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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***Federal Health Update* will not be published on Aug. 12 and 26, 2011**

Executive and Congressional News

- **On July 20, 2011, the Senate passed H.R. 2055 (as amended), the *Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2012.***

  The legislation provides $142 billion for fiscal year 2012, including $72.5 billion in discretionary funding and $69.5 billion in mandatory funding.

  The bill provides $13.7 billion for military construction and family housing, $1 billion below the budget request; $58.6 billion in discretionary funding for the Department of Veterans Affairs for fiscal year 2012, $181 million below the budget request; and $221.4 million for related agencies, a $25 million decrease from the request. No funding was requested or is provided in the bill for military construction related to overseas contingency operations.

Military Health Care News

- **The Army released suicide data for the month of June.**

  Among active-duty soldiers, there were nine potential suicides: none have been confirmed as suicide, and all remain under investigation. For May 2011, the Army reported 21 potential suicides among active-duty soldiers. Since the release of that report, one case has been removed because the manner of death was ruled accidental, two cases have been confirmed as suicide, and 18 cases remain under investigation.

  During June, among reserve component soldiers who were not on active duty, there were five potential suicides: one has been confirmed as suicide, and four remain under investigation. For May 2011, the Army reported six potential suicides among not-on-active-duty soldiers. Since the release of that report, one case has been added for a total of seven cases. Two cases have been confirmed as suicide, and five cases remain under investigation.

  The Army's comprehensive list of Suicide Prevention Program information is located at **http://www.preventsuicide.army.mil**.

- **On July 18th, the Air Force Research Laboratory announced that it plans to grant 10 to 20 awards with the estimated program cost to be $49.5 million over five years.**

  In preparation of these awards, the Air Force Research Laboratory is soliciting white papers on specific medical research areas on behalf of the Air Force Medical Support Agency (AFMSA) Modernization Directorate.

  The Air Force has identified a need for medical modernization in the following areas:

  - Force Health Protection — the focus is on preventing injuries and illnesses and the detection of emerging threats. Key area include bio-surveillance, occupational toxicology and protective countermeasures
  - Enroute care — the focus is on the continuum of care during transport of patients from point of injury to point of definitive care
  - Operational Medicine — focus is on clinical medicine enhancements, personalized diagnosis and treatment, TBI, psychological health, PTSD, regenerative medicine, clinical patient safety, autism, and definitive care
  - Expeditionary Medicine — includes enhancing methods and techniques for remote monitoring and triage systems
  - Human Performance — includes fatigue management, sensory protection and sustainment, vision enhancement, medical team performance, and medical modeling and simulation

  This is a five year two-step solicitation. The first step is to submit the white paper due on Aug 31, 2011. Requests for Proposals will be sent in response to the submission of the white paper.

  For more information, go www.grants.gov to view the cooperative agreement grant notice BAA-11-03-HPW "Air Force Medical Support Agency Modernization Directorate Research/Development and Innovations" announcement.

- **TRICARE Management Activity published a press release outlining little known benefits available to TRICARE beneficiaries.**

  The benefits highlighted include:

  - Electronic Explanation of Benefits—TRICARE beneficiaries can sign up and receive an explanation of benefits (EOB) electronically and eliminate the cost and clutter of paper EOBs. A TRICARE EOB is an itemized statement that shows what action TRICARE has taken on a beneficiary's claim. Beneficiaries can sign up to receive EOBs by going to www.myTRICARE.com.
  - TRR Sign-Up Options Expanded—Since Sept. 1, 2010, members of the Retired Reserve who aren't 60, the so-called "gray area" retirees, have been able to purchase TRICARE Retired Reserve (TRR) to provide health coverage for themselves and their eligible family members. To make purchasing TRR easier, gray area retirees can now get a DS log-on by contacting the Defense Enrollment Eligibility Reporting System/Defense Manpower Data Center Support Office (DSO) and remotely verifying their identity. For instructions on how to qualify for and purchase TRR go to www.tricare.mil/trr.
  - Well-Child Care: No Co-Pays or Cost-Shares—TRICARE provides well-child care for eligible children from birth to age 6. For well-child care, there are no copayments or cost-shares. The well-child benefit includes routine newborn care, comprehensive health-promotion and disease-prevention exams, vision and hearing screenings, routine immunizations and developmental assessments. To learn more about well-child benefit, visit www.tricare.mil/baby.
  - Hospice Care, Zero Deductible—Hospice care is a zero-deductible benefit for all TRICARE beneficiaries. It gives TRICARE beneficiaries access to

personal care and home health aide assistance. It initially provides two 90-day periods of care, followed by an unlimited number of 60-day periods. Each period requires prior authorization from the beneficiary's regional health care contractor. For more information about the hospice benefit, beneficiaries can contact their regional health care contractor or their TRICARE Area Office (www.tricare.mil/contactus).

