FEDERAL HEALTH UPDATE

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Produced by Kate Connelly Theroux in collaboration with the Institute of Federal Health Care (IFHC)

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Executive and Congressional News

- **On June 23, 2010, President Barack Obama signed an executive order amending the 2002 executive order "President's Council on Physical Fitness and Sports" to be the "President's Council on Fitness, Sports and Nutrition," recognizing the importance of good nutrition.** For more details: http://www.whitehouse.gov/the-press-office/executive-order-presidents-council-fitness-sports-and-nutrition

- **On June 22, 2010, the United States Senate unanimously confirmed Sherry Glied as assistant secretary for planning and evaluation for the Department of Health and Human Services and Jim Esquea as assistant secretary for legislation for the Department of Health and Human Services.**
- **Senate Veterans' Affairs Committee Chairman Daniel K. Akaka (D-Hawaii) introduced legislation on June 22, 2010, to make improvements in VA's disability claims processing.**

VA provides disability compensation to approximately 3.1 million veterans across the nation.

As chairman, Akaka has held a series of hearings on improving the veterans' disability compensation system. The Committee will hold a hearing to review disability claims processing on July 1, at which time witnesses will testify about Akaka's legislation.

The Claims Processing Improvement Act of 2010 (S.3517) would make various changes to the way VA processes disability compensation claims, including provisions to:

- Set up a process to fast-track claims that have been fully developed.
- Help veterans with multiple disability claims by allowing VA to provide partial disability ratings.
- Provide that the Department give equal deference to the medical opinions of a veteran's non-VA doctor.

The bill would also establish a test program at several Regional Offices replacing VA's method of identifying musculoskeletal disabilities. Compensation under the pilot would be based on a functional assessment of limitations due to the disability, such as standing, walking or lifting, and would take into account the severity, frequency and duration of symptoms of the disability. To identify disabilities, the pilot would use the common language of the International Classification of Diseases, rather than VA's current Rating Schedule.

Military Health Care News

- **Brig. Gen. Loree Sutton quietly has resigned as head of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.**

Her departure comes amid congressional concern over press reports that military personnel suffering from traumatic brain injuries are not being properly diagnosed and treated. According to a spokesperson for the Centers of Excellence, Sutton's departure is part of routine command rotation; others said she had been expected to leave next year.

Her successor is Col. Bob Saum, who has served as Bejavioral Health Science Advisor to the Chairman of the Joint Chiefs of Staff.

- **The military services and the Veterans Health Administration increasingly use digital technology to reach out to identify and treat service members with traumatic brain injuries and post-traumatic stress disorder.**

The second-ranking officers of each of the four services and a senior VHA leader outlined for the Senate Armed Services Committee the programs and delivery methods they are using to reach service members who may have mild brain injuries or PTSD.

Increasingly, the military services are turning toward the "virtual" intervention of the Internet and digital technology

Some 780,000 soldiers have responded to the Army's Internet-based Global Accessing Tool to measure resilience, and the service plans to expand its Web outreach. Also, the Army uses an Internet-based mental health screening to assess soldiers returning from deployments.

Building on VA's suicide hotline, VA officials last year started an Internet-based chat line for service members to discuss stress. Using consumer-based technology is increasingly important to reach service members, not only because it's a medium they are comfortable with, but also because those not on active duty — National Guard and reserve members, and veterans who have separated from service — are widely dispersed and sometimes hard to reach.

Besides the digitally based programs, the military officers who testified outlined numerous ways their services are reaching out to troops and their families on issues such as traumatic brain injuries, post-traumatic stress disorder and suicide prevention — increased awareness training, starting with new recruits, focusing heavily on noncommissioned officers, and extending to flag officers. All said they are doing pre- and post-deployment screening, and reaching out to families.

The Army, in a program with the University of Pennsylvania, has trained more than 1,200 soldiers to be resilience trainers to others, with plans to place them in every battalion.

The Navy has a program called ACT — ask, care, treatment, or "ask about your shipmate, care for your shipmate, and help him or her get treatment," said Adm. Jonathan W. Greenert, vice chief of naval operations. The Navy began 10 training workshops at 20 locations this year and plans to open five more by fall. More than 100 sailors have been trained to teach others about controlling stress.

