Report on diagnosis-related errors could open doors for reps
448,000,000
NEW CURABLE SEXUALLY TRANSMITTED INFECTIONS EACH YEAR

Did you know the most common, non-viral, curable STI in the world is 2.5 times more prevalent than Chlamydia and almost 3 times more prevalent than Gonorrhea1?

Largely under diagnosed and undertreated, Trichomonas vaginalis has been shown to contribute to premature birth and increased risk of HIV transmission as well as other serious health consequences.2

Isn't it time we measure the value of a product by the outcomes rather than simply by the cost?

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1. Prevalence and Incidence of Selected Sexually Transmitted Infections, World Health Organization 2011
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The Right Questions
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Opinions

There is no Plan B for healthcare reform.

Distribution

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12-3193_REP_4/13_XE
With summer approaching its end, we are closer to the implementation of many of the components of the ACA. In fact, Oct. 1, 2013 is the launch date of the Healthcare Exchanges set up either by the states, or the federal government, in cases where the state opted out of doing so on their own.

My friend Ted Almon argues in his article that we should adopt and support Obamacare, as we have no Plan B. In his opinion, if we don’t make this work, we are doomed to another 20 years of escalating healthcare premiums with no improvement in the quality of care being delivered. I agree with Ted on a few points, but will argue that Obamacare will do nothing to curb the rise in costs of premiums or care in general. Two recent developments regarding the ACA may have slipped by you as they were subtly announced via a blog over the 4th of July holiday. First, the employer mandate for providing healthcare coverage to employees in lieu of a fine (on companies with 50 or more employees) was postponed for a year. Thus, the business community was given a temporary reprieve, while the individual mandate requiring those not covered by employer based insurance still stands (at least at the time of this writing). Many of you probably either read about this or heard about it as Obamacare opponents freely pointed this out as a serious flaw in the ACA.

Perhaps less widely known, however, was the announcement that people forced onto the exchange to buy insurance will be operating on the “honor system” when reporting their income and employment status. Simply stated, the government was supposed to verify reported income claims from applicants with IRS data to ensure that the right taxpayer subsidy is given.

It is understandable that a data project of this scope and size is enormous, which was one of the criticisms of the bill in the first place. Well, apparently three years was not enough time to put this in place, so the next best option was to let the individual play “priceline” with their healthcare needs. Call me cynical, but isn’t there enough fraud in the healthcare system already?

Don’t get me wrong, I agree with Ted that costs are indeed out of control and somehow need to be reined in. But I struggle finding anything about this law that will begin to accomplish that. It has been estimated that even before the law is fully implemented that it will cost three times the original cost advertised to us. And I ask, how many government programs can you name that have held the line on costs after they were implemented?

I say back to the drawing board.
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It was Henry Ford who said, “Whether you think you can or you think you can’t, you’re right.” His wisdom has an amazing array of applications, and our current effort to overhaul the healthcare system is certainly one.

Back in the ’90s, the Clinton administration attempted sweeping reform of a system that even then was escalating in cost at an alarming rate. The Clinton plan was called “managed competition,” or unofficially, Hillarycare. I didn’t think it would work, and I actively advocated against it in much the same way many critics of the Affordable Care Act, or Obamacare, are so vehemently resisting today.

What I didn’t realize then, was that our victory over Hillarycare would sentence us to 20 more years of the dysfunctional status quo. Two decades more of health premiums rising at twice the rate of inflation, and a healthcare system growing ever further from meeting the needs of patients. Grudgingly, over time, I came to realize that in our well-meaning zeal to get reform right, we had shot ourselves in the foot. The same is true now, I’m afraid. It is Obamacare or the status quo. There is no Plan B.

**Healthcare is no business**

Many Obamacare detractors favor a more market-based, less government-controlled system. So did I back in the ’90s. So what happened to the omnipotent but invisible hand of the markets in which we all had such faith? Over time, I slowly came to realize that healthcare is a social program that simply can’t be made to heel to normal consumerism.

For one thing, we have a federal law in this country requiring all hospitals to treat anyone who shows...
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up in their emergency department, regardless of their ability to pay. That law was signed by the patron saint of the Republican Party, Ronald Reagan. A system that says we are going to treat everyone but not make everyone pay is just not a business. I’m sorry.

The Affordable Care Act isn’t perfect either. There are plenty of things to question in its copious pages, but it does have several powerful elements of reform. Health insurance exchanges are one. You see, today’s Republicans insist on preserving commercial insurance as the financing mechanism for healthcare. With the expansion of coverage to near universal scope, it is a terribly clumsy tool for the job. Health insurers can only compete on their margin, administrative costs and profits, which make up only about 20 percent of premiums. The rest are the medical costs they pay to healthcare providers. But the system is so fragmented, that no insurer has the leverage to drive reform back down through the delivery system by changing the way we pay providers. Nor do they really have much incentive to do so. As essentially a cost-plus business, insurers actually benefit from rising costs.

The health insurance exchanges set up by Obamacare serve to consolidate the financing of care through a single channel so as to create the market leverage necessary to effect real payment reform. Healthcare professionals know that will transform the delivery system quickly and in a most meaningful way. It simply won’t happen any other way, as the past 20 years should have taught us.

**Apples to oranges?**

So let’s get back to Henry Ford’s insight. Recently, the nascent California insurance exchange announced its first round of premium bids from the dozens of insurers there. To many, the rates were surprisingly low in light of the gothic predictions from some insurers and their actuaries. ACA supporters were jubilant, and the *New York Times* ran several positive columns celebrating what appeared to be an early success.

It didn’t take long for opponents to react. Forbes ran several angry columns denouncing the low rates as misleading and even an “apples and oranges” comparison to existing premiums there, saying the Obamacare exchange rates were far higher, just as they had predicted. The truth is, the rates will be higher for some, but they will also be lower for others as the ACA compresses the existing rate bands insurers can use to set premiums. And the comparison IS apples and oranges, because the existing rates aren’t available to everyone. But the ACA/Obamacare rates are. It is easy to offer low rates if you can select only healthy customers.

Reform is difficult, even if everyone is on the same side. The ACA will surely need to be tweaked as implementation moves along. It won’t be able to overcome such obstinate resistance at every stage of its rollout.

So if you are hell bent on defeating Obamacare, you could well be successful. But your reward will be another 20 years of costs spiraling out of control. Can we afford that? I think we should decide we CAN make it work.

**Editor’s note:** Ted Almon is president and CEO of Claflin Co. an independent medical distributor in Warwick, R.I. He is a past chairman of HIDA, presently serves on the HIDA Advocacy Council, and is a past member of the MDSI editorial advisory board. He was inducted into the Medical Distribution Hall of Fame in 2012. He is an active participant in the healthcare reform debate, and writes and speaks frequently on the subject. This piece was originally published by Providence Business News in June.
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The United States Preventive Services Task Force recommends that average-risk men and women ages 50-75 get regular colorectal cancer screening with any of three tests: a high-sensitivity, multi-slide fecal occult blood test (FOBT); a flexible sigmoidoscopy every five years; or a colonoscopy every 10 years.\(^1\)\(^2\) Fecal testing is not recommended for those at high risk of developing colorectal cancer, and these individuals may need to start screening at a younger age.

Colorectal cancer (CRC) is the third most common cancer diagnosed in both men and women in the United States. It is preventable through regular screening and is easily curable if found early.

The fecal occult blood test is one of the most commonly recommended colorectal cancer screening methods by the National Cancer Institute, National Institutes of Health, and the American Cancer Society. FOBT allows patients to procure samples in the comfort of their own homes, at their convenience. Studies have shown that FOBT, when performed every one to two years, can reduce the number of deaths due to colorectal cancer by 15 to 33 percent.

There are currently two main ways of screening for fecal occult blood – the guaiac method and the fecal immunochemical test.

The guaiac method (gFOB) is the most common, mainly due to it being the first FOBT. You are probably familiar with this method. The patient is given three cards, three cups and three sticks. Instructions are to collect a stool sample, smear some feces on the cards and send them back to the office or lab. This method has several issues:

- Not specific to human hemoglobin.
- Calls for diet restrictions – avoid red meat, iron-rich foods and certain medications.
- Low compliance due to the collection process.
- High percentage of false positives.

The other method, sometimes called FIT (Fecal Immunochemical Test) or iFOBT, is designed to detect human hemoglobin and is also specific for blood in the lower gastrointestinal tract rather than blood originating from other sources higher up in the gastrointestinal tract. iFOBT is not affected by food or medication. Therefore, patients can perform the test immediately. Collecting a stool sample is made easier by a disposable paper that catches the feces in the toilet. The feces is then collected using a plastic applicator, brush or probe, attached to a cap. The cap is replaced on the tube and returned to the provider or lab. This new technology has greatly improved specificity, sensitivity, accuracy, and cost-effectiveness of FOBTs.

The iFOBT costs more per test, but also reimburses more.

- The CPT code for testing for occult blood by fecal hemoglobin determination by immunoassay (FIT or iFOBT), qualitative is 82274QW, average $21.86.
- The CPT code for multi-slide take-home FOBT by peroxidase activity (e.g., guaiac) for colorectal neoplasm screening is 82270QW, average $4.48.
- The CPT code for an in-office test performed after a digital rectal exam to confirm the presence or absence of blood on examination by peroxidase activity (e.g., guaiac) is 82272QW. (This should NOT be used as a modality for colorectal cancer screening.)

Check to see which iFOB your company carries, learn all you can about it, and encourage, educate and offer your providers the latest in colorectal cancer screening. They will thank you for it. ☺️

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For Tarheel Physicians Supply, a focus on capital equipment and revenue-producing tests has helped the company evolve with the industry.

By Laura Thill

In 2003, following his college graduation, Matthew Wright purchased his first suit, mustered his confidence and “marched into Wilmington Hospital Supply/Tarheel Physicians Supply (Wilmington, N.C.) and told Jerry Shelton (then head of sales) that I was ready to be a pharmaceutical rep.” Unfortunately for Wright, the distributorship didn’t have a pharmaceutical department. But, that didn’t sink his career plans. He was hired as a sales rep, on the condition that he work in the company warehouse for his first six months. “Each morning, I would come in and speak to Jerry,” he recalls. It was an opportunity to ask questions, learn about the various roles everyone played and understand how the internal process was interconnected with field sales.

At the same time, Wright joined Shelton on sales calls. “After six months, Jerry sent me on the road,” he says. “He told me I’d have to see about 20 accounts each day. I was flying by the seat of my pants! My very first sale was a wheelchair.” Thanks to the knowledge and experience he gained in the warehouse his first six months, there were many more sales to come. He spent the next four years in Charlotte, building a new territory. A couple of years after that, he was promoted to sales manager and hired a rep to take over his territory. Unbeknownst to Wright, there would come a day when he would run the company.

