

U.S. Department of Health and Human Services  
National Institutes of Health

# Thirtieth Meeting of the Clinical Center Research Hospital Board

January 30, 2026

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## **Clinical Center Research Hospital Board**

### ***Leadership***

Jack Leslie, Former Chair, Weber Shandwick; Senior Visiting Fellow, Duke Global Health Institute; Distinguished Professor, Georgetown University; and Chair, National Institutes of Health (NIH) Clinical Center (CC) Research Hospital Board (CCRHB)

Matthew J. Memoli, M.D., M.S., Principal Deputy Director, NIH, and Designated Federal Official, CCRHB

### ***Members***

David M. Baum, PMP, NIH Research Participant, Patient Advocate, and Member, NIH CC Patient Advisory Group (virtual)

David C. Chin, M.D., M.B.A., Distinguished Scholar, Johns Hopkins Bloomberg School of Public Health, and Johns Hopkins University School of Medicine

Regina S. Cunningham, Ph.D., RN, FAAN, Chief Executive Officer (CEO), Hospital of the University of Pennsylvania Health System

Sherin U. Devaskar, M.D., Executive Chair of the Department of Pediatrics at the University of California, Los Angeles (UCLA); Physician-in-Chief, UCLA Mattel Children's Hospital; and Assistant Vice Chancellor of Children's Health, UCLA Health (virtual)

Julie Freischlag, M.D., Ambassador, Advocate Health; former CEO and Chief Academic Officer of Atrium Wake Forest Baptist, CEO and Executive Vice President (EVP) of Advocate Health, and EVP for Health Affairs at Wake Forest University

Steven I. Goldstein, M.H.A., CEO of System Integration, University of Rochester Medical Center (virtual)

Stephanie Reel, M.B.A., Former Chief Information Officer (CIO), Johns Hopkins University and School of Medicine; former Interim CIO, Washington University in St. Louis; and former advisor to CIO, University of Michigan (virtual)

Antoinette Royster, NIH Research Participant, Patient Advocate, and Member, NIH CC Patient Advisory Group

## **Executive Summary**

The Clinical Center (CC) Research Hospital Board (CCRHB) of the National Institutes of Health (NIH) convened its 30th meeting in person and via VideoCast on January 30, 2026. The meeting was webcast live and open to the public. A [VideoCast recording](#) is available.

Mr. Jack Leslie, CCRHB Chair, called the meeting to order at 9:00 a.m. ET.

Dr. Matthew J. Memoli, Principal Deputy Director, NIH, described recent NIH leadership changes. Rick Woychik, Ph.D., is now Senior Advisor to NIH Director Jay Bhattacharya, M.D., Ph.D., for the “Make America Healthy Again” Strategy; Jon R. Lorsch, Ph.D., is Deputy Director for Extramural Research (previously acting), and Nicole C. Kleinstreuer, Ph.D., is Deputy Director for Program Coordination, Planning, and Strategic Initiatives (previously acting). Dr. Memoli reported on progress toward filling key positions across NIH Institutes and Centers (ICs) as well as the CC.

Mr. Pius Aiyelawo, Chief Operating Officer and Acting Chief Executive Officer, NIH CC, provided updates on CC staffing and recruitment; NIH Director approval to establish a Pediatric Intensive Care Unit; and celebrations, honors, and awards since the May 2025 CCRHB meeting. He highlighted CC priorities, including taking care of patients and research participants; taking care of staff and trainees; engaging NIH IC partners to increase CC utilization; resource stewardship; and a safe, seamless transition to the new Surgery, Radiology, and Laboratory Medicine wing. Mr. Aiyelawo summarized key themes from Dr. Bhattacharya’s January Grand Rounds presentation, including strategies for increasing CC utilization and prioritizing gaps in pediatric research and care as a cross-NIH priority.

Presenting on behalf of Dr. Saly Gabriel, Chief of the NIH CC Pharmacy Department, Mr. Aiyelawo provided an overview of the Permanent Intravenous Admixture Unit, including critical paths, a timeline, and progress toward a projected launch in late 2026.

Dr. Colleen Hadigan, Chief Medical Officer and Clinical Director, NIH CC, and Dr. William A. Gahl, Pediatric Planning Group (PPG) Chair and Senior Investigator, Medical Genetics Branch, and Director, Undiagnosed Diseases Program, National Human Genome Research Institute, presented on pediatrics at the NIH CC. They presented challenges, solutions, and recommendations from the original and reinvigorated PPGs and the CC Children’s Working Group.

Dr. Maryland Pao, Clinical Director, National Institute of Mental Health (NIMH) Intramural Research Program, Deputy Scientific Director, and Senior Clinician, NIMH, presented the NIH Intramural Research Program Strategic Planning on behalf of the Clinical Care and Services Task Force. The strategic plan includes a vision for CC clinical care and services, current issues to address, and proposed solutions, emphasizing the need for a permanent chief executive officer, competitive salaries, and increased visibility to enhance patient recruitment and clinical care.

The CCRHB is slated to meet again on June 12, 2026.

Mr. Leslie adjourned the meeting at 12:03 p.m. ET.

# Meeting Summary

January 30, 2026

## Welcome and Chair of the Board Overview

*Jack Leslie, Former Chair, Weber Shandwick; Senior Visiting Fellow, Duke Global Health Institute; Distinguished Professor, Georgetown University; and Chair, National Institutes of Health (NIH) Clinical Center (CC) Research Hospital Board (CCRHB)*

Mr. Leslie began the meeting at 9:00 a.m. ET and asked members of the Board to introduce themselves.