The Air Force has increased training and counseling, and held a "Wingman Day" in May to underscore that every airman, regardless of rank, needs to watch for changes in others and reach out to them if they suspect they're not well, Gen. Carrol H. Chandler, Air Force vice chief of staff, said.

The Marine Corps, which has the most suicides per capita with 52 last year, recently created a hotline with the TRICARE West military health plan, in which Marines and their families can call anonymously 24/7 to discuss stress. Also, the Marines focus on both physical and mental resilience, beginning at boot camp, and conduct pre-deployment immersion training to get young Marines accustomed to a combat environment.

- **Secretary of the Navy Ray Mabus and Chief of Naval Operations Adm. Gary Roughead announced that Rear Adm. (lower half) Michael H. Anderson will be assigned as medical inspector general, Bureau of Medicine and Surgery, Washington, D.C. Anderson is currently serving as fleet surgeon, U.S. Pacific Fleet / command surgeon, U.S. Pacific Command, Camp H. M. Smith, Hawaii.**

- **Lockheed Martin together with TRICARE Management Activity (TMA) and the Military Health System (MHS) are celebrating a significant milestone of one billion TRICARE Encounter Data (TED) healthcare records processed.**

TMA serves as the national headquarters responsible for administering a worldwide medical benefits program for the Department of Defense.

Lockheed Martin has supported the development and implementation of the capability to process and convert TED records since before their inception, having provided technical data-mart, application and consultant support to TMA TEDS operations for the past 10 years.

The TED system, which collects, verifies and tracks MHS managed care records, is now one of the fastest claims processing systems in the world, capable of processing 700,000 records in just over three hours. Since its inception in 2004, TED has processed $140 billion of purchased care services for TRICARE beneficiaries worldwide.

- **The Department of Defense Spinal Cord Injury Research Program has announced a grant of more than a $1 million to support research at the Robarts Research Institute at The University of Western Ontario (Western).**

  The spinal cord injury research team of Gregory Dekaban, Arthur Brown, Lynne Weaver and Paula Foster, in collaboration with Brian Kwon of the University of British Columbia and Kyle Petersen of the U.S. Naval Medical Research Center, is working on a new therapy designed to limit the damage caused by inflammation immediately following spinal cord injury. The grant will move their work, led by Dekaban, closer to a clinical trial.

  Nearly a quarter of wounded military personnel requiring evacuation from the field suffer spinal cord or traumatic brain injury. As well, 12,000 new cases of spinal cord injury occur every year in the North American civilian population. Spinal cord injury creates physical, psychological and financial challenges to the injured and their families. These injuries are also a significant burden for health care systems.

  Spinal cord injury occurs in two stages. The first is the physical injury from trauma; the second stage, that extends the initial damage, is caused in large part by inflammation in the spinal cord. The new therapy involves an antibody delivered intravenously that targets a protein known as CD11d on the surface of inflammatory cells that circulate in blood. CD11d is required by white blood cells to leave the bloodstream and enter the injured spinal cord. The anti-CD11d antibody is designed to block that process. By blocking the entry and retention of these white blood cells at the site of injury, the researchers successfully reduced inflammation and improved neurological recovery in preclinical models of spinal cord injury.

  The research at Robarts so far has employed a mouse antibody that recognizes human CD11d. This new award from the Spinal Cord Injury Research Program funded by the Department of Defense Congressionally Directed Medical Research Program will support the development of a humanized antibody suitable for use in a clinical trial. This research will be carried out in conjunction with Eli Lilly and Company.

Veterans Health Care News

- **California researchers have been awarded about $5.6 million for stem cell research projects.**

  Specifically, the California Institute for Regenerative Medicine is funding projects that aim to discover ways to overcome immune system rejection of transplanted stem cells. The institute is the state stem cell agency created by Proposition 71, and it has approved $25 million for 19 projects.

  According to the institute, using cells derived from stem cells to replace lost or damaged tissue is a major goal of stem cell research, but it is possible the immune system could potentially reject those cells, similar to how an immune system can reject a transplanted organ.