“A new world

From the time Wright entered the medical products industry to the time he became vice president and later president of the company in 2011, much had changed about the market. “When I began, the market was thriving,” he says. “We were running on all cylinders, and Tarheel was able to take [more] risks.” Indeed, those were the days when companies such as Tarheel could adopt a broad plan for growth. “Back then, we sold whatever products we were comfortable selling, and each of us was comfortable selling different products,” he explains. “We were all over the place.

“By the time I became president, this business had weathered a number of storms and the economy was struggling,” he continues. By 2011, as many distributors discovered, it had become prudent to re-organize and offer a focused line of products and services. For Tarheel, that meant providing high-revenue capital equipment or lab solutions, backed by low-cost disposable supplies. “Our reps must be able to bring powerful value to our customers,” he notes. “And, we

“Our reps must be able to bring powerful value to our customers. And, we must show our customers how to bring revenue back into their office.”

– Matthew Wright
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must show our customers how to bring revenue back into their office. It’s easier to sell a tangible, show-me product. But, we are a small independent business. As manufacturers have changed their minimum orders, we have had to change our focus. And, we are confident we are one of the best in the nation [when it comes to] physician office setups.”

Reaching this point meant getting the whole company on the same track, he points out. “Once that happened, our conversations with our physician customers grew and led to more and more sales.” However, getting everyone at Tarheel – a company incorporated in 1959 and very comfortable with its old school approach – to think alike was not easy. If Wright had expectations of immediate, companywide change, he was in for a surprise. Not only was the industry evolving, the company had experienced the death of cofounder Jane Lane and, as a result, a change in management, including the appointment of Wright as new president. So while he had his colleagues’ respect, at the same time “I had the audacity to come in and change the way they did their jobs,” he says.

In his eagerness to affect change, Wright admits he might have pushed too hard, too fast. “I quickly learned that shocking everyone wouldn’t go over well. In retrospect, I could have provided a clearer game plan and [better] explain why we were changing and how that would affect each of them. I think I [stepped into the position] expecting everything to be wrapped up with a big bow in about three months!”

A team effort
Fortunately for Wright, he has had a lot of support from Tarheel’s board of directors in his efforts to move the company forward. When Wilmington Hospital Supply was incorporated in 1959, it was done so by husband-wife team Jim and Lucile Whedbee. When Jim died unexpectedly in 1978 at age 48, Lucile, then a 48-year-old teacher, needed to make some choices that would enable her to provide for herself and her two young daughters. Lucile continued to run the company largely on her own until 1978, when her daughter and son-in-law, Jane and Bill Lane, took on Tarheel Physicians Supply – or the physician products portion of the company. With the help of Jerry Shelton, a marketing professional who would later help keep the business thriving when Jane encountered health issues, the Lanes moved the company into a new decade.

Jane’s passing in 2006 was a shock to Tarheel Physicians Supply. However, Bill Lane and Jerry Shelton, together with Jane’s sister, Lucile Whedbee and niece Carole Ellis, kept the business on course. Although Shelton retired in 2007, the others have remained on the board and continue to work alongside Wright in his efforts to retain Tarheel Physicians Supply’s strong footing in the industry. And, in a sense, he feels that Jane continues to guide him as well. “Jane was the fire and passion of Tarheel Physicians Supply,” he says. “She left a daily message to employees that spoke of clear expectations, was concise and uplifting. She is missed greatly and would truly appreciate the [persistence we have demonstrated] in the industry.”

Looking back, moving ahead
With an eye to Tarheel Physicians Supply’s future, Wright reflects on his past – one that came close to shaping into a baseball career. Indeed, his college baseball team, UNC Wilmington, was successful, making it to the NCAA Regionals his senior year. However, when the professional scouts told him he was a potential late round pick, he took

With an eye to Tarheel Physicians Supply’s future, Wright reflects on his past – one that came close to shaping into a baseball career. Indeed, his college baseball team, UNC Wilmington, was successful, making it to the NCAA Regionals his senior year.
that to mean he would spend a lot of time in Single A ball – meaning an annual salary of $14,000, dorm room living and constant travel. With marriage to his high school sweetheart on the horizon, he removed his name from the draft, opting for a stable career.

Although he dreamed of a baseball career growing up, Wright has never doubted his decision to join the medical products sales industry. Rather, he has applied his experience with team sports to his current role as company president. “I am very happy with the decisions I’ve made and how everything has turned out,” he says, noting that his baseball experience “absolutely factors into how I run the business.”

Baseball is the only sport where one can fail, yet still succeed, he says. Along the same lines, when it comes to growing a distributorship, he’s become an expert at learning from his mistakes and moving forward, he points out. And, just as “every play in baseball requires a team effort, the same holds true [in the medical products distribution business].

“We believe we are as strong as anyone in the country in providing physician office setups,” he continues. “We have spent the past two years coupling that strength with high revenue-producing solutions and specific low-cost disposable supplies. I am confident we will continue to grow, but we will grow in niche areas, which we classify as revenue-producing tests and capital equipment.”
The Right Questions

Take time to prioritize...and don’t get distracted by ‘the tyranny of the urgent,’ IMDA members are told

What’s the most important thing for a business leader to have or to do? It’s not having all the answers. Rather, it’s knowing what questions to ask. And those questions – centered around value – should be focused on three constituencies: your customers, your associates, and your supply channel partners.

Management consultant Barry Banther, CMC, CSP, made the comments during his presentation on “Value Principles” at the IMDA 2013 Annual Conference. IMDA is the association for specialty sales and marketing organizations.

The theme of the event – “Specialty sales and marketing: Coming of age in accountable care” – was intended to highlight the challenges and opportunities for companies that introduce innovative medical devices to the market. IMDA also sponsored its annual Manufacturers Forum, for device manufacturers seeking specialty distribution.

Your customers

Banther advised the specialty distributors to take a look at their important customers and ask the following questions:

- What is the competitive advantage this customer has in the marketplace?
- Who are my customer’s customers?
- What are that customer’s strategic goals?
- How does the customer measure success?
- What is the customer’s internal value?
- What do my customers value about my organization?

These questions aren’t just intended for the leader or business owner to ask, Banther said. Sales reps need to do the same. If they can’t answer them, they’re probably doing little more than disturbing their accounts, instead of helping them.

Your people

The most expensive inventory you have gets in the car and comes to work every morning, Banther told attendees. Yet it’s the one leaders often ignore – their employees. Openness begins with listening with empathy. “Listening has nothing to do with hearing, but with the environment we create.” Employees know when their boss isn’t really listening to them, but only pretending to. “Remember this,” he said. “People will forget what you say and what you did, but they will never forget how you made them feel.”

Supply chain partners

Just as leaders must provide value for their customers and associates, so too must they provide value for their supply chain partners, said Banther. Those partners may be complex, so value may be added incrementally.

Start by building seamless and virtual communication systems, he said. “Communications are important, but systems trump everything,” because automated systems remember things that people forget.
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Seek collaboration with your supply chain partners. And keep in mind the critical distinction between cooperation and collaboration: Cooperation is in the moment; collaboration requires partners to plan together. Align your resources, so each party knows what it has to contribute, he said. “And when something goes wrong, realign them.”

If there’s one thing that can derail the noblest of intentions, it’s the tyranny of the urgent, said Banther. There’s always something at the moment to take precedence over adopting a customer-centric approach. “But the tyranny of the urgent is a myth,” he said. “You always have a choice. And this is a tough choice. We have to take the time to define what’s important to us. Too often, we [revert] to the urgent, because we don’t know what’s important. We use it to avoid the important things.”

Licensed to sell

In a separate presentation, Frank Fazio, Esq., principal, Porzio, Bromberg & Newman P.C., Morristown, N.J., introduced IMDA members to the complex, sometimes burdensome world of licensing for medical device sales.

Laws demanding medical distributors to be licensed were originally put into place primarily to prevent the diversion of pharmaceuticals, explained Fazio, who is also vice president, distribution and licensing services, for Porzio Life Sciences, LLC. But some states have opted to lump medical devices in with pharmaceuticals. Today, approximately 20 states require that manufacturers and distributors of medical devices be licensed to sell medical devices.

Licensure is a fact of life, and will be for the foreseeable future, he predicted. “As states seek new sources of revenue, it’s possible the number of states entering this area will increase in the next few years.” For that reason, device companies need to keep track of the myriad of state requirements and monitor changes in state laws, he said.

ObamaCare: Like it or not

Peter Carmel, MD, a pediatric neurosurgeon and past president of the American Medical Association, offered IMDA members his take on healthcare reform. His blunt assessment: The status quo is not sustainable. “The good old days ain’t coming back. And they weren’t that good anyway,” he said. To wit:

• Too many Americans lack access to healthcare, and an estimated 50 million lack health insurance.
• Care delivery is inequitable. For proof, look at some of this country’s inner city hospitals.
• The system is too expensive for both the states and the federal government.

Medicare, which Carmel called “the linchpin of healthcare reform,” faces a rough road ahead. When the program was created in 1965, the average life expectancy was 66; now it is 78. In the beginning, Medicare covered 19 million people; by 2030, approximately 80 million will be enrolled, and the number of workers supporting each beneficiary will have fallen to about 2:3. In 2011, the average Medicare beneficiary paid roughly $130,000 into the fund, but consumed about $420,000 worth of services. “It’s not a good business plan,” said Carmel.

Say what you will about the Affordable Care Act, aka Obamcare, but health system reform was – and remains – a necessity, Carmel said. The law expands health insurance to more than 32 million Americans, provides subsidies to those who can’t afford insurance, and allows for the purchase of private insurance through competitive exchanges. No longer can insurers deny coverage to someone due to a pre-existing condition. And already, an estimated 54 million Americans have benefited from expanded coverage for prevention and wellness measures.

All sectors of the healthcare industry face change, not the least of which are physicians, added Carmel. A growing number of young physicians are rejecting setting up their own practice or partnering in an existing practice. Instead, they are pursuing employment, most often by hospitals. In fact, physician recruiter Merritt Hawkins & Associates predicts that by the end of 2014, 75 percent of all newly hired physicians will be hospital employees.

Demographics aside, healthcare reform will also affect physicians’ futures, said Carmel. The rapid – and to some, surprising – popularity of accountable care organizations, as well as bundled-payment programs, are changing practice patterns. Already, between 37 million and 43 million Americans are participating in an ACO.