Beneficiaries can view a list of covered TRICARE services on TRICARE's website, www.tricare.mil/mybenefit/home/Medical/IsItCovered. They can also contact their regional health care contractor for more information.

- **A recent study by the Department of Defense finds that binge drinking is increasing among the ranks.**

  In response, the Army has been testing a new program to reach out to soldiers in need of help by offering a confidential treatment option.

  The Army's Confidential Alcohol Treatment Education Pilot, or CATEP, is designed to get soldiers into treatment before they have an alcohol-related incident. Army research shows that many soldiers are reluctant to seek help because it involves notifying unit command. Binge drinking — defined as five or more drinks in a row — is often intertwined with soldiers' mental health issues such as depression and post-traumatic stress disorder.

  Since the CATEP pilot program started at three military installations in 2009, it's been expanded to six. There are 38 soldiers enrolled in the program at Joint Base Lewis-McChord in Washington state.

  Soldiers face numerous consequences if they're arrested for DUI or flagged by a commanding officer for problem drinking. They can lose their rank or even be discharged.

  Officials say CATEP tends to attract older, higher-ranking soldiers and officers who have managed to stay under the radar but have finally decided to get help. While confidentiality is at the heart of the program, weekly meetings and off-duty counseling appointments help make CATEP different. Soldiers can also meet in civilian clothing, which allows them to keep their ranks private.

- **TeamStaff, Inc. announced that retired Army Maj. Gen. Elder Granger, M.D., is joining its company as a strategic advisor.**

  General Granger joins retired Army Gen. Tom Glisson as the second member of TeamStaff's Strategic Advisory Board. The Strategic Advisory Board reports directly to the company's chief executive officer, Zachary Parker.

  During Granger's military career, he served as the deputy director and program executive officer of the TRICARE Management Activity (TMA), Office of the Assistant Secretary of Defense (Health Affairs), in Washington, DC from 2005-2009. In this role, he was the principal advisor to the Assistant Secretary of Defense (Health Affairs) on the DoD health plan policy and performance, and directed TMA research projects. He oversaw the acquisition, operation and integration of DoD's managed care program within the Military Health System.

  TeamStaff is a leading logistics and healthcare services provider to the federal government, including the departments of Defense and Veterans Affairs.

Veterans Health Care News

- **The Department of Veterans Affairs (VA) has approved Bancroft's Traumatic Brain Injury Program to provide services for patients covered by VA benefits.**

  The pilot program allows veterans to participle in the Bancroft program, including residential services through Bancroft at Cherry Hill, Mullica Hill, Brick and Plainsboro.

  After people who suffer traumatic brain injuries leave a hospital, they typically need to re-learn how to function at home and in their community, regain work skills and develop strategies to compensate for memory loss, thinking difficulties and other effects of their injury.

  Bancroft programs are designed specifically to help clients adapt to returning to society. Bancroft's rehabilitation options include residential and day treatment, vocational, in-home and outpatient programs. Services include cognitive rehabilitation, physical, occupational and speech therapies, and psychological counseling.

  Founded in 1883, Bancroft is a leading service provider for people with neurological challenges.

- **The Secretary of Veterans Affairs (VA) Eric K. Shinseki launched a competition to encourage widespread use of Blue Button personal health records (PHRs) to benefit veterans who receive care from non-VA providers.**

  The competition began July 18 and ends when a winner is announced or on Oct. 18, whichever occurs first, according to the VA. The winner of the competition will receive $50,000.

  Blue Button PHRs are currently used by more than 350,000 people, including 300,000 veterans who receive care through the VA health system to download, store or print, or share medical information with caregivers, stated a notice published in the *Federal Register* on July 18.