- Mr. David M. Baum is an NIH patient, a patient advocate, and a participant in the CC Patient Advisory Group.
- Dr. David C. Chin is a Distinguished Scholar at the Johns Hopkins Bloomberg School of Public Health and Johns Hopkins University School of Medicine.
- Dr. Regina S. Cunningham is Chief Executive Officer (CEO) of the Hospital of the University of Pennsylvania Health System.
- Dr. Sherin U. Devaskar is Executive Chair of the Department of Pediatrics at the University of California, Los Angeles (UCLA); Physician-in-Chief at UCLA Mattel Children's Hospital; and Assistant Vice Chancellor of Children's Health at UCLA Health.
- Dr. Julie Freischlag recently retired from her positions at Atrium Wake Forest Baptist and Advocate Health and transitioned to a new ambassador role at Advocate Health.
- Mr. Steven I. Goldstein is CEO of System Integration at the University of Rochester Medical Center.
- Ms. Stephanie Reel has served as a Chief Information Officer (CIO) at Johns Hopkins University and Johns Hopkins School of Medicine, Interim CIO at Washington University in St. Louis, and advisor to the CIO at the University of Michigan.
- Ms. Antoinette Royster is an NIH patient and patient advocate and a participant in the CC Patient Advisory Group.

Mr. Leslie noted that Nina Schor, M.D., Ph.D., former Deputy Director for Intramural Research (DDIR), retired from NIH in December, with plans to return to the University of Rochester, where she chaired the Department of Pediatrics. A letter and certificate of appreciation from the CCRHB will be sent to Dr. Schor in recognition of her contributions.

## NIH Director's Remarks

*Matthew J. Memoli, M.D., M.S., Principal Deputy Director, NIH, and Designated Federal Official, CCRHB*

Dr. Memoli briefly described his background, including 20 years at NIH, and his passion for clinical and translational research. He highlighted recent leadership changes at the NIH Office of the Director (OD).

- Rick Woychik, Ph.D., is now Senior Advisor to NIH Director Jay Bhattacharya, M.D., Ph.D., for the "Make America Healthy Again" Strategy.

- Jon R. Lorsch, Ph.D., is now Deputy Director for Extramural Research.
- Nicole C. Kleinstreuer, Ph.D., is Deputy Director for Program Coordination, Planning, and Strategic Initiatives.

Dr. Memoli described current efforts to fill open director positions at NIH Institutes and Centers (ICs), noting that excellent candidates are being vetted. He expects new directors will be seated this year.

In addition, candidates have been interviewed for DDIR, a position he believes will be the first to be filled.

Dr. Memoli commented on the dearth of physician-scientists who bridge the gap between clinical practice and research, describing the CC as the ideal setting for translational research—connecting with patients, identifying their needs, conducting research toward fulfilling those needs, and implementing research findings in the clinic. He expressed a desire to expand the work so that Clinical Fellows receive training at the CC to become physician-scientists conducting translational work at the CC or at other institutions.

### ***Discussion***

The following discussion ensued:

- Mr. Baum asked about the status of the CC CEO search. Dr. Memoli responded that the search for this position is nearing completion. Recommendations will be submitted to Dr. Bhattacharya soon.
- Mr. Leslie commented on the loss of research talent across universities, hospitals, and other institutions and asked how NIH is addressing this problem. Dr. Memoli responded that traditional models for attracting people to science careers are failing. The work hours, the long career trajectory, and the pay are less appealing than other options. The scientific and medical community need to think seriously about ways to encourage young people in the U.S. to get into research. Physicians need exposure to research and to recognize that their research can have a positive impact on many more people than they will encounter in years of clinical practice.
- Dr. Devaskar mentioned the recent [National Academies of Sciences, Engineering, and Medicine \(NASEM\) report](#) calling for an NIH-wide strategy to prioritize and fund pediatric research. She asked Dr. Memoli about filling the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD) director position. Dr. Memoli reported that interviews for the NICHD position are in the second of a three-tier process leading to a recommendation to hire.
- Ms. Royster described NIH as a hidden jewel. She noted that many people are not familiar with the splendid work that NIH is doing, and they are not interested in participating in clinical trials, in part because of historical abuses. She asked about NIH plans to increase both public awareness of NIH and recruitment of clinical trial participants. Dr. Memoli described NIH's work to convey the message that the 27 NIH ICs are all part of one institution. First, NIH is implementing a more coordinated communications approach—consolidating websites, social media, and other outreach from across the ICs into a single NIH online presence. Second, when the new CC CEO and DDIR are on board, Dr. Memoli plans to strategize ways to bring all the intramural programs engaged in clinical research together and move away from siloed operations.

The physicians working in the CC should all know each other and the work they are doing. Finally, the historical issues that Ms. Royster mentioned present an ongoing challenge that NIH must continue to address. NIH is relying on members of the CCRHB and others to share these important messages in their own communities.

- Ms. Royster suggested that a video would be a good way to send a clear message to the public. Dr. Memoli agreed.
- Dr. Chin commented that the focus on one NIH is reminiscent of what academic medical centers are facing with silos within their systems. He wondered what incentives could be used to bring about change. Dr. Memoli explained that he envisioned bringing the intramural programs together in a collaborative way by increasing interaction and shared resources. He noted that IC directors recognize that solving the big problems requires collaboration, cooperation, and interoperability among the ICs.

## **NIH Clinical Center Acting Chief Executive Officer Update**

*Pius Aiyelawo, M.P.A., FACHE, Acting CEO and Chief Operating Officer (COO), NIH CC*

Mr. Aiyelawo thanked Mr. Leslie and the Board members for their flexibility in rescheduling the CCRHB meeting and acknowledged that support from Drs. Bhattacharya and Memoli helps ensure that patient partners continue to receive safe and quality care.

Mr. Aiyelawo called for a moment of silence in memory of three key CC team members: Dr. David M. Lang, Chief of the Office of Patient Safety and Clinical Quality; Dr. Alexander “Skip” Ling, Staff Clinician, Radiology and Imaging Sciences; and Ms. Diane Huss, Research Nurse, CC Nursing Department.

### ***Staffing and Recruitment Updates***

Mr. Aiyelawo provided an update on CC staffing and recruitment. During the hiring freeze implemented January 20, 2025, and extended multiple times until October, Dr. Memoli was instrumental in obtaining approval of hiring exemptions for 17 critical vacancies. Mr. Aiyelawo is working with the Department of Health and Human Services (HHS) Office of Human Resources on a conditional staffing plan with more than 100 vacancies. Recruitment and hiring for critical positions can begin within a few weeks of approval of the plan.