  Three-year grants, each of about $1.4 million, were awarded to four Stanford researchers: Chris Contag, an associate professor of pediatrics and of microbiology and immunology; Robert Negrin, a professor of medicine and chief of the university's blood and bone marrow transplant program; Judith Shizuru, associate professor of medicine; and Kenneth Weinberg, a professor of pediatric cancer and blood diseases and member of Stanford's Cancer Center.

  Separately, $885,475 was awarded to Husein Hadeiba of the Palo Alto Institute for Research and Education, which facilitates research and education activities at the VA Palo Alto Health Care System.

  The California Institute for Regenerative Medicine has provided Stanford University with a total of about $173 million for various projects since the institute was established in November 2004.

Health Care News

- **The U.S. Centers for Disease Control and Prevention has developed a new test to diagnose human infections with the 2009 H1N1 influenza virus (formerly known as swine flu or pandemic H1N1 flu) that has been authorized for use by the U.S. Food and Drug Administration.**

  The test, called the "CDC Influenza 2009 A (H1N1)pdm Real-Time RT-PCR Panel (IVD)," will help ensure the accuracy of influenza testing results among the different qualified laboratories that conduct influenza subtype testing in the United States and abroad. It uses a molecular biology technique to detect influenza A viruses and specifically the 2009 H1N1 virus. The new test will replace the previous real-time RT-PCR diagnostic test used during the 2009 H1N1 pandemic, called the "Swine Influenza Virus Real-time RT-PCR Detection Panel (rRT-PCR Swine Flu Panel)," which received an emergency use authorization by the FDA in April 2009.

  The earlier test was developed based on the limited number of 2009 H1N1 specimens available at the start of the 2009 H1N1 pandemic in April 2009. The new test has been optimized using the vast amount of 2009 H1N1 genetic information CDC received throughout the pandemic. As a result, the new PCR diagnostic test can detect human infections with 2009 H1N1 virus with sensitivity and specificity greater than 96 percent for upper respiratory specimens.

  The test is used to isolate and amplify viral genetic material present in secretions taken from a patient's upper or lower respiratory tract. Upper respiratory specimens are easily obtainable in a doctor's office, and lower respiratory specimens are typically obtained from severely ill patients in a hospital setting. The test panel and diagnostic system can provide results within four hours, and multiple samples can be tested at the same time.

  The test will be available soon to CDC-qualified laboratories for detecting 2009 H1N1 influenza.

- **The Centers for Medicare & Medicaid Services (CMS) proposed new rules for hospitals that would protect patients' rights to choose their own visitors during a hospital stay, including visitors who are same-sex domestic partners.**

  The new proposed rules implement an April 15, 2010, Presidential memorandum, in which the President tasked HHS with developing proposed standards for Medicare- and Medicaid-participating hospitals (including critical access hospitals) that would require them to preserve the rights of all patients to choose who may visit them when they are inpatients of a facility.

  The proposed rules would require every hospital to have written policies and procedures detailing patients' visitation rights, as well as instances when the hospital may restrict patient access to visitors based on reasonable clinical needs.

  A key provision of the proposed rules specifies that visitors chosen by the patient (or his or her representative) must be able to enjoy visitation privileges that are no more restrictive than those for immediate family members.

  The proposed rules would update the Conditions of Participation, which are minimum health and safety standards all Medicare- and Medicaid-participating hospitals and critical access hospitals must meet.

  Specifically, the proposed rules would add new requirements for hospitals and critical access hospitals to explain to all patients their right to choose who may visit them during their inpatient stay, regardless of whether the visitor is a family member, a spouse, or a domestic partner (including a same-sex domestic partner), as well as the right to withdraw such consent at any time.

  The proposed rules are available for public comment for 60 days and will be finalized after CMS has read and considered the comments. More information about the proposed rules is available on CMS' Web site at http://www.cms.gov/CFCsAndCoPs/06_Hospitals.asp and http://www.cms.gov/CFCsAndCoPs/03_CAHs.asp.

- **The Centers for Medicare and Medicaid Services will be the first federal program agency to test a mapping and data analysis tool developed by a White House oversight board to spot irregularities in the flow of economic stimulus funds.**

  The software tool was developed by the Recovery Accountability and Transparency Board (RATB), established to watch-over the distribution of billions of dollars in funding set up by the 2009 American Recovery and Reinvestment Act.