  The competition aims to promote widespread installation and use of Blue Button PHRs via a simple internet-based application that allows physicians and other licensed clinical professionals (LCPs) to sponsor a Blue Button PHR and offer it to their patients.

  The winner of the competition will be the first to document that it has:

  - Created an internet-based application that allows clinicians to sponsor and offer to their patients, including veterans, a Blue Button PHR.
  - Installed the Blue Button PHR application on public-facing Internet sites by 25,000 clinicians within the U.S. and is available for use by all patients of those LCPs, including veterans.
  - Is freely accessible to all patients of the LCP, including veterans, and it must be operable at the time of judging.

  For more information, please visit here.

- **Two new studies — one in veterans and the other in retired football players — add to the mounting evidence linking head injuries to an increased the risk of dementia later in life.**

  Veterans who had been diagnosed with a brain injury, anything from a concussion to a severe head wound, were more than twice as likely to develop dementia compared to those with no injury to the brain, researchers reported at the Alzheimer's Association' International Conference in Paris.

  The results were even more striking in a study of retired football players: 35 percent of the former National Football League players had signs of dementia, which compares to a 13 percent Alzheimer's rate in the general population.

  For the veterans' study, researchers reviewed the medical records of 281,540 military personnel age 55 and older who received care at Veterans Affairs hospitals from 1997 to 2000 and who had at least one follow-up visit from 2001 to 2007. None of the veterans in the study were diagnosed with dementia at the beginning of the seven year study.

Almost 5,000 of the veterans had been diagnosed with a traumatic brain injury (TBI). Their risk of developing dementia by the end of the study was 15.3 percent. That's compared to 6.8 percent of those with no TBI diagnosis.

The football player study is a follow-up of earlier research that included a survey of nearly 4,000 retired NFL players in 2001. In 2008, new surveys were sent to the 905 players who were over 50 years old.

The two new studies add to rapidly accumulating evidence showing that head injuries, including concussions, can lead to severe consequences many years afterwards. Some earlier research found a two-fold increased risk of Alzheimer's associated with head injuries that caused a loss of consciousness lasting an hour or more. And that risk jumped to 10-fold when people also had a genetic mutation called APOE-e4.

- **Secretary of Veterans Affairs Eric K. Shinseki announced the launch of free, drop-in childcare service centers at three VA medical centers.**

The pilot centers are part of VA's continuing effort to improve access to health care for eligible veterans, particularly the growing number of women veterans. Congress established this childcare initiative as part of the Caregivers and Veterans Omnibus Health Services Act of 2010, which was signed by the President in May 2010. The three sites and childcare details include:

- Northport, NY: 30 child capacity, 7:30 a.m. to 4 p.m., ages 6 weeks to 12 years
- Tacoma, WA: Varying capacity, 7 a.m. to 6 p.m., ages 6 weeks to 10 years
- Buffalo, NY: 6 to 10 child capacity, 6 a.m. to 6 p.m., ages 6 weeks to 12 years

All the pilot childcare centers will be operated onsite by licensed childcare providers. Drop-in services are offered free to veterans who are eligible for VA care and visiting a facility for an appointment.

In a survey, VA found that nearly a third of veterans were interested in childcare services and more than 10 percent had to cancel or reschedule VA appointments due to lack of childcare.

Women veterans are one of the fastest growing segments of the Veteran population. Of the 22.7 million living veterans, more than 1.8 million are women. They comprise nearly 8 percent of the total veteran population and 6 percent of all Veterans who use VA health care services.

VA estimates women veterans will constitute 10 percent of the veteran population by 2020 and 9.5 percent of VA patients.

For more information about VA programs and services for women veterans, please visit: www.va.gov/womenvet and www.publichealth.va.gov/womenshealth.

- **A special supplement of the journal *Women's Health Issues* published July 13 shows the tremendous growth and diversity of VA women's health research in recent years.**

Its publication comes as VA recognizes July as Women Veterans Month, which included a National Training Summit on Women Veterans held July 15-17 in Washington, D.C.

Titled *"Health and Health Care of Women Veterans and Women in the Military: Research Informing Evidence-based Practice and Policy,"* the special journal edition, known as a supplement, features commentaries by VA investigators examining the role, history and future of women's health research.