### ***Five CC Priority Areas***

Mr. Aiyelawo shared five priority areas for the CC.

1. Taking care of our patients and research participants
2. Taking care of our staff and trainees, including staff well-being and professional development
3. Engaging IC partners to increase CC utilization through the NIH DDIR Clinical Care and Services Task Force and the re-established Pediatric Planning Group (PPG 2.0)
4. Taking care of the resources entrusted to us by ensuring that every dollar spent addresses the first three priorities
5. Accomplishing a safe and seamless transition to the new Surgery, Radiology, and Laboratory Medicine (SRLM) wing

Mr. Aiyelawo shared examples of patient feedback (Priority 1). He highlighted key points from Dr. Bhattacharya's Grand Rounds presentation that underscore a commitment to engage IC partners to increase CC utilization (Priority 3), as follows:

- Underutilization of the CC is an opportunity. As the engine of translation with close integration of basic scientists, fully used in service of patients and discovery, the CC has the capacity to do more and better science. Utilization of the CC can be increased by fostering collaborations across ICs, supporting early career scientists to lead clinical studies, reducing structural barriers to CC access, making the CC a destination for rare and high-risk conditions, and expanding who can participate by removing unnecessary age and eligibility barriers.
- Addressing historical gaps in pediatric research and care is a cross-NIH priority. Progress in this area includes re-establishment of the PPG in 2025 to provide recommendations to the NIH Director and approval of a dedicated Pediatric Intensive Care Unit (PICU) that enables admission of patients under 2 years of age and inclusion of infants and critically ill children in research.

### ***Budget***

Despite challenges arising from a 50% reduction of CC acquisition staff, the fiscal year 2025 (FY25) budget was implemented, with a spending plan that reflected lower volume in FY25.

The FY26 budget was presented to the CC Governing Board and approved by Dr. Bhattacharya. Volume and staffing challenges are expected to continue with recruitment, retention, and retirements being key issues in FY26.

The FY26 Capital Investment Fund will be sourced as initial capital outlay for outfitting the SRLM wing, while current hospital capital needs will be managed conservatively with the CC budget.

### ***CC Statistics***

Mr. Aiyelawo reported FY26 CC year-to-date average daily census (ADC) and patient activity (as of January 25, 2026). Compared with the previous fiscal year, the ADC, inpatient admissions, average length of patient stay, total inpatient days, and new patients, as well as outpatient total visits, clinical visits, and day hospital visits, are down. Mr. Aiyelawo attributed some of the drop to the government shutdown and retirement and departure of investigators. He projects that these numbers will increase for the rest of the year. Noting that telehealth capability is being expanded, Mr. Aiyelawo expects the number of telehealth visits to reach 600 for FY26.

### ***Intramural Research Leadership***

Mr. Aiyelawo acknowledged Dr. Nina Schor for her strong advocacy and leadership during her service as the DDIR. He welcomed Roland Owens, Ph.D., who is Acting DDIR while NIH recruits to fill this position.

### ***CC Staff Updates***

Mr. Aiyelawo provided updates on CC staff, including CC CEO and CC Executive Officer vacancies. Recent departures include Dr. Karen Frank, Chief of the CC Department of Laboratory Medicine; Chief Health Information Officer Ms. Patricia Coffey; and Dr. Bradford

Wood, Chief, Interventional Radiology Section, CC Radiology and Imaging Sciences Department, and Director, NIH Center for Interventional Oncology. The following members of CC nursing leadership have retired: Ms. Mary Myers, Nurse Educator, Medical Surgical Specialties; Ms. Tami Williams, RN, Nurse Manager, Intensive Care Unit, Critical Care; and Ms. Debbie Gutierrez, Nurse Manager, Medical/Telemetry/Surgical Services, Special Clinical Studies Unit.

Mr. Aiyelawo acknowledged seven CC Acting Chiefs: Dr. Jennifer Barb, Translational Biobehavioral and Health Promotion Branch; Dr. Katherine Calvo, Department of Laboratory Medicine; Dr. M. Jennifer Cheng, Pain and Palliative Care Service; Dr. Amanda Grove, Health Information Management Division; Dr. Galen Joe, Rehabilitation Medicine Department; Dr. Ninet Sinaii, Biostatistics and Clinical Epidemiology Service; and Dr. David Wendler, Bioethics Department.

Mr. Aiyelawo noted that, due to an organizational change to improve efficiencies, five CC Office of Communications and Media Relations (OCMR) staff members transitioned to the NIH Office of Communications and Public Liaison in October. Two OCMR staff remain with the CC: Mr. Donovan Kuehn, Acting Chief, OCMR, and Ms. Maryia Maslennikov, Special Project Lead and Media Relations Coordinator.

Mr. Aiyelawo congratulated CCRHB member Dr. Julie Freischlag on her recent retirement from Wake Forest Baptist.

### ***Facility Updates***

The Pediatric Clinic reopened on June 16. The renovated space features a redesigned entryway, reception space, and waiting areas and offers a bright, imaginative, and calming environment tailored to children and families.

Mr. Aiyelawo shared recent photos showing progress on the CC SRLM wing. The new wing is scheduled to open in May 2029. [SRLM construction news and updates](#) are available online.

### ***Honors and Events***

Mr. Aiyelawo summarized recent CC honors:

- The CC CEO awards recognized 84 hardworking, compassionate individuals and 96 groups with 861 members.
- The second annual Graduate Medical Education graduation ceremony on June 6 celebrated 82 residents and fellows in the class of 2025. In July, 83 incoming NIH Clinical Fellows took the federal oath of office.
- Dr. Alexandra Freeman, a pediatric infectious diseases physician, received the 2026 Distinguished Clinical Teacher Award.
- In September, CC hospital leaders honored six staff members for extraordinary compassion and teamwork in patient care with dedication that restored dignity and comfort. STARS Awards were presented to Ms. Karen Chandler Axelrod, Ms. Sonia Simpson, Dr. Daanish Memon, Ms. Thuy-Tien Nguyen, Ms. Djeza Kore, and Ms. Isabella Imran, RN, BSN.