  The RATB uses maps, tools and templates developed by geographic information systems vendor ESRI to roll up data from the 50 states to show where and to whom the federal funds have gone. Users can drill down for more information about local spending.

  CMS will use the software tool to identify potential fraud and abuse as well as inaccurate payments to Medicare and Medicaid providers, which together accounted for $65 billion in improper payments last year. The tool will then become available to all federal agencies to use.

  The tool will help CMS sort through the thousands of tips it receives about fraud and abuse. The agency will test the tool to identify suspicious providers among a list of providers in geographic regions where the agency has indications of fraud.

  The results will help to validate providers already identified as high risk and to spot additional high-risk providers whom the agency previously considered legitimate under the current process.

- **Despite having the most expensive health care system, the United States ranks last overall compared to six other industrialized countries on measures of health system performance in five areas: quality, efficiency, access to care, equity and the ability to lead long, healthy, productive lives, according to a new Commonwealth Fund report.**

  Countries that performed better include Australia, Canada, Germany, the Netherlands, New Zealand and the United Kingdom.

  While there is room for improvement in every country, the U.S. stands out for not obtaining good value for its health care dollars, ranking last despite spending $7,290 per capita on health care in 2007 compared to the $3,837 spent per capita in the Netherlands, which ranked first overall.

Provisions in the Affordable Care Act that could extend health insurance coverage to 32 million uninsured Americans have the potential to promote improvements to the United States' standing when it comes to access to care and equity, according to *Mirror Mirror On The Wall: How the Performance of the U.S. Health Care System Compares Internationally 2010 Update*, by Commonwealth Fund researchers.

The report said the United States' low marks in the quality and efficiency dimensions demonstrate the need to quickly implement provisions in the new health reform law and stimulus legislation that focus on realigning incentives to reward higher quality and greater value, investment in preventive care, and expanding the use of health information technology.

Earlier editions of the report, produced in 2004, 2006, and 2007, showed similar results. This year's version incorporates data from patient and physician surveys conducted in seven countries in 2007, 2008, and 2009.

Key findings include:

- **On measures of quality the United States ranked 6th out of 7 countries.** On two of four measures of quality—effective care and patient-centered care—the U.S. ranks in the middle (4th out of 7 countries). However, the U.S. ranks last when it comes to providing safe care, and next to last on coordinated care. U.S. patients with chronic conditions are the most likely to report being given the wrong medication or the wrong dose of their medication, and experiencing delays in being notified about an abnormal test result.
- **On measures of efficiency, the U.S ranked last** due to low marks when it comes to spending on administrative costs, use of information technology, re-hospitalization, and duplicative medical testing. Nineteen percent of U.S. adults with chronic conditions reported they visited an emergency department for a condition that could have been treated by a regular doctor, had one been available, more than three times the rate of patients in Germany or the Netherlands (6%).
- **On measures of access to care,** people in the U.S. have the hardest time affording the health care they need—with the U.S. ranking last on every measure of cost-related access problems. For example, 54 percent of adults with chronic conditions reported problems getting a recommended test, treatment or follow-up care because of cost. In the Netherlands, which ranked first on this measure, only 7 percent of adults with chronic conditions reported this problem.
- **On measures of healthy lives,** the U.S. does poorly, ranking last when it comes to infant mortality and deaths before age 75 that were potentially preventable with timely access to effective health care, and second to last on healthy life expectancy at age 60.
- **On measures of equity,** the U.S. ranks last. Among adults with chronic conditions almost half (45%) with below average incomes in the U.S. reported they went without needed care in the past year because of costs, compared with just 4 percent in the Netherlands. Lower-income U.S. adults with chronic conditions were significantly more likely than those in the six other countries surveyed to report not going to the doctor when they're sick, not filling a prescription, or not getting recommended follow-up care because of costs.

- **In an effort to help providers navigate new health information technology requirements and qualify for meaningful-use payments, the CMS has launched a Web site detailing information about its electronic health record system incentive programs, which are scheduled to launch in 2011.**

  Specifically, the site includes clarification of terms such as "eligible professional" and "certification," both of which appear in provisions of the Health Information Technology for Economic and Clinical Health Act, commonly known as HITECH, under the American Recovery and Reinvestment Act of 2009. In addition, users can download fact sheets on proposed program requirements and the proposed definition of meaningful use.