The supplement also includes 18 peer-reviewed research articles addressing the changing demographics and demands of VA health care presented by the recent surge of women veterans into the VA system. Among the topics addressed are: gender differences and disparities in care; mental health, including military sexual trauma and substance abuse; post deployment health, including posttraumatic stress disorder; quality and delivery of care; and special populations, including homeless women veterans and those with traumatic brain injuries.

Women's Health Issues is the bi-monthly peer-reviewed journal of the Jacobs Institute of Women's Health at the George Washington University School of Public Health and Health Services. The journal focuses on applied research in women's health care and policy issues. The special supplement, focused on research related to the health issues of women veterans and military women, was sponsored by the Health Services Research and Development Service, VA Office of Research and Development, with support from the Women Veterans Health Strategic Health Care group.

Free full-text access to the supplement's articles can be accessed at www.whijournal.com/supplements.

- **Dr. Tracy Gaudet, director of the Department of Veterans Affairs' (VA) newly established Office of Patient-Centered Care and Cultural Transformation, has been selected as one of the top 25 Women in Health Care by *Modern Healthcare* magazine for her leadership in serving veterans.**

Modern Healthcare magazine is one of the health-care industry's leading business news publications. An editorial board of its senior editors selected the Top 25 Women in Health Care for 2011.

Dr. Gaudet began her new position at VA in January after serving as the executive director of integrative medicine at Duke University Medical Center since 2001.

Dr. Gaudet received her Bachelor of Arts degree from Duke University and completed her M.D. at Duke University's School of Medicine.

- **The Department of Veterans Affairs has named Wanda Mims the next healthcare system director for the Bay Pines Veterans Affairs (VA) Healthcare System.**

Mims, 53, has served as director of VA Caribbean Healthcare System in Puerto Rico since 2009, where she oversees health care operations in both Puerto Rico and the U.S. Virgin Islands. She supervises a 480-bed main hospital, two multispecialty outpatient clinics, four community based outpatient clinics, three rural health clinics and an outreach center.

In her new role, Mims will oversee delivery of health care to over 97,000 veterans and an operating budget of $600 million at the nation's fourth largest VA Medical Center.

Mims joined the VA more than 14 years ago and has held progressive leadership positions at the Cincinnati, Cleveland, Hampton, Va., and Louisville VA Medical Centers. She also was the deputy network director for the Veterans Integrated Service Network (VISN) 10, which included oversight for multiple VA Medical Centers in Chillicothe, Cincinnati, Cleveland, and Dayton, Ohio, and a VA Outpatient Clinic in Columbus, Ohio.

Mims enlisted in the U.S. Marine Corps at age 17 and served for four years until her discharge. She holds a master's degree in business administration, is a graduate of the VA's Executive Career Field Program, Healthcare Leadership Institute, and the Federal Institute for Healthcare Executives. She has over 33 years of experience in the federal government.

She replaces Wally Hopkins, who retired in April.

Health Care News

- **The U.S. Department of Health and Human Services (HHS) has given awards to eight organizations for their innovative health promotion projects, which have demonstrated a significant impact on the health of the community within the past three years.**

  The 2011 Healthy Living Innovation Awards are a part of Secretary Kathleeb Sebelius' Healthy Weight Initiative and HHS' continuing focus on highlighting preventive health and recognizing organizations that implement innovative approaches to address chronic diseases and promote healthier lifestyles.

  Nominated organizations had to have an innovative project in at least one of three health promotion areas: healthy weight, physical activity, and nutrition. Awards were granted based on the criteria of creativity and innovation, leadership, sustainability, replicability, and results/outcomes. The 2011 winners are:

  Winning nominations were chosen from among a competitive pool of 245 submissions by an HHS expert panel of judges, and then put before the public for voting. Secretary Sebelius made the final determination of winners based on public votes and recommendations from the expert panel.

  Visit http://healthylivinginnovation.challenge.gov/ to learn more about the Healthy Living Innovation Awards winners.