Recent social events at the CC included a concert by the National Symphony Orchestra and the 2025 CC Gingerbread House Contest supported by the Foundation for the NIH and the NIH Recreation & Welfare organization.

### ***What to Expect for the Rest of FY26***

Mr. Aiyelawo summarized expectations for the remainder of the year. The CC will lead and support efforts to establish a PICU. The CC will continue to focus on staff and trainee well-being; care of patients, including pediatric patients, and research participants; and recruitment to fill approved critical staff positions. More retirements are likely.

The CCRHB is scheduled to meet on June 12 and October 16. Board members will be notified regarding tenure and appointment end dates, with consideration for extension if maximum service has not yet been reached.

### ***CC Quarterly Report on Clinical and Safety Performance Metrics***

Mr. Aiyelawo stated that Dr. David Lang, Chief, Office of Patient Safety and Clinical Quality, prepared the quarterly report for the October 2025 CCRHB meeting that was cancelled. The report included in CCRHB pre-meeting materials for the January 2026 meeting reflects the most current data available. Questions should be directed to Mr. Aiyelawo or Ms. Patricia Piringer.

### ***Discussion***

The following discussion ensued:

- Mr. Baum asked about the impact of the OCMR reorganization on CC patient recruitment activities. Mr. Aiyelawo responded that, for now, the CC Office of Patient Recruitment resides under the Acting CEO and is still actively recruiting patients.
- Mr. Baum asked whether an analysis of the domestic versus international patient population has been conducted and whether a reduction in the number of international patients contributed to the decreased number of patients at the CC. Mr. Aiyelawo reported that international patients account for 7% of CC inpatients and 3% of CC outpatients, a relatively small part of the patient population.
- Mr. Baum commented on the need to increase awareness of the CC and asked whether graduating fellows are encouraged to refer patients to the CC. Mr. Aiyelawo noted that each IC manages its own fellows, and marketing the CC is a corporate focus for the future.
- Mr. Baum asked why the electronic health record (EHR) modernization project was not among the FY26 priorities. Mr. Aiyelawo responded that, although the EHR project is not in the FY26 budget, it is a high priority for leadership. Drs. Bhattacharya and Memoli are working with HHS to identify the optimal way to fund and execute the project.
- Dr. Cunningham suggested that strategies for recruiting outpatients might be applied for inpatient recruitment. Mr. Aiyelawo commented that he could investigate how many of the active trial protocols are outpatient versus inpatient based; however, protocol duration is another variable that affects the outpatient visit numbers versus inpatient admissions.
- Dr. Cunningham noted the inclusion of Dr. Freeman, the Distinguished Clinical Teacher Award recipient, in a documentary. She advocated repurposing existing materials to raise public and patient awareness of the CC.

- Ms. Royster described issues retrieving her lab reports from the FollowMyHealth<sup>®</sup> Patient Portal, which the CC Records Department explained is a systems glitch. Mr. Aiyelawo agreed to investigate the issue and follow up with Ms. Royster.
- Mr. Leslie commented that the EHR issue has been raised at nearly every meeting he has attended and requested a report to the CCRHB. Mr. Aiyelawo responded that the EHR system was built in 2004 and needs to be updated. He is optimistic that this requirement will rise to the top of the priority list shortly.
- Ms. Reel commented that she had conducted two external reviews at the CC and was amazed by the dedicated teams who wanted to do well despite not always having the most modern or reliable tools. She offered her assistance in making a case for investment in technology.
- Dr. Devaskar asked whether the new PICU will be located near the newly renovated pediatrics wing. Mr. Aiyelawo responded that the PICU will be adjacent to the ICU on the top floor, where infrastructure is readily available.
- Dr. Devaskar commented on the increased use of artificial intelligence (AI) and asked whether there are any plans to introduce AI at the CC for applications such as translation for patients and notetaking. Mr. Aiyelawo agreed that AI is a big topic of discussion within NIH. Although its use is limited now, new ways to deploy it are under consideration.
- Dr. Devaskar asked whether there is an NIH Clinical Fellow alumni organization that could be leveraged to keep Fellows engaged and attract them to return to work at NIH. Mr. Aiyelawo said he would investigate whether there is an alumni organization and report back to the Board.
- Ms. Royster and Mr. Leslie both commented on how often Mr. Aiyelawo is mentioned in conversations across the CC and acknowledged his contributions toward building morale and confidence among the staff during challenging times.
- Mr. Leslie noted that key topics for the June 2026 CCRHB agenda should include patient and talent recruitment, EHRs, and AI.

## **Clinical Center Pharmacy Department: Permanent Intravenous Admixture Unit**

*Pius Aiyelawo, M.P.A., FACHE, Acting CEO and COO, NIH CC, on behalf of Saly Gabriel, Pharm.D., M.B.A., Chief, Pharmacy Department, NIH CC*

Mr. Aiyelawo presented an overview of progress on the CC Pharmacy Department's permanent Intravenous Admixture Unit (P-IVAU) project, on behalf of Dr. Gabriel.

Mr. Aiyelawo outlined background activities, critical paths, and progress toward establishing a permanent IVAU, with a projected launch in late 2026. These activities were triggered by a Food and Drug Administration (FDA) inspection in 2015, a Joint Commission visit, and compliance with U.S. Pharmacopeia General Chapter 800 (USP 800) Designated Persons requirements.

Mr. Aiyelawo noted that CC pharmacy spaces were renovated in 2019 and are operating very well now with advanced technology capabilities, including robotics.