“The basis for physician payment has been fee-for-service – you do something, you get paid for it,” he said. “It’s a system that encourages the use of services, but not necessarily the promotion of health.” ACOs, on the other hand, reward providers and other participants, including insurance companies, for providing high-quality, low-cost care, particularly to those with chronic diseases.
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A record number of independent distributors and manufacturers assembled in Nashville, Tenn., June 10-12 for the NDC International Exhibition 2013. This year’s theme – “KAPOW! Impacting the Industry” – was intended to underscore the fact that independent distributors are a force to be reckoned with in the healthcare industry, according to NDC. With rapid change the new norm, finding proven strategies and innovative solutions to adapt to change was the common theme of the three-day agenda.

NDC President and CEO Mark Seitz, opened the General Session at the Ryman Auditorium, stating that despite the uncertainties in healthcare, independent distributors face tremendous opportunity. “Last year, NDC distributors celebrated growth of close to 10 percent on purchases through the NDC portal,” he said. “If anyone claims that independents are not impacting the industry – thanks to this year’s theme – we have a one-word answer…. KAPOW!”

Fletcher Lance, vice president and national healthcare leader, The North Highland Company, identified changes, trends and challenges within healthcare, and provided an update on reform efforts. Lance, who works with some of the nation’s most prominent health systems, advised business owners of the possible implications of these changes on their businesses, demonstrating that now, more than ever, they need to build efficient and lean operations, reduce costs, remain aware of consolidation, and implement new-thinking models.

Midmark Corporation and Smith & Nephew sponsored keynote speaker Dr. Jeanne Liedtka, author and United Technologies Corporation Professor of Business Administration at the University of Virginia Darden School of Business. Liedtka challenged business owners to approach uncertain times armed with “design thinking,” a model based on innovative thinking, used to fuel growth and to differentiate companies in crowded markets. She encouraged attendees to get to know their customers, anticipate their needs, and give them what they don’t even know they need.

Following the opening session, NDC honored members and vendors for their extraordinary achievements over the previous year. Highlights included NDC Member of the Year, Preferred Medical and NDC Vendor of the Year, Graham Medical (see full listing of award winners on page 24).
On Tuesday afternoon, educational sessions covered a variety of business disciplines, including an executive workshop: “Designing for Growth,” led by Liedtka. In the session, “Maneuvering in the Changing Healthcare Environment,” distributors were eager to learn how to navigate the challenging world of GPOs, IDNs, RPCs and ACOs. John Prichard, President, U.S. LifeLine; Cindy Juhas, President of Hospital Associates; and NDC’s VP of Business Development, Dave Rose, delivered valuable market insight to a packed house, on how to maximize NDC’s GPO portfolio – part of NDC’s commitment to keep independent distributors competitive.

In other sessions, NDC Members led the way, sharing their expertise and out-of-the-box ideas that have brought innovative solutions for their companies and their customers. Of note, Alex Caldwell, The Claflin Company, presented “The Data Driven Customer” and Kim Schwieterman, All Med Medical Supply, moderated “Bringing Innovation to the Post Acute Market.”

Wednesday’s trade show offered product demonstrations, business opportunities and a record number of show special incentives and vendor participation.

The exhibition wrapped up Wednesday evening at the Wildhorse Saloon. Entertainment sponsors Innovative Healthcare Corp. and Roche Diagnostics welcomed the crowd to a private concert featuring RCA recording artist, Chris Young.

NDC MOTion1 members enjoy the New Member Reception.

Graham Medical, NDC Vendor of the Year, unveils super powers at the KAPOW-Wow Mixer & Networking Event.

Best in booth winner, Miltex, an Integra Company, livens the show floor.

NDC Member of the Year, Preferred Medical; Todd Ross

Chris Young performs at the Closing Party.

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## 2013 NDC awards

### New Member Recognition
- ABC Medical Instruments, Inc.
- Med-Electronics
- ABS Healthcare Resources & Services, Ltd.
- Medquip
- Advanced Rehab Systems
- OrthoCanada
- Cornish Medical Electronics
- Physical Enterprise
- Current Therapeutics
- PhysioTech
- Dekroyft-Metz & Co Inc.
- QB Medical, Inc.
- ECP Distributors
- Rehab Technologies
- Electro Medical Equipment, Inc.
- Ryan Pharmacy & Orthopedics Supply
- Integrated Medical
- Thera Tek USA
- US Medsource, LLC
- Thor Medical
- Arizona Therapy Source
- Dominion Medical Equipment
- Isokinetics
- Dartmedical
- PMR Newkirk Products
- San Diego Medical Electronics
- Medical Specialities Distributors, LLC
- Global Pharmaceutical Solutions, LLC
- Disposable Medical Resources

### Fast Track Award
- Eye Supply USA Inc.
- Med-Plus, Inc.
- Reidy Medical Supply, Inc.

### Trendsetter Award
- Expert-Med, Inc.

### Million Dollar Club
- ACO Med Supply
- Alko Enterprises, Inc.
- Aoss Medical Supply, Inc.
- Community Surgical Supply
- DDP Medical Supply
- Delcrest Medical Services, Inc.
- Ecologically Sound Medical Services
- Globe Medical Surgical Supply
- Grogan’s Healthcare Supply
- Hankins Surgical Supply
- J & B Medical Supply Co.
- Krasity’s Medical & Surgical
- Long Beach Surgical
- Masterfit Medical Supply, LLC
- Medical Supplies of America
- Metro Medical Supply Inc.
- Midtown Veterinary Supply
- Ontario Medical Supply Limited
- Park Surgical, Inc.
- Southeastern Emergency Equipment
- Suncoast Surgical & Medical LLC
- Turenne PharMedco
- Vessel Medical

### Multi-million-dollar Club
- Affiliated Materiel Services
- All Med Medical Supply L.L.C.
- American Medical Depot
- Anda, Inc.
- Buffalo Hospital Supply Co. Inc.
- The Claflin Company
- Kreisers, Inc.
- Lynn Medical, Inc.
- Medical Mart Supplies
- Mercedes Medical, Inc
- Neil Medical Group
- Pocket Nurse Enterprises Inc.
- Preferred Medical
- Professional Hospital Supply, Inc.
- Shared Service Systems
- The Stevens Company

### Diamond Elite Club (double-digit growth for three consecutive years)
- All Med Medical Supply
- American Medical Depot
- Community Surgical Supply
- DDP Medical Supply
- Expert-Med, Inc.
- J & B Medical Supply Co.
- MyMedSource
- Southeastern Emergency Equipment
- Suncoast Surgical & Medical, LLC

### Distributor Representative of the Year
- Charlie Simpson, Medical Supplies Depot
- Greg Russell – Graham Medical

### Vendor Representative Of The Year
- GOJO Industries

### Rising Star Award
- DUKAL Corporation

### Outstanding Performance – Warehouse Vendor
- Midmark Corporation

### Outstanding Performance – Vendor Direct
- Graham Medical

### NDC Medical Vendor Of The Year
- Preferred Medical
Mortara Instrument proudly announces the acquisition of the Cardiac Science Diagnostic Cardiology product solutions.

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- Exceptional Service and Support
- Innovative Product Solutions

The dedicated team of professionals that has served you for years is anxious to exceed your expectations, once again.
Contact your local Burdick sales representative today!
All roads (and penalties) lead to quality improvement

One thing Washington seems to agree on is pushing healthcare improvement through payment initiatives. Specifically, continuing the shift to pay-for-performance by linking Medicare and Medicaid reimbursements to quality measures.

Covering inpatient and outpatient services, physicians, skilled nursing facilities, and long-term care hospitals, every major reimbursement regulation from the Centers for Medicare and Medicaid Services (CMS) includes a focus on quality measurement. From hospitals getting dinged for readmissions to providers facing penalties tied to low performance on quality measures, this much is certain: reimbursement will be tied to performance and value-based purchasing will up the ante.

At press time, final rules were not yet out, but Washington's efforts to hold providers accountable for the quality of care will continue. The next phase in quality measurement will be an increasing focus on outcomes rather than processes.

Pioneer ACOs leave program

CMS confirmed that nine of the 32 pioneer accountable care organizations (ACOs) are set to walk away from the program for a variety of reasons. Experts cite fundamental challenges associated with managing expensive Medicare populations, along with administrative complexity and problems with quality benchmarks. Several groups are expected to become “regular” Medicare ACOs (known as Medicare Shared Savings ACOs) which comes with less financial risk.

Those who have been watching the Pioneer program closely will recall a February letter pushing CMS to adjust more than half of its quality measures, citing methodology problems and unrealistic goals. Providers threatened to leave if CMS didn’t act, and while CMS Administrator Marilyn Tavenner has been open to discussions, no final adjustments have been made. It now looks as though some ACOs will walk away regardless.

Don’t expect this news to dampen health reform cost saving goals. ACOs represent a small piece of the savings pie and CMS expected some would leave the program.

Employer mandate delayed one year, but exchange enrollment set to begin this fall

The Obama Administration recently announced it will delay by one-year a requirement mandating most employers provide coverage to all full-time employees or pay a penalty. This is unlikely to derail health reform’s progress – the health insurance exchanges for individuals and small businesses remain on schedule for enrollment to start October 1. The delay is a headache for providers expecting employer mandate and Medicaid expansion to bring more individuals with health coverage through their doors.

Eyes remain on other expansion provisions to see how they will impact consumer demand for services and where care is ultimately provided.

Distribution leaders visit Capitol Hill

As Medicare’s competitive bidding program enters its second round and a national “pedigree” solution works its way through Congress, distribution leaders talked to lawmakers stressing challenges both issues present for healthcare and specifically the supply chain. The Capitol Hill blitz was coordinated by HIDA to ensure that elected officials hear the supply chain perspective. At time of print, pedigree legislation had passed the House and was expected to pass the Senate, becoming law late this summer or early fall. ☝️
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Embracing Change

With an eye to the future, Deborah Petretich Templeton ensures Geisinger Health System remains an industry leader.

By Laura Thill

The writing is on the wall. As accountable care organizations become the predominant model for healthcare delivery, IDNs will need to transform the way they provide care – particularly as more care is delivered outside of hospitals, at outpatient centers. Geisinger Health System, for one, has stepped up to the plate by extending its scope to include outpatient facilities, such as nursing centers and ambulatory surgical centers. The IDN also has developed multidisciplinary clinical-use evaluation teams, which are clinician-led and supported by its supply chain team. While maintaining its focus on efficiency, standardization and cost-savings, the teams can make clinically relevant product and equipment decisions.