  The site will include more specific information about requirements after the final rule on the EHR incentive programs is released this summer, according to the CMS.

- **The Office of the National Coordinator for Health Information Technology (ONC) issued a final rule to establish a temporary certification program for electronic health record (EHR) technology.**

  The temporary certification program establishes processes that organizations will need to follow in order to be authorized by the National Coordinator to test and certify EHR technology.

  Use of "certified EHR technology" is a core requirement for providers who seek to qualify to receive incentive payments under the Medicare and Medicaid Electronic Health Record Incentive Programs provisions authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act.

  Certification is used to provide assurance and confidence that a product or service will work as expected and will include the capabilities for which it was purchased. EHR technology certification does just that: It assures health care providers that the EHR technology they adopt has been tested and includes the required capabilities they need in order to use the technology in a meaningful way to improve the quality of care provided to their patients.

  This final rule is issued under the authority provided to the National Coordinator for Health Information Technology in section 3001(c)(5) of the Public Health Service Act (PHSA) as added by the HITECH Act.

  For more information about the temporary certification program and rule, please visit http://healthit.hhs.gov/certification.

Reserve/Guard

- As of June 22, 2010, the total number of Guard and Reserve currently on active duty has **decreased** by 377 to 122,870. The totals for each service are Army National Guard and Army Reserve 92,373; Navy Reserve, 6,363; Air National Guard and Air Force Reserve, 17,596; Marine Corps Reserve, 5,712; and the Coast Guard Reserve, 826. www.defenselink.mil

Reports/Policies

- **The Congressional Budget Office (CBO) published *"Budgetary Effects for an Act to Provide a Physician Payment Update, to Provide Pension Funding Relief, and for Other Purposes,"* on June 18, 2010.**

- **The Congressional Budget Office (CBO) published *"Additional Information About High-Risk Insurance Pools Under the Patient Protection and Affordable Care Act,"* on June 21, 2010.**

- **BMC Health Services Research published "Comparison of outpatient health care utilization among returning women and men veterans from Afghanistan and Iraq," on June 22, 2010.** This study examines gender differences among OEF/OIF Veterans in utilization of VA outpatient health care services. http://www.biomedcentral.com/1472-6963/10/175/abstract

Legislation

- **H.R.5570** (introduced June 22, 2010): To provide that no funds are authorized to be appropriated to the Internal Revenue Service to expand its workforce in order to implement, enforce, or otherwise carry out either the Patient Protection and Affordable Care Act or the Health Care and Education Reconciliation Act of 2010 was referred to the House Committee on Ways and Means.
  Sponsor: Representative Fred Upton [MI-6]
- **H.R.5574** (introduced June 22, 2010): Making Work and Marriage Pay Act of 2010 was referred to the Committee on Ways and Means, and in addition to the Committees on Agriculture, Veterans' Affairs, Financial Services, Energy and Commerce, and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned
  Sponsor: Representative Thomas E. Petri [WI-6]
- **S.3515** (introduced June 21, 2010): Department of the Interior Research and Technologies for Oil Spill Prevention and Response Act of 2010 was referred to the Committee on Environment and Public Works.
  Sponsor: Senator Jeanne Shaheen [NH]
- **S.3516** (introduced June 24, 2010): Outer Continental Shelf Reform Act of 2010 was referred to the Committee on Energy and Natural Resources.
  Sponsor: Senator Jeff Bingaman [NM]
- **S.3517** (introduced June 22, 2010): Claims Processing Improvement Act of 2010 was referred to the Committee on Veterans' Affairs
  Sponsor: Senator Daniel K. Akaka [HI]

Hill Hearings

- The House Veterans Affairs Committee will hold a hearing on **June 30, 2010**, to examine the U.S. Department of Veterans Affairs Office of General Counsel.
- The Senate Appropriations Subcommittee on Defense will hold a hearing on **June 23, 2010** to examine outside witness statements
- The House Veterans Affairs Committee will hold a legislative hearing on **July 1, 2010,** on H.R. 3407, H.R. 3787, H.R. 4541, H.R. 5064, and draft legislation.
- The Senate Veterans Affairs Committee will hold a hearing on **July 1, 2010**, to examine veterans' claims processing, focusing on if current efforts are working.
- The House Veterans Affairs Committee will hold a hearing on **July 14, 2010**, to examine the progress of suicide prevention outreach efforts at the U.S. Department of Veterans

Department of Veterans.