P-IVAU critical paths are construction and commissioning, qualification, and validation (CQV); environmental monitoring performance qualification (EMPQ); personnel qualification; an

external audit; and, finally, an FDA audit. The team expects to complete the CQV within the next few weeks, which will enable entry into the EMPQ phase.

Moving into the P-IVAU is predicated on success at each stage. Roadblocks include staffing continuity, coordination with contractors for CQV activities (with full support from NIH Office of Research Facilities leadership), and arrangements for the FDA audit.

### ***Discussion***

The following discussion ensued:

- Dr. Cunningham asked about strategies to mitigate the roadblocks, such as advance conversations with FDA. Mr. Aiyelawo noted that Dr. Gabriel has extensive experience, obtained guidance from FDA, and put plans in place to address those potential roadblocks.
- Mr. Baum asked whether the external audit will be to FDA or USP 800 standards. Mr. Aiyelawo clarified that everything is being done to meet USP 800. FDA is aware.

## **Pediatric Care and Research at the NIH Clinical Center**

*Colleen Hadigan, M.D., M.P.H., Chief Medical Officer and Clinical Director, NIH CC; and William A. Gahl, M.D., Ph.D., PPG Chair, Senior Investigator, Medical Genetics Branch, and Director, Undiagnosed Diseases Program, National Human Genome Research Institute*

Dr. Hadigan presented an overview of pediatric care and research at the NIH CC, including updates on the PPG and the CCRHB Children's Working Group.

The changing landscape of pediatrics—advances in gene therapy and the expansion of cellular therapies and stem cell transplantation—created a need for the CC to have state-of-the-art resources and expertise to provide care for high-acuity pediatric patients. Over the past few decades, practice standards have shifted to a preponderance of subspecialty care in pediatrics. It is no longer acceptable for an adult emergency room doctor to provide emergency care to a child or manage an acutely ill child without subspecialty training. The model of floating between internal medicine and pediatric training needed to shift toward having in-house expertise and training to support children in research protocols.

### ***Pediatric Planning Group (PPG) 1.0***

In spring 2021, the NIH CC Governing Board called for a PPG (PPG 1.0) to assess feasibility and identify how to expand pediatric volumes within the CC, enhance resources for high-acuity patients, and reduce the lower age limit for inpatients from 3 years to infancy. In 2022, the first PPG presented its recommendations. Key recommendations focused on capacity for emergency care (i.e., emergency response for children to be led by pediatric expertise and to increase availability of airway and anesthesia management for children), critical care (i.e., create a PICU), and enhanced pediatric subspecialties (i.e., identify resources and partners to address unmet needs such as nephrology, dialysis, surgery, and radiology/interventional radiology).

### ***CC Children's Working Group***

In response to the PPG report, the CCRHB commissioned a Children's Working Group (CWG), led by Dr. Devaskar, to identify what the CC needed to implement the PPG recommendations. The CWG identified CC strengths and challenges.

### ***Strengths and Recommendations***

- The CC is uniquely poised to conduct first-in-human trials for rare diseases and pair expertise with patient populations followed closely by investigators.
- A PICU would be justifiable if activity increased as estimated (143 pediatric patients each year).
- Age-competent emergency responses are needed for anesthesia, Code Blue, respiratory therapy, and pharmacy.
- A closed PICU model could be supplemented via a partnership with tertiary pediatric facilities to maintain skills.
- Medical director, nurse manager, and clinical nurse educator positions should be created for support.
- Contract coverage might be needed for days, with an in-house hospitalist with ICU training.
- Specialty service contracts might be considered, with telehealth leveraged wherever possible.
- Age limits should be reduced via a staged approach.
- A more child-friendly environment should be created (e.g., a Child Life program) and lab tests performed using lower blood volumes.

### ***Challenges and Solutions***

- Maintaining staff and provider competency and adequate staffing for full coverage of a 3-bed PICU would require a robust simulation, performance improvement, and quality assurance, which might be accomplished through a partnership with another institution.
- Maintaining staff numbers needed for full coverage might require a float pool.
- A pediatric quality and safety program that addresses pediatric, young infant, and ICU-level care led by appropriately trained individual(s) would be required.
- Clear protocols that trigger transport to escalate when care exceeds CC capacity would be required.
- Additional equipment would need to be acquired and maintained.

The CWG also provided an alternative to the PPG 1.0 plan: conducting NIH studies at other children's hospitals or academic medical centers that have the infrastructure required to care for critically ill children, robust research portfolios, and leading experts in the field, familiar with conducting clinical research studies in neonates, infants, and toddlers. However, this plan separates NIH researchers with disease and novel treatment expertise from patients and clinical trials.

Progress since the 2022 reports has included elevating pediatrics from a service to a full department and implementing a pediatric model of care that calls for all inpatients less than 18 years old to have a pediatrician as primary attending. To accomplish this, a pediatric hospitalist medicine team that provides 24/7 in-house coverage was established in fall 2022. As of 2024, all pediatric codes are led by CC pediatricians or ICU colleagues from Children's National Hospital via contract. Between September 2022 and September 2025, the hospitalist team provided care for 474 patients for a total of 2,895 patient days.

Additional progress includes a Child Life Specialists program that was launched in December 2024, with more than 250 consults provided to children enrolled in studies from 11 ICs. Anesthesia and urgent airway management have been increased to be in-house 24/7; pediatric ICU attending coverage has been expanded to be in-house Monday through Friday and available for call back on nights and weekends. Code Blue responses for children are now led by pediatric ICU attendings or hospitalists.

The general admission age was lowered from 3 years to 2 years in 2024. ICU admissions age remains at 3 years and minimum weight of 15 kg, which means that if a child under age 3 had an event, they would be transported out for ICU care.

Dr. Hadigan presented a snapshot of pediatric ICU activity for FY22, FY23, and FY24 and an overview of subspecialty coverage. During this period, nine pediatric patients aged 4 to 16 years were transferred to Children's National Hospital for escalated care, with one patient accounting for four transfers.

