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U.S. Small Business Administration

Manufacturer of the Year for New England and Vermont 2024

Q2 2025

The Quarterly

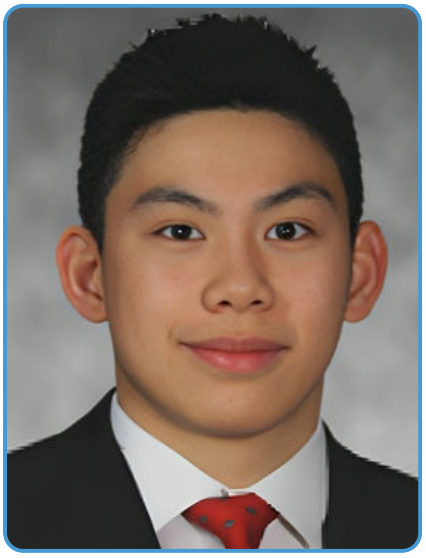
INSIDE THIS ISSUE:

"AI will never replace doctors, we will always need doctors. AI will help in diagnosis when there is enough data built and will aide doctors to perform their jobs more effectively."

- Jason

Employee Spotlight

Meet Jason Warren Lee



Since joining HD***medical*** as a Product Development Engineer last May, Jason has been a key player in driving innovation. Having earned both a bachelor's and a master's degree in biomedical engineering from Purdue University, coupled with a strong foundation in machine learning models and neural networks, Jason has been integral in applying these technologies to our cutting-edge products.

Jason had touched upon multiple aspects of biomedical engineering including the completion of a data science internship where he developed regression models and machine learning models to calculate insurance costs for healthcare companies based on various risk factors, "Calculating these costs is a multi-factorial calculation. When it's only 2 or 3 factors, its simple enough to do manually, but when its 30, MLMs play a critical role in predicting costs accurately." He also had done research in type-1 diabetes, specifically in gene cell therapies and insulin pumps. Born on New Year's Eve in Long Island, NY, Jason has always embraced an active and dynamic lifestyle. When he's not pushing the boundaries of biomedical engineering, you can find him on the basketball court or training for his next half-marathon.

Did You Know?

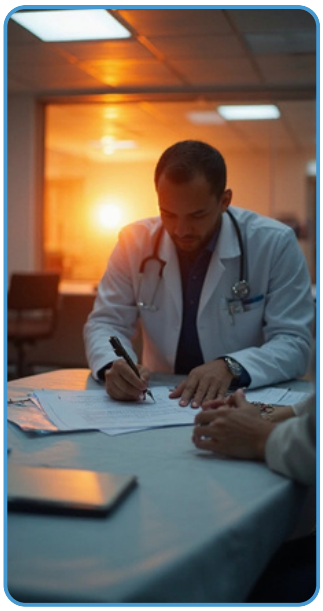
NIH Grant Funding Undergoes Major Reduction to Allowable Costs

On February 7, 2025, the National Institutes of Health (NIH) released a notice of updated policy that would significantly reduce the amount of funding that research institutions and universities can receive under the terms of their federal grants with the NIH. The updated policy would deviate from the negotiated indirect cost rates that these institutions establish annually under applicable regulations, and would instead place a 15% indirect cost rate on all new and existing grant awards regardless of whether actual indirect costs exceed this rate. The federal government requires many categories of costs to be treated as "indirect" under cost accounting regulations, and as a result of these rules, indirect rates at research institutions commonly exceed 15%. Over the past 5 years, the indirect spending rates for grantees has typically been in the 27-28% range (and as high as 60%).

Based on 2023 NIH spending levels, this reduction amounts to a $9 billion cut annually. So, what is being cut? Essentially, "indirect costs" refer to overhead, or "F&A" (facilities and administrative), and are costs that aren't assigned to specific grant objectives. This reduction will limit the resources available for grant recipients to support administrative salaries, facility maintenance, grant management, accounting & bookkeeping, and IT, for example. Many of these roles have historically been addressed through consulting and contractor firms that are active in the NIH network, and a key part of the NIH value proposition is ready access for recipients to these firms and experts. A roughly 50% reduction (28% to 15%) will likely render many of these resources cost-prohibitive. While this haircut is very disruptive to current practices and culture of the NIH ecosystem, it has been argued the new rate is more aligned with other, private funding sources:

Maximum Indirect Cost Rate	Organization
10%	• Gates Foundation • Smith Richardson Foundation
12%	• Gordon and Betty Moore Foundation • Robert Wood Johnson Foundation
15%	• Carnegie Corporation of New York • Chan Zuckerberg Initiative • John Templeton Foundation • Packard Foundation • Rockefeller Foundation (for institutions of higher education

"Medical institutions count on the indirect funding allocation to cover their general facilities costs. If they lose this source of funding, they will need to make it up in other ways or cut services and staff..."



Medical institutions count on the indirect funding allocation to cover their general facilities costs. If they lose this source of funding, they will need to make it up in other ways or cut services and staff, which are already strained resources.

According to the NIH, most of its nearly $48 billion budget is invested in "medical research seeking to enhance life and to reduce illness and disability."[1] Over 80% of the NIH's funding is awarded for "extramural research" through competitive grants to thousands of researchers at universities, medical schools, and other research institutions across the US.[2]

The NIH planned to implement this rate cap on February 10, but states and research institutions rapidly filed lawsuits that placed the updated policy on a temporary hold, including a lawsuit filed by 22 state attorneys general, a lawsuit from the Association of American Universities, and a lawsuit from the Association of American Medical Colleges (AAMC). Select members of Congress also responded swiftly, with Senator Susan Collins (R-Maine), Senator Bill Cassidy (R-La.), and Senator Katie Britt (R-Ala.) publicly expressing concerns with the updated policy and the impact on universities and research facilities in their states.