- The House Veterans Affairs Committee will hold a roundtable on **July 21, 2010**, to on innovative treatments for TBI and PTSD.
- The House Veterans Affairs Committee will hold a hearing on **July 27, 2010**, to examine Gulf War Illness: and the future for unsatisfied veterans.
- The Senate Veterans Affairs Committee will hold a hearing on **Sept. 22, 2010,** to examine a legislative presentation focusing on the American Legion.
- The Senate Veterans Affairs Committee will hold an oversight hearing on **Sept. 23, 2010;** examine Veterans' Affairs disability compensation, focusing on presumptive disability decision-making.

Meetings / Conferences

- The International Papillomavirus Conference & Clinical and Public Health Workshop are scheduled for **July 3-8, 2010**, in Montreal, Canada. http://hpv2010.org/main/
- The International Society for Infectious Diseases Neglected Tropical Diseases Meeting will be held on **July 8-10, 2010,** in Boston, Mass. http://www.isid.org/
- The CDC 7th International Conference on Emerging Infectious Diseases will be held on **July 11-14, 2010**, in Atlanta, Ga. http://www.iceid.org/
- The 2nd Annual Mobile Health (mHealth) Summit will be **July 29-30, 2010**, in Boston, Mass. www.worldcongress.com/mHealth
- Association for Healthcare Resource and Materials Management's Annual Conference will be held on **Aug. 1-4, 2010**, in Denver, Colo. http://www.ahrmm.org/ahrmm_app/conference/annualconf10/index.jsp
- The 8th Annual Health Care Quality Congress (HCQ 2009) will be held on **Aug. 2-4, 2010**, in Boston Mass. http://www.worldcongress.com/events/HL10025/
- The 9th International Rotavirus Symposium will be held **Aug. 2-3, 2010**, in Johannesburg, South Africa. http://www.rotavirus2010.com
- 13th Annual Force Health Protection Conference: *"Military Preventive Medicine and Public Health"* will be held on **Aug. 10-13, 2010**, in Phoenix, Ariz. http://www.theconferencewebsite.com/conference-info/FHPC-2010\
- National Conference on Health Statistics will be held **Aug. 16-18, 2010**, in Washington, D.C. http://www.cdc.gov/nchs/events/nchs.htm
- The 2010 Advanced Technology Applications for Combat Casualty Care (ATACCC) Conference will be held **Aug. 16-19, 2010**, in St. Pete Beach, Fla. https://www.ataccc.org/
- AHRA 2010 Annual Meeting and Exposition will be held on **Aug. 22-26, 2010**, in National Harbor, Md. http://www.ahraonline.org/AM/Template.cfm?Section=AnnualMeetingRegistration
- 13th Battlefield Healthcare event: Pre and Post Deployment Combatant Care will be held **Sept. 20-22, 2010**, in San Diego, Calif. http://www.battlefieldhealthcare.com/Event.aspx?id=331874
- USU-HJF Military Medicine Symposium: Advancing Public-Private Partnerships will be held on **Sept**. **23, 2010**, in Washington D.C. www.hjf.org/symposium
- The 5th Annual Obesity Congress will be held on **Sept. 28-30, 2010**, in Washington D.C. http://www.worldcongress.com/events/HL10088/
- The 6th Annual World Healthcare Innovation and Technology Congress *(WHIT v.6.0)* will be held **Nov. 8-10, 2010**, in Washington D.C. http://www.worldcongress.com/events/HL10010/

If you need further information on any of the items in the Federal Health Update, please contact Kate Connelly Theroux at (703) 447-3257 or by e-mail at katetheroux@fedhealthinst.org. To subscribe, please visit http://fedhealthinst.org/subscriber.cfm. To unsubscribe, please send an email to newsletter@fedhealthinst.org with UNSUBSCRIBE as the subject.

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5185 MacArthur Blvd. NW, Suite 103-656, Washington, DC 20016
(202)271-5814 postmaster@fedhealthinst.org