Dr. Hadigan noted an issue with subspecialty coverage provided by a cadre of highly skilled, credentialed pediatricians throughout the CC. Even with 21 pediatric subspecialties represented, there is a lack of coverage for pediatric surgery, radiology, and interventional radiology.

Currently, the CC pediatric clinical care space includes an 18-bed inpatient unit, a 14-bed day hospital, a 4-bed pediatric behavioral health unit with 2 beds for day hospital, and a 21-room dedicated pediatric outpatient clinic. As of January 2025, 329 protocols were enrolling children, 18 of which were pediatric only. Efforts are ongoing to perform labs on low blood volumes, and a simulation training program is underway to maintain age-specific skills.

### ***PPG 2.0***

Dr. Gahl provided an overview of the reinstated PPG (PPG 2.0), which focused on identifying what is necessary to have an onsite PICU and serve inpatients 6–24 months old. The PPG 2.0 met in September, reviewed the 2022 PPG recommendations, and established subgroups. Submission of the group's report is imminent.

The PPG 2.0 Pediatric Critical Care subgroup reviewed the 2022 recommendations for establishing a three-bed PICU managed by pediatric staff, with specified full-time equivalent positions, and phased changes to reduce the admission age limit from 24 to 18 months and then to 6 months. Dr. Gahl outlined subgroup recommendations for a three-bed PICU. Patients needing extracorporeal membrane oxygenation (ECMO) and dialysis would be transferred. Nurses suggested a 1:1 nurse:patient ratio, two RNs per shift, a PICU manager, team lead coverage, and a clinical educator, a pediatric advanced practice RN, and PICU-trained staff RNs 24/7. Ancillary staff and on-call consultants were specified.

The Pediatric Subspecialties subgroup recommended enhancing on-call coverage of selected services. The subgroup recommendations follow the American Academy of Pediatrics 2025 recommendations for PICU required positions, including cardiology, neurology, nephrology, radiology, and pediatric surgery. The subgroup also specified Tier 2 subspecialties not required for a PICU but with immediate needs and additional supportive care.

Mechanisms to enhance pediatric subspecialty include expanding in-house services, incentivizing ICs to hire staff, collaborating with Walter Reed National Military Medical Center, and contracting with another hospital center to fill gaps.

The Infants and Toddlers subgroup recommended enhancing nursing training/experience with younger children, providing ancillary support personnel (e.g., child life specialists), establishing lactation and infant nutrition services, providing supplies, making areas child-friendly, and creating a nutrition formula room.

Dr. Gahl summarized reasons for admitting young children and having an onsite PICU. NIH disease experts are integral to the PICU management of their intensively ill patients. Transfers to other hospitals cause delays and safety risks. Research on rare diseases and other types of research (e.g., gene therapy, bone marrow transplants) are not being performed at the CC in the absence of an onsite PICU. Finally, admitting young children to an onsite PICU is what is best for children.

### ***Discussion***

The following discussion ensued:

- Dr. Devaskar lauded the PPG's decision to follow recently released guidelines from the American Academy of Pediatrics to ensure that every detail is covered. She remarked that state-of-the-art technology is making life-altering changes when introduced early in infancy, particularly in genetic disorders for which therapies have not been available. Children receiving this kind of care can require intensive care, which means an onsite PICU is absolutely necessary.
- Dr. Devaskar asked for more details about the after-hours rapid response calls. Dr. Hadigan responded that the ICU intensivist is in-house Monday through Friday and shares an office with the hospitalists, so they are aware of what is happening with patients. It seems likely that the rapid response calls were made so that the intensivist could evaluate whether the care being provided was heading in the right direction or the child needed to be relocated to the ICU.
- Dr. Devaskar asked to confirm the ages of the children who were transferred out. Dr. Hadigan replied that patients under the age of 2 are not being admitted. Protocols that bring in children under age 2 are screened; for the most part, their visits are for blood drawing or imaging. General anesthesia and invasive procedures in that age group are rare.
- Dr. Devaskar asked about video capabilities. For example, can an intensivist call in to see a patient outside of regular hours? Dr. Hadigan responded that the CC has video capability, but there are billing and insurance barriers to its use when patients are not enrolled in the external consultant's health care system. However, during COVID, a child receiving gene therapy at the CC developed liver failure and was transferred to Children's National Hospital; the CC team was able to videoconference on rounds at the Children's National Hospital ICU.
- Dr. Freischlag encouraged enhancement of telehealth. For example, telehealth enables a pediatric surgeon to see a child who is at home instead of in a clinic where they may be stressed and crying. It also supports at-home and virtual care. Dr. Hadigan noted that the internal medicine consult service has leveraged telehealth for prescreening oncologic surgical patients, which contributes to high success rates when the patients arrive in person. The pediatric team can do the same.
- Dr. Freischlag commented on ways to make children feel comfortable, adding that music is incredibly helpful during blood draws. She looks forward to hearing many more

remarkable stories from the CC, especially about the children—incredible stories to share with the public.

- Mr. Baum asked for more information about the patients who were transferred for ECMO and dialysis. Dr. Hadigan responded that NIH does not provide ECMO for any patient at any age. The CC does provide dialysis and continuous renal replacement therapy down to a certain age and weight.
- Mr. Baum noted that the extraordinarily informative presentations demonstrated CC professionals' high level of interest in making pediatrics a success. He asked about availability of accommodations for families as the CC extends pediatric care to younger children. Mr. Aiyelawo responded that the CC is exploring what can be done to provide lodging and other accommodations for families to support the increased pediatric patient population.
- Mr. Baum asked about availability of pediatric ophthalmology specialists. Dr. Hadigan noted that the National Eye Institute director is a pediatric ophthalmologist, so the CC can engage him in support.
- Ms. Royster commended the inclusion of professionals who are comfortable with pediatric needs in all departments across the CC, including pharmacy and rehab medicine.
- Dr. Devaskar pointed out that the Children's Inn is located on campus. She added that healthy children make healthy adults; thus, interventions received during childhood go through the entire lifespan—healthy children, healthy adults, healthy society.

