. Schrier. Thank you. And, you know, you noted this impact of kind of getting people that acceleration, that boost, early on. Can you talk about some of the challenges that early career pediatric researchers might face at the beginning of their careers, and how this legislation helps?

*Dr. Walker-Harding. Yes, we really saw it play out in COVID.

You know, early on in -- when you are trying to balance being a clinician, being a researcher, and, you know, especially if you are a woman and you have to care for the family, trying to figure out the time that you have to actually ask a question, do the research, get your partners, get your mentors in place, it really takes a lot time and work. And if you don't have the funding to give you that

time, and you don't have the mentors that the funding allows, you just -- it is really hard for people to keep up.

And so we have seen people want to switch from being a researcher to being a clinician, which is fine, except we are losing that mind, and we need all of the minds we can find to focus on pediatric research.

*Ms. Schrier. Thank you.

And I think about the impact, for example, of autism on an entire family, like how kids' health affects adult -- all the adults around them. And I am interested in your comments about how the diseases and conditions of childhood are often -- excuse me, of adulthood are often rooted in the pediatric years, and how this stronger commitment to pediatric research and the pediatric workforce can help all through life and into adulthood.

Can you elaborate a little bit on that [inaudible]?

*Dr. Walker-Harding. Absolutely. It is -- most of the health concerns that we deal with in adults have their underpinnings, origins, or beginnings in pediatrics. If you are talking about heart disease, diabetes, obesity, substance use, depression, cancer, you know, all of those things, if we are going to pay attention to them in pediatrics, could be mitigated, decreased, eliminated.

We have to start thinking about how we developmentally look at how we are going to address health problems in this

country, so that we can prevent and have treatments for them, instead of just waiting for people to have a disease and work toward it. That is critical in pediatric research.

*Ms. Schrier. Thank you. I really appreciate it. It is one of the reasons that I talk so much about, for example, using our nutrition programs effectively to really channel kids to liking fruits and vegetables and the things that will stave off those adult diseases later. So thank you again.

I yield back.

*Ms. Eshoo. The gentlewoman yields back. It would be good to know how many pediatric researchers we have in the country today, in comparison to others.

The chair is now pleased to recognize the gentleman from Texas, Mr. Crenshaw, for your five minutes of questions.

*Mr. Crenshaw. Thank you, Madam Chair. I thank you to the ranking member for holding this hearing today, and thank you to the panel of witnesses for being here. My questions are for Michael Shannon, so I will premise this with these following facts.

The U.S. Government estimates that every year China steals $225 billion worth of things like patents and trade secrets from American companies. The Chinese consulate in Houston was shut down because it had become a hotbed of spying and intellectual property theft in both the energy and medical sectors. The FBI raided MD Anderson and several of

our other prestigious medical institutions because of incidents where Chinese spies were physically stealing data sets and samples from our medical labs.

So my question is, has the U.S. Government been successful in actually prosecuting these types of cases?

*Mr. Shannon. In some cases, yes. And those have been widely publicized. Where they have not been successful was early on focusing on this issue from a counter-intelligence perspective, when it is much more an espionage type of issue, when you get beyond the compliance questions, and you get into the actual action with the intent to do something and to violate the law.

So they have found success. I think the refocus of the Federal Bureau of Investigation on the broader spectrum, to focus on those types of activities that are espionage-like, or result in a theft of IP, or are foreign agent action is a much better approach, and I think they will find success that way, even greater success that way.

*Mr. Crenshaw. Okay. And for the times that they do have trouble prosecuting, what exactly are the challenges to prosecuting these cases? Why are they difficult?

*Mr. Shannon. Well, I think early on a couple of issues.

First, again, the use of the 1001 charge, 18 U.S.C. 1001, lying on a Federal document or something of that

nature, it is not a very strong charge when brought by AUSAs, as I understand it. It is not a very popular charge for them to bring. That is one challenge.

The other is the -- that a large portion of this is compliance and procedural misconduct. So things that were brought forward criminally might have been better dealt with administratively. You know, again, as they are refocusing their efforts and focusing on an espionage and foreign agent-type focus when the evidence suggests that, I believe they will find greater success.

*Mr. Crenshaw. Chinese institutions and individuals gave about $1 billion to U.S. universities from 2015 to 2019 to incentivize soft collaboration between U.S. institutions and Chinese research institutions. How is China -- how are Chinese institutions designing these collaboration activities to avoid prosecution by the U.S. Government?

*Mr. Shannon. Well, it has been a concerted effort for a couple of decades, and it has been built over time. It is a generational issue. So you have got researchers who grew up being taught how to do this.

There are contract agreements that come into play that make demands on individuals. And once you have accepted that remuneration, you are kind of in the trap. And so that -- the -- they are also instructed -- or once we started identifying these issues, we found instructions that

indicated how they would try to avoid that: first deny that it is you; say that it is -- you know, it is something other than what it is, you didn't know; or, where we were somewhat vulnerable, the policy wasn't clear, or I wasn't told, which is why training and education is a big part of the solution, as well.