Transforming a supply chain from one focused on delivering supplies, to one that supports patient care, requires strong leadership and oversight. At Geisinger Health System, Deborah Petretich Templeton, RPH, M.H.A./vice president, supply chain services, has taken the helm, beginning with the launch of project HELP, designed to increase efficiency in the IDN’s nursing department, followed by a move toward expanding patient care beyond the bedside. If her experience at Geisinger has taught her one thing, it’s that “the patient is always the center of the day,” she says.
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Meeting the challenge
Prior to joining the supply chain division at Geisinger Health System, Templeton worked in the IDN’s pharmacy department, first as an intern in 1980, and then as a staff pharmacist beginning in 1981. She assumed her current position in 2000. “My past clinical work as a pharmacist has given me experience with formulary management, clinician interactions, as well as an understanding of medical procedures and terminology – all of which [are conducive] to building better processes to support clinicians,” she says. Today, she oversees four acute and 78 non-acute facilities, accounting for over $400 million in annual supply spend. Her supply chain responsibilities include procurement, sourcing, contracting, logistics, patient transport, linen, central sterile processing and mail activities throughout the health system.

Perhaps one of the most rewarding projects Templeton has headed at Geisinger Health System in the past year is the launching of HELP (Healthcare Enabled Logistics Program). “Supply chain, in conjunction with nursing and a small team of process engineers and student interns, has completed a study that shows about 18 percent of a nurse’s day is consumed in logistics activities, which take them away from patient care,” she explains. The supply chain division’s goal is to make process changes that result in greater efficiency in nursing, enabling nurses to focus as much as possible on patient care, she notes.

“Our first redesign began in the linen delivery area,” she continues. “We have moved away from exchange carts and now deliver linen five times a day to nursing units. This was done with no additional staff, and has resulted in the elimination of phone calls for additional linen, as well as eliminated rework, resulting in linen cost savings and increased nursing satisfaction.”

“Help is but one part of a broader goal at Geisinger Health System, says Templeton. “The HELP project is part of a larger strategy to move supply chain to a new model called Care Support Services,” she says. “Recognizing that the patient care areas are expanded beyond the bedside, the model will continue to develop in all care areas. The ideas emanating from project HELP include the application of new technology, cultural changes and a willingness to push boundaries beyond traditional methods. [The model] relies heavily on collaboration between multiple departments, with anticipated outcomes [designed to] drive a higher quality of care delivery and more cost-effective methods, all benefiting the patients that we care for.”

Partnering with the right suppliers has been key to enabling Templeton to achieve her goals. Which is why she looks for suppliers that demonstrate a “willingness to look at root cause analysis of issues and make an honest attempt at fixing and improving things,” she points out. “Successive, small successes in this area result in bigger wins and long-term partnerships.”

In years to come, with the growth of new care delivery models, such as accountable care organizations, she anticipates a number of industrywide changes. “This could include one contracting party on behalf of many; the elimination of class of trade, as we are accountable for the care of patients across the continuum; and the development of safe harbors for information sharing, contracting, etc. to benefit the new models.” Moving forward with HELP and Care Support Services, she aims to help Geisinger Health System embrace such changes, while remaining an industry leader. 

“We have moved away from exchange carts and now deliver linen five times a day to nursing units. This was done with no additional staff, and has resulted in the elimination of phone calls for additional linen, as well as eliminated rework, resulting in linen cost savings and increased nursing satisfaction.”

– Deborah Petretich Templeton
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Don’t forget these other great products to help fight the spread of germs.

HealthLink® offers a wide variety of diagnostics, medical devices and infection-control products to meet all your customer needs.
Windshieldtime

Chances are you spend a lot of time in your car. Here’s some automotive-related news that might help you appreciate your home-away-from-home a little more.

**Staying connected**

Intelligent Mechatronic Systems (IMS), a Connected Car™ company, recently introduced IMS DriveSync®. Designed to connect drivers to the driving ecosystem, including OEMs, dealers, insurers, service providers and other drivers, IMS DriveSync works through a smartphone or other mobile device. Using a voice-powered tap-and-talk interface, drivers can safely send and receive texts and emails, access Internet radio, and update Facebook and Twitter. A self-install device plugs into a vehicle’s on-board diagnostics (OBD-2) port to monitor vehicle health and support preventative maintenance. The device enables OEMs, dealers, insurers, etc. to communicate with the driver using custom notifications. In addition, the driver can access the social community, where he or she can chat, meet-up and upgrade to premium services, such as usage-based insurance and young drivers programs. IMS DriveSync is expected to be available to consumers and dealers this summer.

**Premium parking**

ParkMe, a provider of real-time parking information to navigation companies and users of the ParkMe app and website, has built a comprehensive parking database with live data for both on-street and off-street parking. It has announced partnerships with Amano McGann, a company with an off-street parking footprint in the industry, and CASE Parking in San Diego. These new collaborations will reportedly allow ParkMe to deliver more accurate, real-time occupancy counts and guide more motorists to more available parking spaces. ParkMe has also teamed up with in-car entertainment and navigation consumer electronics companies, and it continues to expand its network of partnerships with parking operators across the country, giving it the ability to connect transient drivers with accurate, up-to-the-minute parking data streamed to mobile phones, in-car navigation systems, GPS devices and operator websites.

**A greener drive**

Mazda models with SKYACTIV technology are reportedly proving popular for motorists looking to go greener, and SKYACTIV low carbon demonstrates that downsizing is not the only answer to go greener, according to the company. Mazda’s SKYACTIV engines are 2.0-litre petrol and 2.2-litre diesel, and CO2 emissions start from as low as 108g/km (2.2-litre 150ps Diesel), with combined fuel consumption of up to 67.3 mpg on the official cycle. Mazda’s low emission SKYACTIV technology is standard on all sixth generation models, Mazda CX-5 and all-new Mazda6, and all future Mazda models.

**Leasing on the rise**

Experian Automotive announced that new vehicle leasing has risen by 12.5 percent to achieve the highest level since it began tracking the data in 2006. According to its *State of the Automotive Finance Market* report, leasing accounted for a record 27.5 percent of all new vehicles financed, up from 24.4 percent in the first quarter of 2012. The report also noted that the average monthly payment for a new vehicle financed in the first quarter of 2013 was $459, down from $462 in the first quarter of 2012. And, it showed a decrease in interest rates: 4.5 percent in the first quarter of 2013, down from 4.6 percent in the first quarter of 2012, which helped to keep payments low for new vehicles financed. In the first quarter of 2013, the average loan amount for a new vehicle financed in the first quarter of 2013 was $461, from $17,071 in first quarter 2012 to $17,532 in first quarter 2013. Other findings included:

- Consumers within all credit tiers were able to obtain financing in the first quarter of 2013.
- Loans to consumers with credit outside of prime (nonprime, subprime and deep subprime) jumped to 45.2 percent of the overall loan market in the first quarter of 2013, up from 44.4 percent in the first quarter of 2012.
- The share of loans for new vehicles jumped to 25.1 percent in the first quarter of 2013, from 23.2 percent in the first quarter of 2012.
- Nonprime, subprime and deep-subprime loans for new vehicles accounted for 57.7 percent of the market share in the first quarter of 2013, up from 56.8 percent in the first quarter of 2012.

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Traffic updates
Livio has introduced FM Traffic Button, which provides updated traffic reports for U.S. markets every few minutes. The system, which is enabled by a code added to an embedded app on the in-vehicle infotainment system, and accessed by a button on its user interface, offers real-time audio traffic updates.

Solar charging
Empower Energies, a renewable portfolio solutions provider focused on enterprise energy management, commercial-scale renewable energy, and clean transport infrastructure for General Motors and other customers, announced the completion and commissioning of a solar electric-vehicle charging station. The eight-space installation is designed to charge about 3,000 electric vehicles per year – from empty to full – directly from the sun.

Engine trouble
Car owners and enthusiasts are finding that late and popular Dodge/Chrysler models, such as the Durango, Dakota, Ram, Charger, Chrysler 300, Jeep Grand Cherokee & Jeep Liberty, are having premature (V6 3.7, V8 4.7 and 5.7) engine troubles. Unfortunately, the original three-year warranties have expired, making it necessary to replace the failing engine or purchase another vehicle altogether. There are two reasons reportedly contributing to the failure of late model Dodge/Chrysler engines. First, in the manufacturer’s original design, the engine’s valve seats, which are pressed into the cylinder heads, are dropping, leading to failure. Dodge’s valve seats are made of a powdered metal, and as the metal expands, the valve seats drop, leading to contact with the valve and pistons. When this occurs, the seat breaks into many pieces leading to piston, cylinder wall, valve and cylinder head failure. (The metal has also been known to fly back into the intake manifold, and if not cleaned out properly, it can lead to a failure in both new and replacement engines.) The second reason for failure is that the engines run at a higher-than-normal combustion-chamber temperature due to an engineering flaw in the piston ring landings. This, in conjunction with smaller than feasible drain back holes in the heads and block, create a frying pan effect by breaking down new oil faster and leaving sludge in the engine, which ultimately gets blocked. This leads to oil-starvation and absolute failure of the engine.

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Innovative iPad charger
Strut, a maker of grills and wheels for luxury cars, recently introduced its Strut LaunchPort charging system for the iPad, with plans to soon offer one for the iPad mini. The chargers include a pedestal and sleeve that interact to charge the iPad. After being secured in the plastic sleeve, the iPad attaches to the pedestal by strong magnets. Once situated, it begins drawing power automatically through induction technology. The pedestal – a sphere that rests on a chrome-plated stainless-steel ring – rotates and pivots, allowing multiple viewing angles. The sphere comes in three colors – chrome, white and black – and the sleeve is available in five ready-made finishes. A mini-USB cable is included for charging when the Strut LaunchPort is not at hand. For more information, visit http://www.launchport.com/products.

Lawn service
For many, summertime weekends tend to be devoted to lawn care. The RoboReel Water hose is designed to make the job a $650 breeze. A press of a button starts a battery-powered motor, which is said to quietly and smoothly wind a garden hose back into the housing. The hose system also has a timer, enabling it to be set to spray at the same time daily. The reel, which is warranted for four years or 4,000 winds, is reported to have the capacity to retract about 100 times on a single charge. For more information, visit http://roboreel.com/water-hose-reel/overview/.

Street View
Apple Maps users now can incorporate Google’s Street View (using the Street app), which enables them to see photographic images of a particular location – reportedly in a higher resolution than Google offers. The app can be downloaded for $1.99. For more information visit http://www.futuretap.com/apps/streets-en/.

Inner balance
HeartMath, a creator of science-based solutions to reduce stress, has introduced an app, called Inner Balance. Available free for Apple iOS devices, the app provides instructions and feedback on techniques for breathing and focusing. It works with the company’s sensor, which costs $99. When the sensor is clipped to one’s earlobe, the app reads the user’s pulse and develops a pattern to help him or her synchronize heart and breathing rhythms. Sessions typically last about three minutes. Because the sensor does not have a Lightning connector, it is not compatible with the iPhone 5. However, it does include an adapter for other iOS devices. For more information, visit http://www.heartmath.com/innerbalance/.