## **NIH Intramural Research Program Strategic Planning 2025: Clinical Care and Services Task Force**

*Maryland Pao, M.D., Co-Chair, NIH Intramural Research Program (IRP) Clinical Care and Services Task Force; Clinical and Deputy Scientific Director, Senior Clinician, National Institute of Mental Health*

Dr. Pao presented an overview of the NIH IRP Clinical Care and Services Task Force that she co-chairs with Dr. Richard Childs, Scientific Director, National Heart, Lung, and Blood Institute.

In April 2025, then-DDIR Dr. Schor established task forces to review the NIH IRP portfolio, mission, and vision to inform development of a strategic plan. Task forces were organized for the following topics: Science; Training and Mentoring; Clinical Care and Services; and Community Engagement and Communication. Task force members included IC directors, scientific directors, clinical directors, and clinical staff from across NIH.

### ***NIH IRP Clinical Care and Services Vision***

The vision for NIH IRP clinical care and services is to provide the highest quality clinical care in the context of innovative clinical research that would be challenging to perform and is, therefore, complementary to that performed in academic and industrial settings and in other settings funded through individual project-allocated grants or contracts. This research includes first-in-human, rare diseases, and life course longitudinal studies.

The Clinical Care and Services Task Force conducted a landscape analysis of unique capabilities of the NIH clinical enterprise (i.e., CC, personnel and funding, patient census and activity, concrete capabilities), identified CC gaps or deficiencies to be addressed, and proposed horizon

goals to be accomplished within the next 5–10 years in the context of therapeutics, diagnostics, and discovery.

The CC personnel year to date total is 1,187 full-time employees. In addition, the CC has 1,182 credentialed physicians (including 309 postdoctoral Clinical Fellows), 305 advanced practice providers, 998 nurses, and 182 allied health professionals from 18 CCs.

As “America’s Research Hospital,” the CC plays a key role in human-based research technologies and therapeutics. The CC is the nation’s bench-to-bedside incubator for first-in-human research by IC researchers who also provide cutting-edge clinical care. The CC is a leading model of NIH IRP enterprise-wide coordination, coupling long-term investments with the ability to pivot quickly to meet the nation’s needs.

Dr. Pao noted that the CC is having difficulty maintaining the patient census. This decline is due, in part, to declining numbers of clinical investigators, public concern about coming to NIH, and lack of awareness that the CC exists. Overall inpatient average length of stay has decreased. This reflects improved efficiency and a move toward increased outpatient activity. New patient enrollment has also declined.

Although the number of active protocols has not changed significantly, the number of protocols with patient activity dropped 11% from FY19 to FY24, which has contributed to a decline in new patient enrollments. Dr. Pao attributes part of the change to a growing focus on data-driven research that investigators can publish faster, perhaps allowing them to achieve tenure sooner. Dr. Pao pointed to the need to find ways to promote and incentivize engagement in clinical care.

### ***What the NIH CC Needs to Thrive***

Dr. Pao described actions to address concerns and help the CC thrive going forward.

- Address NIH CC leadership needs and the hospital staffing/hiring freeze.
  - Hire a permanent CEO. Progress: A search is underway, with a decision expected in March 2026.
  - Achieve the critical mass required to run a hospital by hiring replacements 1:1 for clinical staff (physicians, nurses, other providers, and clinical support staff) to care for medically complex, high-acuity patients. Progress: Approval was received to fill some clinical positions.
  - Offer competitive salaries to improve recruitment and retention of talent, especially in deficit areas. Progress: Data from a key salary-setting subcommittee have been reviewed; the Department of Veterans Affairs structure is being considered as a model.
- Build a consistent, sustainable funding model.
- Implement a modern electronic medical record (EMR) system that is interoperable with national-scale EMRs and clinical research databases and is integrated with resource utilization management tools. This will be a costly, one-time investment in alignment with IT modernization efforts.
- Enhance visibility of the CC to the American people through a web and social media presence that clearly communicates the depth and breadth of credentialed expert physicians and the clinical services they provide at the CC under one NIH.

## ***Proposed Initiatives***

The task force recommends multiple ways to strengthen the CC.

### Immediate Initiatives

Dr. Pao described ways that IC clinical directors collaborate with the CC now. “Operation Heads in Beds” monitors the CC census daily and aims to increase inpatient numbers by increasing and sharing the number of on-call clinicians in-house across ICs to encourage smaller ICs to utilize inpatient beds as well as outpatient clinics. “Operation Grand Slam” will provide additional pulmonary and cardiology coverage for acute care and critically ill patients for all ICs.

In addition, the task force proposed immediate implementation of a few initiatives: developing a general adult medicine inpatient service and expanding in-house pharmacy compounding for investigational products, with a longer term feasibility study for expansion to include onsite placebo development. The proposed inpatient service would be staffed by internal medicine physicians and advanced practice providers from across ICs and would support inpatient utilization for multidisciplinary clinical research trials. Participants would range from healthy volunteers to critically ill patients.

A survey of the scientific review of clinical protocols aims to increase uniformity across ICs and reduce time to obtain protocol approval. Regulatory requirements are also being considered to avoid redundancy and decrease time from protocol conception to initiation.

### Short-Term Cross-Cutting Initiatives

The task force proposed cross-cutting initiatives that could be achieved in 0 to 3 years.

- Improve intramural–extramural collaboration by:
  - Establishing clinical research “nodes” at partner hospitals led by IRP clinical investigators to screen and enroll patients for IRP protocols, enabling transfer of patients or patient samples to the CC and fostering collaboration.
  - Developing and implementing a mechanism for IRP physicians to attend at partner hospitals (e.g., 5/8 time at NIH and 3/8 at partner hospital) to develop collaborations, increase patient recruitment, and maintain clinical skills.
- Partner with FDA to fast-track therapeutics development.
- Open the new SRLM wing.