- **Centers for Disease Control and Prevention (CDC) researchers have revealed that all 50 states have 20 percent or more adults who were obese in 2010.**

  The data also show 30 percent or more of adults in 12 states were obese, compared to no states with that level of obesity in 2000, and nine states in 2009. The new data and updated national obesity trends map was released online at http://www.cdc.gov/obesity/data/trends.html.

  The data come from the most recent Behavioral Risk Factor Surveillance System (BRFSS), a state-based phone survey that collects health information from approximately 400,000 adults aged 18 and over.

  The nine states in 2009 that reported an obesity rate of 30 percent or more are: Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and West Virginia. In 2010, three more states reported an obesity rate of 30 percent or more: Michigan, South Carolina, and Texas.

  The BRFSS data highlight how obesity affects some regions more than others. The South had the highest rate, at 29.4 percent, while the Midwest had an obesity rate of 28.7 percent, the Northeast had a rate of 24.9 percent; and the West had a rate of 24.1 percent.

  The BRFSS, a CDC-supported surveillance system, collects state-level public health data and provides a way for states to monitor progress toward national and state health goals. To assess obesity prevalence, phone survey respondents were asked to provide their height and weight, which was used to calculate their body mass index (BMI). An adult is considered obese if he or she has a BMI of 30 or above. For example, a 5-foot-4 woman who weighs 174 pounds or more, or a 5-foot-10 man who weighs 209 pounds or more both have a BMI of 30 or more so are considered obese.

  For more information on obesity prevalence, including an animated map, visit www.cdc.gov/obesity.

- **The U.S. Food and Drug Administration (FDA) has included medical imaging apps in a new draft guidance for its regulation of mobile medical applications (apps) used on smart phones and other mobile computing devices.**

  The draft guidance defines the mobile medical app designed for mobile computing devices and smart phones that the agency intends to regulate and delineates mobile medical apps that affect or could affect the performance or functionality of currently regulated medical devices. These include mobile medical apps that are either used as an accessory to medical devices already regulated by the FDA or which transform a mobile communications device into a regulated medical device. A number of medical imaging categories are included in the draft.

  For the subset of mobile medical apps subject to FDA regulatory oversight, manufacturers must meet the requirements associated with the applicable device classification. If the mobile medical app falls within a medical device classification, its manufacturer is subject to the requirements associated with that classification.

  Mobile medical apps subject to regulatory oversight include:

  - Apps that are an extension of one or more medical devices by connecting to the device(s) for the purpose of controlling the device, or for the purpose of displaying, storing, analyzing, or transmitting patient-specific medical device data. These include display of medical images directly from a PACS or similar display functions.
  - Apps that transform the mobile platform into a medical device by using attachments, display screens, or sensors, or by including functionalities similar to those of currently regulated medical devices. These include apps that attach electrocardiograph (ECG) electrodes to a mobile platform to measure, store, and display ECG signals.
  - Apps that allow the user to input patient-specific information and/or output a patient-specific result, diagnosis, or treatment recommendation to be used in clinical practice or to assist in making clinical decisions. These include apps that perform calculations that result in an index or score, that calculate dosage for radiation treatment, or that provide recommendations that aid a clinician in making a diagnosis or selecting a specific treatment for a patient.

  Comments and suggestions may be submitted to the FDA within 90 days from the date of publication on July 19 of this draft guidance.

- **The U.S. Food and Drug Administration(FDA) has approved the influenza vaccine formulation for the 2011-2012 season that will be used by the six manufacturers licensed to produce and distribute influenza vaccine for the United States.**

  Vaccination remains the cornerstone of preventing influenza, a contagious respiratory disease caused by influenza virus strains. The vaccine formulation protects against the three virus strains that surveillance indicates will be most common during the upcoming season and includes the same virus strains used for the 2010-2011 influenza season.

  Between 5 percent and 20 percent of the U.S. population develops influenza each year, leading to more than 200,000 hospitalizations from related complications, according to the U.S. Centers for Disease Control and Prevention (CDC).

  The brand names and manufacturers of the vaccines for the upcoming season are: Afluria, CSL Limited; Fluarix, GlaxoSmithKline Biologicals; FluLaval, ID Biomedical Corporation; FluMist, MedImmune Vaccines Inc.; Fluvirin, Novartis Vaccines and Diagnostics Limited; and Fluzone, Fluzone High-Dose and Fluzone Intradermal, Sanofi Pasteur Inc. Fluzone Intradermal, approved on May 9, 2011, will be available for those ages 18 years through 64 years. This vaccine is delivered into the skin, rather than the muscle, using a very small needle.