*Mr. Crenshaw. So is it better distinctions and disclosure requirements and peer review? Will that help?

*Mr. Shannon. Well, I think the disclosure requirements are there. It is just there hasn't been, until recently -- and some of the tools that we deploy can rapidly identify those potential conflicts that are out there with potential threat actors. And risk rating that, and then addressing those risks, starting from a compliance perspective -- if you identify a relationship like that, does -- did the employer know about it? And if they didn't know about it, are they okay with it?

Again, it is people accepting risk at a level that is above their authority to do so on behalf of their organization that is causing a lot of these problems. So being able to put internal controls, ensuring that there is accountability.

I have advocated also for, again, research security or -- and other considerations as sort of a stewardship consideration for additional grant conditions.

All of those things will help motivate awardees to take that step. There is a tuition cliff coming. They are going to be relying on research to fund their organizations. It is important for them to be competitive, and those with the best research security should have the best opportunity to be those trusted partners for those investments.

*Mr. Crenshaw. I appreciate your time. It looks like I am -- and I am out of it.

I yield back. Thank you.

*Ms. Eshoo. The gentleman yields back.

The chair is pleased to recognize the gentlewoman from Minnesota, Ms. Craig, for your five minutes of questions.

*Ms. Craig. Well, thank you so much, Chairwoman, and thank you for holding this important hearing, as well as to our witnesses for being here today.

Many of the bills up for discussion today focus on the health care issues most important to my constituents, including the unique barriers facing rural communities, and how we can best address them. Americans living in rural communities are more likely to travel long distances to access care. They are more likely to be uninsured or under-insured. And they face skyrocketing costs that serve to a -- as a barrier to access.

On top of that, health care workforce shortages are increasingly widespread, and hospitals in rural communities

have been closing at a high rate for decades. But like many districts, access to broadband has been a significant issue that only deepens these disparities.

With that, Ms. Sweeney, in your testimony you spoke about the lack of broadband access in the area that NEW Health serves. How would better infrastructure and the adoption of telehealth technology strengthen your ability to serve your patients?

*Ms. Sweeney. Yes, thank you for that question. I think it is best illustrated by an experience.

And so every day at 3:30 our internet broadband for my health care physicians was declining, and our EHRs would really bog down. So as our IT department further analyzed what was going on, what happens at 3:30 in most of our areas? Our students are getting out of school and they are coming home. So they are jumping on their gaming systems, and competing for that same broadband that we are trying to do our health records, and it really became problematic.

And so in rural communities we are competing for that same broadband. We don't have dedicated lines, we don't have fiber. Like I mentioned earlier, we have some of our communities that are still on dial-up internet. And so it is really just a big challenge for our employee -- or our -- excuse me, our patients as a whole. So it limits our ability to build out that telehealth.

So we did talk about telephonic as an opportunity we have utilized. But I think, too, the cost prohibitive nature of our ISP providers, and so the cost for rural broadband for our constituents, is much higher than it is for our urban partners. And so much so we had utilized the USAC funding historically this last year. Our broadband provider did not submit a bid. There is nothing we can do about it, so our cost for broadband will go back up to its original cost, which is -- takes a significant part of our budget, and takes away from our primary care resources because we have to fill that budget shortfall.

*Ms. Craig. Thank you so much, Ms. Sweeney. And I was sort of chuckling here as you were talking about competing with kids for broadband coverage. I -- as the mother of four sons, I certainly can remember those days of competing with Xbox and other gaming systems. So thank you for that.

Dr. Croston, how can deployment of broadband funding through Federal programs help improve access to trauma care, particularly in rural areas?

*Dr. Croston. Thank you, Representative Craig. Certainly, having visual connections to remote emergency room sites would provide the opportunity to give better guidance and help triage more effectively.

The biggest problem rural areas face is getting to definitive care as quickly as possible, and sometimes that

means a short stay in an emergency room remotely, and sometimes people would prefer to recover at home if it is at all possible.

So having access to telehealth or a connection to a level one trauma center and staff there might provide support that would be needed to keep people locally, when possible. So it should work both ways.

*Ms. Craig. Thank you so much for that. I know that telehealth accessibility is an issue we can all agree should demand more Federal attention.

And I was proud to introduce H.R. 8169, the Rural Telehealth Access Task Force Act, with my colleague, Congressman Pence. This bill will form an HHS-led task force to study barriers to telehealth access and identify potential solutions.

I am really proud of the investments most recently that we are making in many of our states through the bipartisan infrastructure bill to expand access to broadband, to the internet, and I look forward to continuing to work with each of you to make sure that it reaches all Americans.