### Long-Term Initiatives

- Create a shared in vivo gene therapy and/or vector core that will enhance collaboration across ICs, reduce redundancy, and accelerate innovation.
- Expand capability to care for younger children (0–2 years) to conduct pediatric gene therapy and other clinical trials.
- Develop a lifespan sleep center to study circadian rhythm and sleep across diseases and treatments and hire a pulmonologist and additional staff to scale up.
- Update and expand ICU capabilities to maintain critically ill patients safely within the CC. Acute care patients (sepsis/acute respiratory distress syndrome) identified at partner hospitals could be transferred to the CC for care on research protocols, including long-term follow-up outcomes research.

## ***Conclusions***

The CC continues to offer unique opportunities for cross-cutting, high-impact research to improve the health of Americans. Through strategic efforts fostering collaboration between basic and clinical investigators, we can continue to illuminate fundamental disease mechanisms that drive bench-to-bedside research that leads to novel diagnostics and therapeutics. Despite significant challenges, strategic collaborative efforts can reverse recent trends. The task force has proposed multiple short-, medium-, and long-term initiatives to reinvigorate the NIH's "crown jewel."

## ***Discussion***

The following discussion ensued:

- Mr. Leslie noted that the presentation wrapped up many topics discussed in earlier presentations.
- Dr. Chin asked whether the decline in patient recruitment at the CC reflects a secular decline across research or is specific to NIH and/or the CC. Dr. Pao responded that the reduction in force affected nonclinical positions, particularly in communications. The CC stepped up to use its outpatient recruitment to assist ICs with communications but was hampered by limitations of expertise in IC-specific areas of research.
- Dr. Chin remarked that NIH has an incredible value proposition in this era of affordability. Combining free care with the one-NIH message should resonate with the entire population. Dr. Pao noted that intramural researchers were never allowed to push the affordable care aspect forward as an incentive to participate. She agreed that there is a need to tell more stories and be "proud and loud," as mentioned by Dr. Freischlag. Mr. Aiyelawo added that presenting a unified marketing message will go a long way.
- Mr. Baum commended the task forces for looking across the IRP from both 30,000 feet and 1,000 feet. He suggested that inpatient population is affected by misinformation about admissions charges and their impact on protocol budgets. Secondly, relying on the database for recruitment is reactive; CC recruitment efforts need to be proactive, reaching out to the medical community. Mr. Baum stated that the concept of partnership must be considered in patient recruitment, recalling that CC doctors reported that metropolitan area physicians were reluctant to refer to the CC due to unfounded concerns about patient loss.
- Mr. Baum noted that EHR interoperability is important, but so is patient access. The CC patient portal is not a true patient portal; rather, it is a third-party database to which the CC pushes patient information. He added that the CC EHR system needs to be built for the CC's unique requirements, not squeezed into a one-size-fits-all system. Dr. Pao agreed that a new medical record system is needed that is interoperable and supports everyone, including patients. However, this is a big financial "ask."
- Mr. Leslie remarked that the CCRHB can advocate for funding and additional support for this patient portal and for EHR systems. He noted that this was a recurring theme that should be discussed again during the June CCRHB meeting, along with the hiring freeze and staff cuts.
- Mr. Leslie added that consolidating NIH communications would only have value if each IC (as a client) has a voice and that enhancing patient recruitment at the CC should be

prioritized. A consolidation effort needs clear priorities and an accountability metric for evaluating effectiveness of the centralized communication function.

- Ms. Royster asked about the OD Office of Research on Women’s Health. Dr. Pao responded that there also are different protocols across the ICs that relate to women’s health.
- Dr. Devaskar asked how the NIH Pediatric Research Consortium (N-PeRC), which brings together all the pediatric protocols from across NIH, interacts with the CC. Dr. Hadigan replied that she presented to N-PeRC as well as to NASEM in preparation for the January 28 NASEM report with NICHD support to ensure coordination of efforts and to raise awareness of CC capabilities. Dr. Pao added that she worked with the American Academy of Pediatrics on the Blueprint for Youth Suicide Prevention. ICs want to work with extramural collaborators because ICs and the CC cannot do it alone.

### **Closing Remarks and Adjournment**

Mr. Leslie applauded the lively discussion and thanked participants for the productive meeting. He reminded CCRHB members that the next meeting is scheduled for June 12, 2026, and will include a tour of the SRLM wing. He strongly encouraged in-person attendance, if possible.

Mr. Leslie adjourned the meeting at 12:03 p.m. ET.

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/s/

Matthew J. Memoli, M.D., M.S.

Principal Deputy Director, NIH

Designated Federal Official (DFO)

NIH Clinical Center Research Hospital Board

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April 15, 2026

## Definitions of Abbreviations and Acronyms

ADC	average daily census
AI	artificial intelligence
CC	Clinical Center
CCRHB	Clinical Center Research Hospital Board
CEO	chief executive officer
CIO	chief information officer
COO	chief operating officer
CQV	commissioning, qualification, and validation
CWG	Children's Working Group
DDIR	Deputy Director for Intramural Research
ECMO	extracorporeal membrane oxygenation
EHR	electronic health record
EMPQ	environmental monitoring performance qualification
EMR	electronic medical record
EVP	executive vice president
FDA	U.S. Food and Drug Administration
FY	fiscal year
HHS	Department of Health and Human Services
ICs	Institutes and Centers
ICU	intensive care unit
IRP	Intramural Research Program
NASEM	National Academies of Sciences, Engineering, and Medicine
NICHD	<i>Eunice Kennedy Shriver</i> National Institute of Child Health and Human Development
NIH	National Institutes of Health

NIMH	National Institute of Mental Health
N-PeRC	NIH Pediatric Research Consortium
OCMR	Office of Communications and Media Relations
OD	Office of the Director
PICU	pediatric intensive care unit
P-IVAU	permanent Intravenous Admixture Unit
PPG	Pediatric Planning Group
SRLM	Surgery, Radiology, and Laboratory Medicine
UCLA	University of California, Los Angeles
USP 800	U.S. Pharmacopeia General Chapter 800