  Based on that information and the recommendations of the FDA's Vaccines and Related Biological Products Advisory Committee, the strains selected for the 2011-2012 influenza season are:

  - A/California/7/09 (H1N1)-like virus (pandemic (H1N1) 2009 influenza virus)
  - A/Perth /16/2009 (H3N2)-like virus
  - B/Brisbane/60/2008-like virus

  There is always a possibility of a less than optimal match between the virus strains predicted to circulate and the virus strains that end up causing the most illness.

- **The Centers for Medicare and Medicaid Services expects to start a pilot program to accept electronic attachments that support submitted claims on Aug. 1, 2011.**

  Under the pilot, providers, who normally fax or mail clinical documentation to support claims to Medicare Audit Contractors and Recovery Audit Contractors,

can use selected health information vendors to electronically transmit requested information.

Seven health information technology vendors are on tap to support the esMD Gateway Services program starting in August: EHRDOCTORS, HealthPort, Health IT Plus, IVANS, MRO Corp., NaviNet Inc. and RISARC Consulting.

Other vendors expected to join in October include AKIRA, eSolutions Electronic Commerce, BACTES, Secure Exchange Solutions, Cobius, Greenway Medical Technologies, IOD, Proficient Health, Craneware, AT&T and Medical Electronic Attachment.

The pilot starting in August is a first-phase test during which Medicare's contractors will continue to send documentation requests via postal mail and providers will have the option of electronically sending the information. During Phase 2, starting in 2012, contractors will electronically send the documentation requests in addition to electronically receiving the materials.

Participating vendors will build and use "esMD gateways," compatible with the federally developed Connect downloadable health information exchange software. For vendorsthat operate Web portals enabling providers to exchange administrative and financial transactions with insurers, the pilot is an opportunity to significantly enhance services.

More information on the esMD Gateway Services program, including a schedule of when contractors will start participating in the pilots, is available at cms.gov/esMD.

Reserve/Guard

- As of July 19, 2011, the total number of Guard and Reserve currently on active duty has declined by 665 to reach 93,296. The totals for each service are Army National Guard and Army 71,608; Navy Reserve, 4,761; Air National Guard and Air Force Reserve, 10,055; Marine Corps Reserve, 6,096, and the Coast Guard Reserve, 776. www.defenselink.mil

Reports/Policies

- **The National Center for Disaster Medicine and Public Health (NCDMPH) released the *"Pediatric Disaster Preparedness Curriculum Development Conference Report,"* on July 5, 2011.**

  The report is a summary of the proceedings, outcomes and next steps that were intended as the first step toward establishing a role-specific, competency based, pediatric disaster preparedness education and training program.

  The conference brought together world-renowned pediatricians, surgeons, nurses and emergency responders to begin to address the unmet education and training needs of medical responders who care for children in a disaster. Specifically, role-specific recommendations were discussed for personnel who would be characterized as "Ambulatory Care Clinicians," "Emergency Department Hospital Staff" or "EMS First Responders."

  The report outlines the objectives accomplished, including the identification of the many health care provider roles that need to be trained, the priority of their training and the preliminary curriculum recommendations for the three previously mentioned personnel categories.

To read the full report and learn more about the NCDMPH's work, visit http://ncdmph.usuhs.edu.

- **The GAO published "VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed," (GAO-11-570) on July 19, 2011.** This report examines what progress VA and DOD have made implementing the Executive Agreement to establish and operate the FHCC, and what plan, if any, VA and DOD have to assess FHCC provision of care and operations. http://www.gao.gov/new.items/d11570.pdf

- **The GAO published "World Trade Center Health Program: Administrator's Plans for Evaluating Clinics' Capabilities to Provide Required Data," (GAO-11-793R) on July 15, 2011.** This report focused on the Centers for Disease Control and Prevention (CDC)/NIOSH schedule for awarding contracts to CCEs, health care claims data requirements for the CCEs and planned procedures, and Administrator's plans for evaluating each CCE system's health care claims data capabilities during and after the award of the contracts. http://www.gao.gov/new.items/d11793r.pdf