And with that, Madam Chair, I am going to yield my five seconds back to you.

*Ms. Eshoo. I appreciate it. The gentlewoman yields back.

It is a pleasure to recognize the gentlewoman from

Massachusetts -- almost last, but not last at all -- a great member of our subcommittee, Congresswoman Trahan.

*Mrs. Trahan. Well, thank you, Madam Chairwoman, and thank you to the witnesses here today.

Throughout the COVID-19 pandemic, community health centers across the nation have delivered lifesaving care to the American people. Ms. Sweeney, in your testimony you recognize that not all communities can support a full-time, brick-and-mortar health center site, and that your new mobile unit has been a cost-effective alternative that breaks down transportation and access barriers to your patients.

In my district few have done more to serve numerous patient populations before and throughout the pandemic than the hardworking men and women at the Greater Lawrence Family Health Center, the Lowell Community Health Center, and Community Health Connections in Fitchburg, Massachusetts. And since 2017, the Greater Lawrence Family Health Center has utilized mobile health units to connect with the homeless population in Lawrence. This population does not typically access the brick-and-mortar health center, but instead they rely on the health centers -- two mobile units to receive substance use disorder treatment, behavioral health care, primary care, and acute care.

These mobile units also screen for social determinants of health to get vulnerable populations access to necessities

like food and housing.

The Lowell CHC currently does not have a formal mobile health clinic. However, they host numerous preventative screenings and COVID-19 vaccination clinics in the community, which have been very successful, and have demonstrated the ability to close disparities in access to such services. Lowell CHC is currently exploring expanding this model as a mobile health clinic.

So the Mobile Health Care Act will achieve the goal of allowing more health centers the flexibility to acquire and develop innovative mobile clinic solutions to serve some of the hardest-to-reach populations such as veterans, homeless individuals, agricultural workers, and those in remote areas.

So, Ms. Sweeney, if you could, just describe how the Mobile Health Care Act helps health centers like Lawrence and Lowell and Fitchburg either build up or establish their mobile health units.

*Ms. Sweeney. Yes, that is -- thank you for asking that question. So the legislation enables mobile units to qualify as a new access point, regardless of whether it is associated with a permanent site. This designation and funding flexibility will facilitate more mobile units being utilized by health centers, and getting our patients access where they need access.

So it takes a really -- you know, aligning it to a site,

and we can more easily get it to multiple sites within our service area. Like we mentioned earlier, we are three-county location, so we can better serve patients more cost effectively.

*Mrs. Trahan. And Ms. Sweeney, in your testimony you also discuss the critical workforce shortages and the high staff turnover health centers grapple with daily. What are some of the difficulties your health center faces in staffing your mobile unit?

And then what Federal resources do health centers across the nation need to overcome these workforce barriers to be able to continue providing culturally competent and quality care to their under-served patient populations?

*Ms. Sweeney. Yes, so our mobile unit has actually been a very positive thing when we are talking about provider burnout, that people are looking forward to a care model that is -- you know, more readily meets the patient's needs. And so our plan for our existing clinical staff is to roll out our existing staff into the mobile clinic, and then we will look at evaluating a dedicated mobile clinic staff team individually.

And so it is important to note that our workforce challenges predated COVID. And so our workforce challenges are not just limited to clinical positions. It is across all things. So we need resources for those capital projects, for

workforce development programs.

And again, community health centers have multiple gaps that we are trying to do. And in our testimony we did talk about NEW Health University, our strategic workforce program. So we are very excited about our initial results with that, and how we are overcoming not only our mobile staffing, our behavioral health staffing, and our general staffing challenges in general.

*Mrs. Trahan. Well, it is such an important time. And I am thrilled to see this piece of legislation, you know, move forward with the support -- and also your testimony, which validates the need for getting beyond the brick-and-mortar clinic.

Thank you so much, Madam Chair. I yield back.

*Ms. Eshoo. The gentlewoman yields back. That concludes members of the subcommittee questioning. And I now would like to recognize a member of the full committee, the gentlewoman from New York.

And we are very grateful to you, Congresswoman Clarke, for H.R. 2007, named for our late colleague, Stephanie Tubbs Jones. So it is a pleasure to have you with us. You can waive on to this subcommittee any time you would like. You are recognized for five minutes of questions.

*Ms. Clarke. And I thank you very much, Madam Chair, for including a piece of legislation in this hearing that not

only holds great personal significance to me, but is especially important during a time where women's basic reproductive rights are under attack.

Let me thank the witnesses. This has been a fascinating hearing, and has really driven home the challenges we face as a multi-ethnic, multi-racial, multi-religious society.

My legislation, H.R. 2007, the Stephanie Tubbs Jones Uterine Fibroid Research and Education Act, is named in tribute to our dear colleague, friend, mentor, the late, great honorable Congresswoman Stephanie Tubbs Jones. We know that, during her tenure in Congress, this legislation was one of her top priorities, as Black women are disproportionately impacted by uterine fibroids more than any other women. And she would often say, as has been stated by our witness, that Black women deserve better.