On February 10, a judge from the US District Court of Massachusetts granted the state attorneys general request for a temporary restraining order (TRO), and granted a TRO in the AAMC case, enjoining the NIH from enforcing the new policy "in any form with respect to institutions nationwide." The court has preliminarily assigned the three cases to the same judge, who has scheduled in-person hearings on the TROs for February 21. (The judge has also requested more information on how the multiple cases are related.) On February 21, the US District Court of Massachusetts ordered that the existing TROs entered on February 10, 2025, be extended and remain in effect until further order of the court.

There are other, more politically polarizing mandates being applied to the NIH and HHS, but among the actions being taken, this order has the broadest financial impact on institutions reliant on NIH funding, and is also the least likely to be reversed or repealed. Its impact on the parts of the NIH that support innovation and entrepreneurism will force researchers, founders, investors, and service providers to adapt, and could have an existential impact on the current support model for the NIH.

[1] (NOT-OD-25-068: Supplemental Guidance to the 2024 NIH Grants Policy Statement: Indirect Cost Rates, 2024)

[2] Office, A. P. (2025, March 27). HHS Announces Transformation to Make America Healthy Again.

A Message from C4 (Chief Culture Change Catalyst)

My friends, the storm is here. Healthcare is under scrutiny and being tossed around as if in a tempest. NIH and SBA funding is under siege with unheard of cuts, and courts in session as opposition fights to keep support for innovation, research, and development, particularly for small and early-stage businesses. Medical institutions are scrutinizing procurement and tightening purse strings in preparation for an uncertain future. We have not seen much in the way of middle management cuts or staff reform, and we are not sure if it is on the agenda.

There is still room to move in this tight space. Existing budgets can be better allocated, and we could focus on what works and what doesn't work toward a goal of better outcomes for all citizens – patients, family, staff, insurance payors, innovators, researchers, and uninvolved taxpayers, to name some. We must also keep in mind that 'patients' is a broad category in itself and includes young outpatients with minor concerns, critically ill frail older adults with decisions being made by others, powerful policy influencers, destitute and powerless health system users, and those within the system itself who may be afforded special privileges.

It's time to turn our attention to what would make sense for all categories of patients and citizens. After all, the people within these categories change affiliations all the time. There is much waste and there is much need. Silos of administrators focus on their parts and hope for the best. Some try to obstruct pathways to make their job appear to have substance. Some work tirelessly to collaborate with those around and above them to make change from the trenches.

What is our role in keeping our ship upright in this storm? First and foremost, do the right thing. Policies and structures will be changing but humanitarianism shouldn't. If you see someone caught in a broad policy, or someone the healthcare structure didn't account for, think outside the box. Be creative within the over-arching rules, and let people know that you value them, and then help them. Don't say that you hope they have a nice rest of their day, or thank them for coming when you haven't helped them – that's mean. If you find yourself slipping into being a policy-spouter or clock-watcher, stop and pretend you are dealing with your favorite person or pet.

Secondly, add your voice to the change you want to see. It's not helpful to know everyone's dreams and desires, but speaking up for basic human preservation is always welcome. You're in healthcare, it's expected. While speaking up for yourselves, try to gather where the source of those frustrations are coming from. This will help you consolidate your requests and figure out concessions that might be possible that could be acceptable by both parties.

1. We have been tossed in the air and we don't know how we will land.
2. Keep steady and do what's right. 3. Be bold yet thoughtful about requests for improvements. Good luck fellow do-gooders. Remember that you are loved and supported. Lead us all to a better place.

Yours truly,

Marie Pavini

Marie Pavini, MD, FCCM, FCCP

"Be creative within the over-arching rules, and let people know that you value them, and then help them."

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"... where common sense meets healthcare..."

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A Few Good Mentions

Q2 conferences and health awareness days

3/30–4/2 **AONL** (American Organization for Nursing Leadership) Boston, MA (Booth#1401)

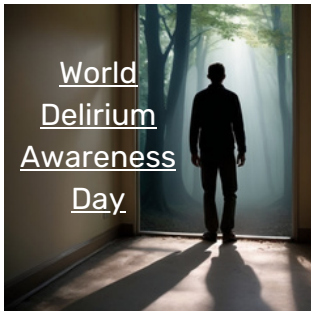
5/20-5/21 **AACN NTI 2025**, New Orleans, LA
(in coordination with earlymobility.com Booth #911)

April	May	June
7th: World Health Day **20-26:** Pediatric Sepsis Week **20-24:** National Healthcare Quality Week **28-2:** Patient Experience Week	**National Nurses Month** **6th:** National Nurses Day **6-12:** National Nurses week **11-17:** Neuroscience Nurses Week **18-24:** Healthcare Documentation Integrity Week	**Alzheimer's & Brain Awareness month** **16-20:** Healthcare Risk Management Week **27th:** National PTSD Awareness Day

In the News

The NIH's new policy capping indirect cost rates at 15% for all grants would cut $9 billion annually from research institutions, limiting funds for administrative and facility expenses. Legal challenges have temporarily halted enforcement, but if upheld, the policy could force institutions to cut services, seek alternative funding, and reshape the NIH's research support ecosystem. Read more here.

HD***medical*** is growing on social media. Follow our *Unlocking Minds* series and more.



Home in Vermont

Spring in Vermont brings blooming wildflowers, maple festivals, and scenic hikes as the Green Mountains awaken from winter. With warmer days and crisp nights, it's the perfect season for exploring covered bridges, visiting sugarhouses, and enjoying the state's vibrant outdoors.

As the snow melts, Vermont's landscapes transform into lush greenery, attracting hikers, cyclists, and nature lovers eager to experience its peaceful beauty!