Google has reported that about 390 million people use its network of services each month, with slightly less than half using the core service, called the stream, which features updates and posts from a user’s social network.
Quick Bytes

**Photo shoot**

Google has reported that about 390 million people use its network of services each month, with slightly less than half using the core service, called the stream, which features updates and posts from a user’s social network. Recently, Google has redesigned its service, including photo sharing. Reportedly, when users now upload photos to Google’s online photo album via Picasa or mobile devices, Google’s algorithms will sort through them, eliminating blurry shots, duplicates and bad exposures, and selecting photos of smiling people, landmarks and aesthetically pleasing sites. In addition, users can take advantage of a one-click option to automatically enhance photos to fix red eye, adjust exposure, soften the look of human skin and correct other flaws. Another new photo feature, called “auto awesome,” reportedly can stitch together a series of snapshots into a short animation, or merge multiple photos shot at different exposures into a single image with high dynamic range. Users can set up their mobile devices to automatically upload all photos to Google, with unlimited free storage at standard resolution, and 15 GB of storage at full resolution for high-quality prints.

**Stay cool**

Dependable air conditioning provides a respite from the summer heat. But, continuously running an air conditioning unit during a hot summer can lead to breakdowns. This summer, Atlanta Heating and Air Conditioning (Atlanta, Ga.) offers tips for homeowners to avoid overworking their units. One of the most common problems is a poor refrigerant charge. A home that has a unit that is constantly running, but isn’t getting cool, may have a refrigerant problem. The power source should always be checked first if a unit stops working. Home owners should check to be sure the thermostat is on the correct setting and the unit is properly plugged in. If that’s not the problem, they should check the fuse box to be sure a switch has not been flipped. Lack of maintenance can also contribute to air conditioning breakdowns. Homeowners should properly change air filters, clean the system and maintain regular check-ups to maintain a unit’s efficiency. Yearly maintenance appointments should also be scheduled with a licensed technician. Finally, homeowners should locate the unit’s drain outside and use a wet/dry vacuum to clean it of any debris. A drain cap can keep it clean of debris. Cleaning the outside unit also helps maintain maximum efficiency.

**Portable sound**

Anchor Audio, Inc. recently announced its newest portable sound system, the Go Getter. The battery-powered system is said to be user-friendly and designed for a wide variety of audio needs, including school, sporting, and corporate and military training. The sound system, which includes a speaker and wireless receiver, a built-in MP3/CD player, and a wireless microphone, retails for $995. It features 110 dB of sound and weighs 23 pounds. A built-in rechargeable battery is designed to operate up to eight hours on a single charge. Additional options include a built-in MP3/CD player and a single or dual UHF wireless receiver(s) with 16 user selectable channels.

**Staying on track**

mCube, a supplier of single-chip MEMS motion sensors and software, announced the availability of the GO2OTM Pedestrian Navigation Engine, which offers indoor navigation capabilities for motion sensor-equipped mobile devices. GO2O takes advantage of positioning information derived from the inertial-sensors available in most current smartphones, and combines it with GPS and Wi-Fi positioning and indoor map information to produce a more accurate indoor location. GO2O reportedly can determine if a user is stationary, walking, running or traveling in a vehicle and maintain position accuracy to within 10 percent of distance traveled, while only relying on inertial sensor data.
Eliminating Errors

Report on diagnosis-related errors could open doors for reps
A recent study showing that errors in diagnosis are responsible for more deaths, disabilities and medical liability payments than any other kind of medical error could open doors for reps to discuss rapid tests, diagnostic equipment and other diagnostic tools with their physician customers. The study was published online April 22 in BMJ Quality & Safety.

In reviewing 25 years of U.S. malpractice claim payouts, Johns Hopkins researchers found that diagnostic errors – not surgical mistakes or medication overdoses – accounted for the largest fraction of claims, the most severe patient harm, and the highest total of penalty payouts. Diagnosis-related payments amounted to $38.8 billion between 1986 and 2010, they found.

The researchers also found that more diagnostic error claims were rooted in outpatient care than inpatient care, (68.8 percent vs. 31.2 percent), though inpatient diagnostic errors were more likely to be lethal (48.4 percent vs. 36.9 percent). The majority of diagnostic errors were missed diagnoses, rather than delayed or wrong ones.

There is a message for distributor reps, says Jim Poggi, director, laboratory category management, McKesson Medical Surgical. “The distribution sales rep needs to understand the big picture in diagnostic challenges their physician customers encounter every day, and then they can take needed steps to present solutions that may improve care,” he says. “Respiratory tests, cardiac markers, and diagnostic and monitoring tests for diabetes are all important to offer, especially since diabetes and heart disease are among the top 5 causes of illness and death in the United States today. In addition, the sales rep should present the advantages of EMR and high-quality patient record-keeping as sound elements of acquiring and maintaining patient records to present a comprehensive view of the patient’s overall health picture.”

**Biggest patient safety problem**

“This is more evidence that diagnostic errors could easily be the biggest patient safety and medical malpractice problem in the United States,” said David E. Newman-Toker, MD, PhD, an associate professor of neurology at the Johns Hopkins University School of Medicine and leader of the study published online in BMJ Quality and Safety. “There’s a lot more harm associated with diagnostic errors than we imagined.”

While the new study looked only at a subset of claims – those that rose to the level of a malpractice payout – researchers estimate the number of patients suffering misdiagnosis-related, potentially preventable, significant permanent injury or death annually in the United States ranges from 80,000 to 160,000.

Diagnostic error can be defined as a diagnosis that is missed, wrong or delayed, as detected by some subsequent definitive test or finding, according to researchers. The ensuing harm results from the delay or failure to treat a condition present when the working diagnosis was wrong or unknown, or from treatment provided for a condition not actually present.

“Overall, diagnostic errors have been underappreciated and under-recognized, because they’re difficult to measure and keep track of owing to the frequent gap between the time the error occurs and when it’s detected,” Newman-Toker said when the study was released. “These are frequent problems that have played second fiddle to medical and surgical errors, which are evident more immediately.”

Experts have often downplayed the scope of diagnostic errors “because they were afraid to open up a can of worms they couldn’t close,” he said. “Progress has been made confronting other types of patient harm, but there’s probably not going to be a magic-bullet solution for...
diagnostic errors, because they are more complex and diverse than other patient safety issues. We’re going to need a lot more people focusing their efforts on this issue if we’re going to successfully tackle it.”

For their review, Newman-Toker and his colleagues analyzed medical malpractice payments data from the National Practitioner Data Bank, an electronic repository of all payments made on behalf of practitioners in the United States for malpractice settlements or judgments since 1986. They found that of the 350,706 paid claims, diagnostic errors were the leading type (28.6 percent) and accounted for the highest proportion of total payments (35.2 percent). Diagnostic errors resulted in death or disability almost twice as often as other error categories.

The human toll of mistaken diagnoses is likely much greater than his team’s review showed, Newman-Toker said, because the data they used covers only cases with the most severe consequences of diagnostic error. Many others occur daily that result in costly patient inconvenience and suffering. One estimate suggests that when patients see a doctor for a new problem, the average diagnostic error rate may be as high as 15 percent.

**Keys to prompt, accurate diagnoses**

Poggi says he isn’t surprised at the study’s findings. “Diagnostic errors are related to a number of factors, including time spent with the patient, timing of patient visit to physician post onset of symptoms, vague complaints (muscle weakness, generalized aches and pains, respiratory symptoms and lethargy). A number of medical conditions, ranging as widely as Lyme disease, flu, [respiratory syncytial virus], hepatitis C, and lupus can be the cause of these symptoms.

“In addition, the wide range of patient care locations available complicates having a full picture of the patient’s history readily available to the primary caregiver,” he says. “Add in patient reluctance to openly discuss high-risk behaviors and negative emotional states, and there are a number of reasons differential diagnosis can be complicated, late or in error.

“In many instances, point-of-care testing can provide needed lab information and help enable a rapid effective treatment regimen. This is especially true of respiratory infections, including flu, strep and [respiratory syncytial virus], where symptoms can be similar and differential diagnosis can be tricky. Access to needed lab information can help make informed decisions at the point of care and speed effective treatment.”

**Need for a systematic review**

“After more than 20 years in the diagnostic industry, I’m acutely aware that errors in diagnosis are both dangerous and costly,” says Bob Gergen, vice president of sales, Rapid Pathogen Screening. “Thus, I am not surprised that diagnostic error is the most common type of medical error, affecting approximately 160,000 patients annually in the United States.

“Diagnostic errors need to be acknowledged and tracked to help determine the root cause and to help provide solutions to mitigate those errors, knowing that they will never be fully eliminated,” he says. “Unfortunately, there doesn’t seem to be a governing body responsible to oversee this area, and even [The Joint Commission] doesn’t track diagnostic errors as a category. There is a need to systematically look at, and try to remedy, diagnostic errors.”

Laboratories and physicians in primary care, urgent care, hospitals and other healthcare settings have the best of intentions, adds Gergen. “However, there seems to be a lack of visibility to the value and availability of various diagnostic options, as well as a lack of training at the lab and physician level.

“I also think a trap that busy physicians fall into is one of treating patients based only on history, signs and symptoms because they have experience in seeing a specific malady often and use their clinical experience to guide them. The challenge – and they know this – is that many disease states have clinically overlapping symptoms and signs.”

For example, with ocular viral and bacterial infections, physician specialists have been shown to be less than 50 percent clinically accurate without diagnostic testing. Diagnostic testing is frequently not performed, or results are not provided in time because of the added cost and time delay. But
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new rapid tests allow clinicians to elevate their accuracy to 90 percent and bring a laboratory quality diagnostic solution to the patient visit, with results available in as little as 10 minutes.

“When dealing with infectious disease, a rapid and accurate diagnosis is essential to reduce spread of disease, reduce empiric antibiotic treatments and their associated adverse events, as well as to reduce overall healthcare costs.”

**Diagnosing STDs is challenging**
Says Lisa Williams, director, global marketing services, Sekisui Diagnostics LLC, “In my discussions with physicians, I found quickly and accurately diagnosing sexually transmitted diseases to be one of our biggest healthcare challenges. According to the CDC, there are about 20 million new STDs per year, and direct costs to the U.S. healthcare system are over $16 billion per year.

“Getting high-risk patients (females 15-24 years) to consent to testing is a huge challenge,” she continues. “However, once they do come in to a clinic or doctor’s office, many are lost during follow-up and fail to receive treatment.