And myself personally living through my own challenges with uterine fibroids, I think often times about the millions of marginalized women who possess little to no means for treatment, and can -- and cannot access any solutions for their pain and suffering, and they are suffering in silence.

For my colleagues who may not be as in-tuned, uterine fibroids are non-cancerous growths on the uterus, and are among the country's most common gynecological conditions. About 26 million women and girls in the United States between the ages of 15 and 50 have fibroids, with more than 15

million experiencing what is classified as severe symptoms. And no group of women suffer more from fibroids than Black women, who are at an increased risk compared to their White counterparts to get fibroids at a younger age, and suffer with more severe symptoms.

It is estimated that fibroids cost the health care system between 5.9 billion to $34.4 million each year [sic] in productivity.

This issue has not received the attention nor the funding it deserves. And increasing awareness on uterine fibroids is critical to our efforts to address the national maternal mortality crisis and prevent pregnancy-related deaths. We must allocate funding towards research and education, so that those being impacted are receiving the proper care that they deserve. But in doing so, we can close the gap on this glaring disparity that has been disproportionately borne out in the lives of Black women.

Lastly, I would like to thank and recognize the work of the Fibroids Foundation, the White Dress Project, and other organizations and individuals that continuously and tirelessly advocate and create awareness about this condition.

Let me say, Madam Chair, that it is critical that we look at the whole woman and the health care. These are the most important reproductive years in the lives of women. And

to be afflicted with such a condition during that time is devastating in many ways, and dangerous in others.

So I would like to direct my first question to Ms. Tanika Gray Valbrun.

Tanika, thank you for being here today and sharing with the committee your personal experiences with fibroids. Why do you believe we need to research and disseminate public information on fibroids?

*Ms. Valbrun. Thank you so much, Congresswoman, for your advocacy and for sharing your story.

It is imperative that we collect data and research so that we can know what is happening with this condition. On a very base level, there is so much information that we still don't know for the general public. A lot of women still don't know that a lot of times the symptoms they are experiencing are as a result of uterine fibroids.

So for this condition, there are just base definitions and clinical studies that need to be done so that we are aware of what is happening with this condition, and really that we can educate people. There is really --

*Ms. Clarke. And could you --

*Ms. Valbrun. -- just a lot of lack of awareness.

*Ms. Clarke. And could you elaborate on how disruptive uterine fibroids can be to a woman's overall workplace performance and quality of life?

*Ms. Valbrun. Yes, absolutely. Quality of life is one of the biggest symptoms. The impact on quality of life is one of the biggest symptoms of uterine fibroids. Taking multiple days off work, not feeling comfortable, having stains and embarrassment, as I spoke about in my testimony.

So it really is something that is daunting, and that many women have to think about when they think of their social life, when they think of the jobs they are going to get, even sitting -- standing up from a chair can be a crucial part in a woman's life when she is dealing with fibroids.

*Ms. Eshoo. The gentlewoman's --

*Ms. Valbrun. So it is --

*Ms. Craig. Thank you. I have run out of time. I appreciate it.

*Ms. Valbrun. Yes.

*Ms. Craig. Madam Chair, I yield back. Thank you.

*Ms. Eshoo. The gentlewoman yields back. I wanted to be a little more generous with your time, because you have waited since 8:00 a.m. or 11:00 a.m. to join us today.

That now concludes our hearing. I want to thank, on behalf of all of my colleagues, Dr. Bibbins-Domingo, Dr. Croston, Ms. Gray Valbrun, Mr. Shannon, Ms. Sweeney, and Dr. Walker-Harding for your very important and highly instructive testimony today.

Please know that members have 10 business days to submit additional questions for the record. And so I ask the witnesses to please respond promptly to any questions that you receive.

And I do have a submittal of documents to the record. I request unanimous consent to enter the following documents into the record: a letter from the Medical Imaging and Technology Alliance in support of H.R. 2007; a letter from the American College of Surgeons regarding H.R. 8163; a letter from the March of Dimes in support of H.R. 7565 and H.R. 2007; a statement from the Fibroid Foundation on H.R. 2007.

Does the ranking member join me in the unanimous consent request?

*Mr. Guthrie. Yes, Madam Chair. We have no objections on our side.

*Ms. Eshoo. Okay. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. Thank you very much, Mr. Guthrie.

And not seeing anything else to come before the subcommittee this morning, I want to thank all of my colleagues for your important work. I am so proud of this subcommittee and what each member brings forward to make a difference to the people of our country.

So at this time, in gratitude and respect for the rest of your day, the subcommittee is adjourned.

[Whereupon, at 1:58 p.m., the subcommittee was adjourned.]