Legislation

- **H.R.2573** (introduced July 18, 2011): the Rural Health Care Capital Access Act of 2011was referred to the House Committee on Financial Services.
  Sponsor: Representative Ruben Hinojosa [TX-15]
- **H.R.2595** (introduced July 20, 2011): the National Neurological Diseases Surveillance System Act of 2011 was referred to the House Committee on Energy and Commerce.
  Sponsor: Representative Chris Van Hollen [MD-8]
- **S.1376** (introduced July 18, 2011): A bill to conform income calculations for purposes of eligibility for the refundable credit for coverage under a qualified health plan and for Medicaid to existing Federal low-income assistance programs was referred to the Committee on Finance.
  Sponsor: Senator Michael B. Enzi [WY]
- **S.1381** (introduced July 18, 2011): the Lyme and Tick-Borne Disease Prevention, Education, and Research Act of 2011was referred to the Committee on Health, Education, Labor, and Pensions
  Sponsor: Senator Richard Blumenthal [CT]
- **S.1391** (introduced July 20, 2011): A bill to amend title 38, United States Code, to improve the disability compensation evaluation procedure of the Secretary of Veterans Affairs for veterans with post-traumatic stress disorder or mental health conditions related to military sexual trauma and for other purposes was referred to the Committee on Veterans' Affairs.
  Sponsor: Senator Jon Tester [MT]

Hill Hearings

- The House Veterans Subcommittee on Health will hold a legislative hearing on **July 25, 2011**, to examine on pending legislation.
- The House Veterans subcommittee on Oversight and Investigations will hold a legislation hearing on **July 27, 2011**, to markup pending legislation.

Meetings / Conferences

- National Veterans Small Business Conference and Exposition will be held on **August 15-18, 2011**, in New Orleans.
- CFHA's 13th Annual Conference: Accelerating Adoption of Collaborative Care: Reaching the Tipping Point will be held on **Oct. 27-29, 2011**, in Philadelphia, Pa. http://www.cfha.net//pages/Conference/
- 2011 Congress on Reducing Hospital Readmissions will be held on **Aug. 11-12, 2011**, in Las Vegas, Nev. http://www.globalmediadynamics.com/upcoming-events/hospital-readmissions/register-for-congress
- The National Medical Home Summit West will be held on **Sept. 20-22, 2011**, in San Francisco, Calif. http://www.medicalhomesummit.com/
- The 13th annual World Vaccine Congress will be held **Oct. 10-13, 2011**, in Lyon, France. http://www.terrapinn.com/2011/world-vaccine-congress-lyon/index.stm
- American Medical Informatics Association (AMIA) 2011 Annual Symposium will be held on **Oct. 22-26, 2011**, in Washington, DC. https://www.amia.org/amia2011
- CFHA's 13th Annual Conference: Accelerating Adoption of Collaborative Care: Reaching the Tipping Point on **Oct. 27-29, 2011**, in Philadelphia, Pa. http://www.cfha.net//pages/Conference/
- The American Public Health Association Annual Meeting & Exposition will be held on **Oct. 29-Nov. 2, 2011**, in Washington D.C. http://www.apha.org/meetings/

- The CDC's 2011 Symposium on Identification, Screening and Surveillance of HCV Infections in the Era of Improved Therapy for Hepatitis C will be held on **Dec. 1-2, 2011**, in Atlanta Ga. http://www.cdc.gov/hepatitis/hcvsymposium2011/.
- 17th Annual Maternal and Child Health Epidemiology Conference will be held on **Dec. 14-16, 2011**, in New Orleans, La. http://www.cdc.gov/reproductivehealth/MCHEpi/Conference/AboutConference.htm
- mHealth Summit will held on **Dec. 5-7, 2011, in** Washington, D.C. http://www.mhealthsummit.org/
- The International Conference on Emerging Infectious Diseases 2012 (ICEID) will be held on **March 11-14, 2012**, in Atlanta, Ga. http://www.cdc.gov/eid/content/16/11/e1.htm.
- The 15th International Congress on Infectious Diseases (ICID) will be held on **June 13-16, 2012**, in Bangkok, Thailand. http://www.isid.org/15th_ICID/

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