“Since we have yet to realize highly sensitive, CLIA-waived, point-of-care STD tests in this country, we still rely on lab-based tests, which can take hours or days to get a result. This is not conducive to immediate counseling, treatment and prevention of further transmission while you have the patient sitting in the office. This is a serious gap in the healthcare system, considering STDs have severe health consequences if left untreated.”

**How reps should respond**
The Johns Hopkins study offers opportunities to reps who take the time and make the effort to understand its implications, according to those with whom Repertoire spoke.

The Johns Hopkins study offers opportunities to reps who take the time and make the effort to understand its implications, according to those with whom Repertoire spoke. A new generation of point-of-care immunoassays can help avoid those failure points, he adds.

“[Sales reps] should inform themselves of the performance characteristics of these tests. This information will help them advocate for their customers and do their part to support better patient care. A distributor rep is a key partner in the selection of a physician’s tool kit. That position of trust will be strengthened when quality, high-performing products are first out of their bag.”

**Downstream impact on patients**
Says Debra Feinberg, executive director, marketing and distributor relations, Accumetrics Inc., “We need to understand as manufacturers and distributors that the value of a diagnostic may be in the downstream effect on the patient. For example, a test that could impact 30-day readmits needs to be ordered well within that time period to help assure the patient is receiving the maximum benefit from the treatment program. The cost of the test is miniscule compared to the possible penalties the facility can face financially, to say nothing of the clinical outcomes desired as a result of that treatment.”

Says Lisa Williams, “Our goal this year is to educate and train reps on how to talk to physicians about linking patient outcomes and expense management. We can’t continue to simply consider the cost of a test; we need to consider the cost of improper diagnosis and the long-term consequences.

“Reps need to get comfortable talking about outcomes and the studies linking improved healthcare to our diagnostic tests. Physicians and healthcare systems want proof, not just conjecture, so we are building the case for them.”

Distributor reps have a couple of to-dos following the Hopkins study, says Gergen. “First, [they] should provide better visibility to diagnostic tests that are rooted in evidence-based medicine and demonstrate clinical guideline support. Second, highlight diagnostic tests that limit empiric treatments and allow for pathogen-directed therapy. Such tests reduce the rate of diagnostic errors, save costs, and help clinicians provide better care.

“Lastly, clinical guidelines standardize approaches to clinical problems and minimize variability. In other words, remember that your customer is counting on you to continually provide new and innovative tools, backed by solid clinical and economic proof, to help them better serve their patients.”
A new recommendation from the United States Preventive Services Task Force could spur sales of screening tests for hepatitis C virus.

In June, the Task Force issued its most current recommendation for screening for hepatitis C virus, calling for one-time screening of all adults born between 1945 and 1965, and screening of persons at high risk for infection as well as those who received a blood transfusion before 1992. The hepatitis C recommendation, released June 25, mirrors recommendations by the Centers for Disease Control and Prevention, which also recommends that everyone in the United States born from 1945 through 1965 be screened for hepatitis C.

Meanwhile, an analysis by the Centers for Disease Control and Prevention shows that only half of Americans identified as ever having had hepatitis C received follow-up testing.

The USPSTF is an independent panel of non-federal experts in prevention and evidence-based medicine, and is composed of primary care providers (such as internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists). The Task Force conducts scientific evidence reviews of a broad range of clinical preventive healthcare services (such as screening, counseling, and preventive medications) and develops recommendations for primary care clinicians and health systems. These recommendations are published in the form of “Recommendation Statements.”

Three in four don’t know
In its recommendation regarding hepatitis C screening, the USPSTF noted that up to 3.9 million people in the United States are infected with the virus, which can cause inflammation, permanent liver damage and cancer. Up to three in four people who are infected don’t know they have hepatitis C, according to the Centers for Disease Control and Prevention.
The most significant risk factor for HCV infection is past or current injection drug use. Receiving a blood transfusion before 1992 is also an established risk factor. Additional risk factors include chronic hemodialysis, being born to an HCV-infected mother, incarceration, intranasal drug use, getting an unregulated tattoo, and other percutaneous exposures, such as being a healthcare worker or having surgery before the implementation of universal precautions.

HCV infection is most prevalent among people born from 1945 through 1965, that is, Baby Boomers. In fact, Boomers account for three out of four people with hepatitis C, said Task Force co-chair Albert Siu, MD, MSPH, in June. The Task Force found that a risk-based approach may miss detection of a substantial proportion of HCV-infected persons in the birth cohort because of a lack of patient disclosure or knowledge about prior risk status. “Even though they may have no symptoms yet, the evidence is convincing that one-time screening will help find millions of Americans with the infection before they develop a serious liver disease,” said Siu.

The most recent recommendation overturns a 2004 Task Force decision, which recommended against routine screening for hepatitis C virus infection in asymptomatic adults who were not at increased risk for infection.

Follow-up being neglected

Meanwhile, in a separate development, the Centers for Disease Control and Prevention reported that as many as half of those who test positive on an initial hepatitis C test are failing to receive the necessary follow-up test to know if their body has cleared the virus or if they are still infected. “Complete testing is critical to ensure that those who are infected receive the care and treatment for hepatitis C that they need in order to prevent liver cancer and other serious and potentially deadly health consequences,” said CDC Director Tom Frieden, MD, M.PH.

Testing for hepatitis C includes a blood test, called an antibody test, to determine if an individual has ever been infected with the virus, says CDC. For people with a positive antibody test result, a follow-up test – an RNA test – should be given to determine whether they are still infected, so they can get needed care and treatment. A small number of people with antibody-positive tests will have cleared the infection on their own, but most people with hepatitis C (about 80 percent) remain infected and can go on to develop significant health problems.
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A Perfect Order?

UDI could be a game-changer to optimize the healthcare supply chain and improve outcomes, say experts

Magic number? Not quite. Still, a unique device identifier, or UDI, affixed to every medical product sold in the United States could go far in cleaning up supply chain inefficiencies, according to proponents.

“The benefits of UDI will apply to any type of customer that uses medical devices – ranging from large hospitals to ambulatory surgical centers to small doctors’ offices,” says Michael Groesbeck, senior vice president, quality and regulatory affairs, Cardinal Health. “We expect that all participants in the medical device supply chain, from manufacturer to end user, will benefit from UDI.”

“Wide implementation of UDI will ensure the ability to track devices across all care settings, support safe and accurate device usage, create a standard of documentation in IT systems, streamline recall management, eliminate back-end rework due to poor data quality, eliminate the need to re-label products, and facilitate implementation of Perfect Order,” says Gene Kirtser, president and CEO of Resource Optimization & Innovation, or ROI, the supply chain arm of the Mercy health system in St. Louis, Mo. (“Perfect order” refers to an order processed electronically, that is, without human intervention, from order to payment.)

“Incorporation of UDIs into an electronic health record will allow providers to harness data in a standardized format to understand safety and effectiveness of devices,” continues Kirtser. “In addition, UDIs will lead to broader adoption of automatic-identification-and-data-capture (AIDC) technology across healthcare, which
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will greatly improve accuracy and reduce costs of manual data entry. Furthermore, UDIs will facilitate more accurate and timely reporting of adverse events, which will help the industry address device problems quicker.

“We believe that all stakeholders in healthcare – patients, providers, distributors, manufacturers, the FDA – will benefit from broad adoption of UDI.”

Long time coming
A UDI is a unique numeric or alphanumeric code, which acts as a key to certain basic identifying information about a device, such as the name of the manufacturer and the type of device, and may represent certain other information about the device, such as its expiration date and batch or lot number, according to the U.S. Food and Drug Administration. Plans call for this information to be contained in a publicly available UDI database.

“The unique identification system will enhance the flow of information about medical devices, especially adverse events, and, as a result, will advance our ability to improve patient safety.”

– FDA Commissioner Margaret A. Hamburg, MD

No shortage of supporters
Many players in the healthcare supply chain embrace the idea of the UDI.

“A robust UDI system will significantly enhance product identification, improve the device recall process, ensure the integrity of the product throughout the transportation process, and most importantly, advance and improve patient safety,” Dan Sweeney, senior vice president of information and data services at Novation, said in a statement following publication of the FDA’s July 2012 proposed rule. “A UDI system also has the potential to generate significant savings for the health care industry through improved efficiencies and automated processes.”

“Many in the supply chain have been supporting, and preparing for, a system in which we all use a single set of data standards to globally communicate important product information every step of the way, ensuring we are all speaking the same electronic language,” Joe Pleasant, chief information officer for Premier, said in July 2012. “With regulation in place, we should see a rapid increase in the adoption and implementation of GS1 standards that facilitate the flow of accurate information in the supply chain.”

GS1 Healthcare US is an industry group that focuses on driving the adoption and implementation of GS1 Standards in the healthcare industry in the United States. Its UDI system is called the GTIN, or Global Trade Item Number. (Formerly known as the Uniform Code Council, GS1 developed the now-ubiquitous Universal Product Code, or UPC, for the retail and grocery industries almost 40 years ago. GS1 US created GS1 Healthcare US in January 2008 to make its mark in healthcare data standards.) Another system, that of the Health Industry Business Communications Council, or HIBCC, is the HIBC Supplier Labeling Standard. The FDA’s proposed rule would

It’s a decades-old dream. And developments in the past couple of years could bring the dream to reality…eventually.

In July 2012, the FDA proposed a rule that would phase in implementation of the UDI, focusing on the highest-risk medical devices first and exempting low-risk devices from some or all of the requirements. The agency proposed exempting over-the-counter devices sold at retail, most of which already have UPC codes in place.

With certain exceptions, under the proposed rule, a UDI would include:

• A device identifier, which is a unique numeric or alphanumeric code specific to a device model.
• A production identifier, which includes the current production information for a device.
allow either the GS1 or HIBCC systems to be used as the basis of a UDI. Distributors would benefit from a UDI as well, according to those with whom Repertoire spoke.

“One of the primary benefits of UDI will be a significant enhancement of the industry – including manufacturers, distributors, and customers – to more efficiently and effectively manage product recalls,” says Groesbeck. “Recalls are infrequent for a given product, but occur with regularity across the broad portfolio of medical devices in the market.”

“UDI will enable Cardinal Health to have a more accurate picture of its inventory, including the lot numbers and expiration dates of the products,” Groesbeck continues. “When fully implemented, the UDI will take the place of what is now called the ‘factory catalog number.’ Distributors will no longer have to manage situations in which multiple manufacturers offer different products with the same factory catalog number.”

What’s the hang-up?

With all this support, why is it that the UDI still has a ways to go before the healthcare supply chain implements it?

“Part of the challenge is, the final UDI ruling isn’t out yet,” says Michael Pheney, vice president, healthcare, GS1 US. Manufacturers may be taking a hard look at UDI, but without a final rule, many are holding back on implementation, he says. But there are exceptions. “What I think is exciting is the fact that we’ve been working with a number of more cutting-edge manufacturers who have already started to figure out how they’re going to supply information to the FDA database, which is part of the requirement for UDI. They have models laid out, though they may have to tweak them, depending on where final regulation comes down.”

Says Kirster, “We believe that, by far, the majority of the manufacturing sector is working towards adoption of UDI, although the pace is relatively slow. This is largely due to three main reasons: First, the final UDI regulation has not been published by the FDA; second, the UDI adoption is a large undertaking, and manufacturers are having a difficult time prioritizing the project
in light of other objectives; and third, it is difficult to estimate an ROI on the work to support UDI.”

The Healthcare Transformation Group (HTG) – a supply chain group with executives from Mercy, Geisinger Health System, Intermountain Healthcare, Kaiser Permanente and Mayo Clinic – recently met with its 18 largest manufacturers at its third HTG Summit, says Kirster. Surveys conducted with these manufacturers revealed that while all of them intend to comply with the regulation long-term, to date only six label their products with a GTIN at unit of use, and seven support use of GTIN on a purchase order. However, 14 of 18 have assigned GTINs to their products at point of use.

“These data points demonstrate that operational use of GTIN has not yet taken hold, but progress is being made,” he says. “We believe that the FDA’s issuance of a final regulation, ongoing pressure from the providers and GPOs, and case studies demonstrating improved efficiencies and reduced costs will continue to drive manufacturers to wider adoption.”

Groesbeck points out that the medical device industry has been working on UDI for several years and that, as a result, many products currently in the market already have UIDs in the form of linear, or one-dimensional, barcodes.

“There are a number of questions under review in the medical device industry,” he says. “The industry is actively working with the U.S. FDA to define the technical requirements for product marking, product labeling, and the data registries.

“There are challenges represented by durable medical devices for which UDIs must be applied directly to the devices themselves,” Groesbeck points out. For single-use medical devices, the UDI will be applied to the product packaging, but not directly on the product. There are questions related to convenience kits and sets consisting of more than one type of medical device, but these are questions that will ultimately be resolved during the next few months.”

Thumbs-up from providers
Healthcare providers appear ready to embrace the UDI.

“The interest level varies widely, but a subset of our customers are asking that Cardinal Health move toward implementing UDI as soon as possible,” says Groesbeck. “We are working directly with a number of customers to prepare for the eventualty of doing business by UDI, including the establishment of data pools and running transaction simulations.” Cardinal Health plans to use GS1 standards to implement UDI, and the company is working with its trading partners to support their efforts to implement GS1 GLN and GTIN standards, he says.

“The customers look to eliminate confusion concerning the identities of the numerous products they manage, better manage their inventories, and be more effective and
efficient in managing product recalls,” Groesbeck continues. “Once fully implemented, the medical device UDI will enable access of detailed product information in data pools and product registries. Among the best known of these is GS1’s Global Data Synchronization Network. The FDA is also planning to establish a product registry that can be accessed by UDI stakeholders.”

According to GS1, the Global Data Synchronization Network will allow providers and suppliers to share data in real time, so that when one trading partner updates product information, others will have the update as well. The network will increase the accuracy of orders, reducing invoice errors and the number of duplicate processes, says GS1.

What’s required of distributors?
All supply chain members – including distributors – will have to make some changes to accommodate the UDI.

“There aren’t specific requirements [in the FDA proposed rule] for distributors,” notes Pheney. “The key thing is being able to transact using the GTIN and production ID – that is, lot or serial number.” In the case of product recalls, distributors will be expected to have the ability to go to their shelves with the lot and serial numbers of the affected products, and pull them out of the marketplace quickly.

“Implementation and adoption of UDI will require investment and work from all stakeholders, not just the manufacturer,” says Kirster. “While manufacturers own the responsibility for establishing and registering a GTIN for their products, all healthcare stakeholders must integrate the use of UDI for all downstream benefits to be realized. Distributors will need to modify their IT systems to facilitate use of UDI and will need to adjust their processes to ensure that all order,
Benefits of Unique Device Identification

When fully implemented, the UDI system may:
• Allow more accurate reporting, reviewing and analyzing of adverse event reports so that problem devices can be identified and corrected more quickly.
• Reduce medical errors by enabling healthcare professionals and others to more rapidly and precisely identify a device and obtain important information concerning the characteristics of the device.
• Enhance the FDA’s analysis of devices on the market by providing a standard and clear way to document device use in electronic health records, clinical information systems, claim data sources and registries. A more robust postmarket surveillance system can also be leveraged to support premarket approval or clearance of new devices and new uses of currently marketed devices.
• Provide a standardized identifier that will allow manufacturers, distributors and healthcare facilities to more effectively manage medical device recalls.
• Provide a foundation for a global, secure distribution chain, helping to address counterfeiting and diversion and prepare for medical emergencies.
• Lead to the development of a medical device identification system that is recognized around the world.


receipt, shipping and billing transactions are utilizing that UDI. Once fully implemented, distributors should realize benefits in data quality, information exchange and supply chain efficiency. Furthermore, distributors that are required to re-label products for their provider customers should see that requirement diminished.”

Says Groesbeck, “As the UDI replaces the factory catalog number as the basis of commerce, both manufacturers and distributors will need to configure their order/entry and inventory management systems to work with the UDI format. Similarly, hospitals and other medical facilities will need to take the same steps if they wish to conduct electronic commerce with manufacturers and distributors.”

What’s next?

Though it may be easy to identify the advantages of the UDI for the highest-risk (Class III) medical devices, how about commodities?

“All classes of medical devices (I, II, III) will need to adopt UDI for the industry to realize full safety, efficiency and cost benefits,” says Kirster, pointing out that the FDA proposed a phased adoption process, starting with  

Pheney is optimistic about what lies ahead. “We’re at a great point, a threshold,” he says. “With everyone identifying products the same way, we have a huge opportunity to really improve patient safety.”

Class III devices. “Documentation in an EHR occurs for all medical products used on the patient, and providers require an efficient method to capture and track device consumption across all product classes. In addition, recall management of all product classes must become more efficient and accurate.”

Says Groesbeck, “The primary benefits include the unambiguous and unique identification number for the particular model of the device, the ability to track inventory by lot and/or expiration date, and the ability to manage recalls. We also see value in the ability to access detailed product information in the Global Data Synchronization Network or FDA’s product registry.”

Pheney is optimistic about what lies ahead. “We’re at a great point, a threshold,” he says. “With everyone identifying products the same way, we have a huge opportunity to really improve patient safety. Recalls are a great example. And we have a tremendous opportunity to optimize the entire healthcare supply chain.” Hospitals will benefit greatly, he says. “They are under tremendous pressure with reimbursement models changing. Putting standards in place offers tremendous opportunities to stamp out inefficiencies.”
Healthcare providers have a lot to gain by jumping aboard the UDI train. By standardizing and cleansing source data, they can: 1) gain deeper insight into their spend, 2) prevent pricing and/or unit-of-measure errors, 3) level pricing across departments and facilities, and 4) aggregate spend throughout the supply chain. These are among the findings of the GPO Novation in its 2012 white paper, “The Cost of Dirty Data.”

Industry research has shown that through the use of data cleansing and advanced spend analytics, healthcare organizations can realize savings of 0.5 to 1.5 percent of their annual supply chain spend, says Novation. But “dirty data” can impede these initiatives. Everyone in the supply chain suffers. To wit:

• Product descriptions that lack a consistent and standardized format (e.g. noun, application, attribute, etc.).
• Products missing vendor or manufacturer information (e.g. name or catalog numbers).
• Products with incomplete packaging data (e.g. missing unit of measure and conversion factors, as well as standardized to the ANSI code).
• A high number of errors reported through EDI transactions.
• A high number of invoice discrepancies.
• A high number of manual purchase orders routinely submitted.
• A high number of purchase order discrepancies.
• Poor contract pricing utilization with procurement processes.

Four keys to clean data
Healthcare providers can take several steps on the path to clean data and supply chain efficiency, says Novation:

• View data cleansing as an enterprise-wide endeavor. Many healthcare organizations view data cleansing as a critical initiative but one belonging only to materials management.

While materials management may be the “gatekeeper” for many data management processes, these processes are often ineffective as they relate to data cleansing.

• Establish effective data management policies and processes throughout the supply chain. Many healthcare organizations are unsure of the number of duplicate records within their item master; the number of routine, manual record orders that sidestep the item master; or the number of manual orders requested within a given month by department and requestor. The ability to report this information to stakeholders and establish attainable goals that are directly aligned with the organization’s data cleansing strategy will facilitate faster supply chain savings.

• Implement critical controls at each point where source data enters the supply chain. Adding, deleting and changing product information in the item master is important for successful contracting, procurement, inventory, accounts payable and reimbursement processes. In addition, validating and enriching product information at the initiation of a request to add a record to the item master is essential.

• Implement a proactive data cleansing approach. To realize the most value from the supply chain, the process must channel clean, accurate product information at the beginning of the process. Many of today’s item master maintenance processes are reactive in addressing new product request enrichment and validation, due to limited staffing and a lack of the necessary skills needed to validate, standardize and enrich product information.

The unique device identifier, or UDI, may do more than clean up the supply chain. It may also help providers associate specific medical devices with patient outcomes.

“We believe that the industry must move towards using comparative effectiveness research for product selection,” says Gene Kirster, president and CEO of Resource Optimization & Innovation, or ROI, the supply chain arm of the Mercy health system in St. Louis, Mo. “Adoption of UDI will facilitate our ability to analyze attributes across medical devices and look for meaningful trends in clinical outcomes tied to each device. Additionally, broad adoption of UDI should greatly improve data quality and exchange across all healthcare stakeholders. Doing so should have a meaningful positive impact on costs.”

As part of the Healthcare Transformation Group, Mercy is participating in an R&D team, comprised of physicians and clinical researchers, to stimulate implementation of a UDI system. (The Healthcare Transformation Group comprises Mercy, Geisinger Health System, Intermountain Healthcare, Kaiser Permanente and Mayo Clinic.)

“UDI will greatly facilitate research in both safety and effectiveness of medical devices when incorporated into clinical data,” says Joseph Drozda, Jr., MD, director of outcomes research, Mercy. “For maximal benefit, UDIs need to be associated with key device attributes that will be found in the FDA’s Global UDI Database, along with additional attributes that are thought to be clinically significant by experts.

Mercy is in the final stages of an FDA Demonstration Project that is showing the feasibility of creating a database containing both device- and EHR-derived clinical data, says Drozda. The next phase of the work would be to create similar data sets at each of the other Healthcare Transformation Group systems, and then to link those data sets in order to increase the robustness of any research. In order to accomplish this, the group is considering creating a distributed data network around national device registries in a hub-and-spoke model, he says.

“This is a very large undertaking, but it will create powerful tools for doing device safety and effectiveness research in the real world.”
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C. difficile: The good fight

APIC guide advises healthcare professionals in preventing the spread of C. difficile. Distributor reps can do their part when working with customers.

Are health professionals doing all they can to prevent the spread of Clostridium difficile (C. difficile) infection? As new strains have led to more frequent, more severe infection, the disease has become increasingly difficult to treat, according to the Mayo Clinic. Yet, according to a recent survey by the Association for Professionals in Infection Control and Epidemiology (APIC), many professionals are not adopting advanced monitoring technologies.

Seventy percent of survey respondents have adopted additional interventions to address C. difficile since March 2010, according to the survey. However, only 42 percent of respondents have seen a decline in their healthcare facility-associated C. difficile rates during that period, while 43 percent have seen no decline. In response, APIC and Clorox Healthcare released the 2013 APIC Clostridium difficile Implementation Guide to help healthcare professionals improve patient safety initiatives and help prevent healthcare-associated infections (HAIs), such as C. difficile.

It should be no surprise to physicians and healthcare professionals that C. difficile – a spore-forming, gram positive anaerobic bacillus that produces toxin A and toxin B – is capable of spreading so easily in hospitals and long-term-care facilities.

Distributor sales reps should ask their long-term-care customers what they are doing to prevent the spread of C. difficile, beginning with a surveillance program.
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facilities. According to the Implementation Guide, “C. difficile produces spores that can persist in the environment for many months and are highly resistant to cleaning and disinfectant measures.” As such, it can survive in hospital or long-term-care environments on hard surfaces, equipment and patients’ items. Patients, in turn, can transmit or acquire it from contact with infected surfaces and equipment.

There are two major reservoirs of C. difficile in healthcare settings, according to the Guide: infected humans and inanimate objects. Patients with symptomatic intestinal infection are considered to be the main reservoir, with potential for contamination increasing with the severity of the disease. That said, asymptomatic patients should be considered a risk as well.

C. difficile is commonly associated with previous antibiotic use and is often contracted by the elderly and those who have had recent exposure to hospitals, nursing homes and other healthcare facilities.

**Surveillance**

Distributor sales reps should ask their long-term-care customers what they are doing to prevent the spread of C. difficile, beginning with a surveillance program. Given the high cost associated with treating the disease (as much as $7,000 per case), the only place healthcare administrators should want to see C. difficile is on their radar.

Surveillance is the ongoing, systematic collection, analysis, interpretation and dissemination of data regarding a health-related event, to reduce the death rate and improve patients’ health, according to the Guide. Essential components of a surveillance program include:

- Standardized definitions.
- Identification of patient populations at risk for infection.
- Statistical analysis of disease rates.
- Feedback of results to all stakeholders.

A good surveillance program designed to aid in early recognition of C. difficile should include the following:

- Patient care rounds to identify those who have diarrhea that may be associated with C. difficile.
- Contact precautions (including isolation) for all symptomatic patients in whom C. difficile is suspected.
- Increased communication with the local health department and other infection prevention sources in the community.

In addition, physicians and other healthcare professionals should discuss any C. difficile rate increase with the microbiology staff and evaluate testing methods.

**Prevention**

Because risk factors for developing C. difficile are often present in long-term-care and skilled nursing facilities, particularly given that residents often stay no longer than three months at a time – the Guide advises caregivers to take several steps when the facility is in contact precaution. For one, they should assess the resident’s ability to contain bodily fluids and manage bowel control. They should ensure the resident performs hand hygiene and (depending on the severity of the disease) wears a clean gown over his or her clothing. And, assistive devices, such as walkers, canes and wheelchairs, should be disinfected before their removal from the resident’s room. Healthcare workers may need to wear gloves, and should remove them (followed by proper hand hygiene) prior to touching other items.

Prevention of C. difficile does not rest solely with caregivers. Residents, family members and other visitors should be educated about their role as well. Explanations, such as the following, can help residents understand how certain behavior can limit the spread of disease, according to the Guide:

- The infection caused by C. difficile.
- The spectrum of the disease and reoccurrences.
- How C. difficile is spread, including skin contamination, colonization, shedding and environmental contamination.
- What residents can do to help prevent the spread of the disease, including practicing hand hygiene.

Reminding long-term-care customers to take the necessary steps can make the difference between life and death, as well as save the facility time and expense.
Who might be at higher risk for acquiring C. difficile, such as individuals on antibiotics who are immunosuppressed.

Precautions to take to prevent transmission of the disease.

Steps individuals can take to maintain a clean environment at home, including not sharing towels or hygiene products, cleaning and laundry practices.

Likewise, families and visitors should understand that removing items from an infected resident’s room can lead to the spread of the disease.

To kill C. difficile spores, it’s necessary to clean surfaces with a 1-in-10-dilution bleach product – preferably one that is ready-to-use and, as such, properly diluted, according to experts. Some wipes also are Environmental Protection Agency-registered as C. difficile spore disinfectants, but it’s important to follow the manufacturer’s directions. For instance, the product must remain on the surface for a certain length of time in order to kill C. difficile spores.

The use of gloves when working with patients/residents contaminated with C. difficile can help prevent the spread of disease, according to the Guide. And, after gloves are removed, the caregiver should wash his or her hands with a non-antimicrobial or antimicrobial soap and water. Although this reportedly will not kill the C. difficile spores, it will remove them from one’s hands.

Sometimes, the most basic precautions go a long way in preventing disease outbreaks. Reminding long-term-care customers to take the necessary steps can make the difference between life and death, as well as save the facility time and expense.

It only takes one patient infected with C. difficile for the disease to spread throughout a facility floor or wing. So, it is imperative that providers have the right tests on hand to screen for – and diagnose – the disease.

The Centers for Disease Control and Prevention (CDC) lists the following tests that are available for detecting C. difficile:

- **Stool culture.** While this is the most sensitive test available, it is the one most frequently associated with false-positive results due to the presence of nontoxicogenic Clostridium difficile strains, according to the CDC. Also, stool cultures are labor intensive, with a relatively slow turn-around time.

- **Molecular test.** FDA-approved PCR assays, which test for the gene-encoding toxin B, are highly sensitive and specific for the presence of a toxin-producing Clostridium difficile organism.

- **Antigen detection.** These rapid tests detect the presence of Clostridium difficile antigen by latex agglutination or immunochromatographic assays. Because results of antigen testing alone are non-specific, antigen assays are often used in combination with tests for toxin detection, PCR or toxigenic culture in two-step testing algorithms, according to the CDC.

- **Toxin testing.**
  - Tissue culture cytotoxicity assay detects toxin B only.
  - Enzyme immunoassay detects toxin A, toxin B or both A and B. These tests are relatively inexpensive and easy to use.

Molecular tests, while more sensitive than antigen detection and toxin testing, are also more expensive, and a smaller facility may not be able to afford them. As such, some experts consider a rapid test, such as a toxin A and B test, to be a good starting point.

That said, not all rapid tests are the same. For instance, some are multi-step tests, while others are simpler. By taking time to understand what rapid tests are available and how they work, sales reps can better service their customers.
Influenza

Basic precautions, such as flu vaccine, go far in protecting you, your co-workers and your customers from the flu.

It’s back – or soon will be. Although flu season technically doesn’t begin until October, the time to start planning is now. Especially as another school year begins, and students spend more time indoors in closer proximity, physician practices are in need of solutions to help prevent the spread of germs. From gloves, masks and table paper to hand hygiene solutions and surface disinfectants, sales reps can prepare their customers well to at least come close to flu-proofing their offices.

Just as important is the flu vaccine. Although experts can never predict exactly how a particular flu season will play out, they do know this: when more people are vaccinated per the Centers for Disease Control and Prevention (CDC) recommendations, fewer people likely will contract the disease and the less opportunity there will be for it to spread.

About the disease

The timing, severity and length of each flu season can vary from one year to the next, according to the CDC. However, seasonal flu generally runs from October through May. That’s eight months of opportunity for physicians to protect their patients and sales reps to help them do so.

Indeed, influenza is nothing to thumb one’s nose at. Even the most resilient people can be hard-hit by the disease. A highly contagious respiratory illness caused by influenza viruses that infect the nose, throat and lungs, influenza can sometimes lead to death. Over a period of 30 years, between 1976 and 2006, estimates of flu-associated deaths in the United States range from a low of about 3,000 to a high of about 49,000 people, according to the CDC. Generally, however, people experience such symptoms as:

- Fever and/or chills.
- Cough.
- Sore throat.
- Runny or stuffy nose.
- Muscle or body aches.
- Headaches.
- Fatigue.
- Vomiting and diarrhea, although this is more common in children.

There are three types of flu viruses: Type A and B, which are responsible for seasonal epidemics, and type C, which is a less severe form of the disease. Flu viruses spread via droplets when infected people cough, sneeze or talk. Sometimes it is transmitted when a person touches an infected surface and then touches his or her mouth, eyes or nose. Most adults with flu can infect others a day before they develop symptoms, and then up to seven days after becoming sick, according to the CDC.

People at increased risk of developing flu include:

- Young children and adults over 65.
- Pregnant women.
- American Indians and Alaskan natives.
- People who have:
  - Asthma.
  - Neurological conditions.
  - Chronic lung disease.
  - Heart disease.
  - Blood disorders.
  - Endocrine, kidney or liver disorders.
  - Metabolic disorders.
  - Morbid obesity.
  - Long-term aspirin therapy.

Nursing home residents and healthcare workers also are at high risk of developing the flu. Because adults and children at higher risk are more likely to develop such
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complications as pneumonia, bronchitis, or sinus or ear infections, the CDC recommends annual vaccination for all people six months and older.

**Why vaccinate?**
Flu vaccines may not be foolproof. But, when combined with commonsense steps to prevent the spread of germs, the injection goes a long way in preventing illness and sometimes saving lives. As such, physicians and pharmacists continue to depend on a steady supply of vaccine for their patients. It’s true that the customer base continues to shift as more hospitals acquire physician practices, and patients take advantage of pharmacy and retail clinics. Still, experts believe physician practices – for now – continue to account for the bulk of vaccine sales for distributor sales reps.

Distributor sales reps play an important role with their customers – whether physician practice, hospital or retail clinic – and as such, must understand their varied needs, not only for influenza vaccine but for needles and syringes, soaps and sanitizers and rapid influenza diagnostic tests as well. In addition, they should help their customers understand the different types of flu vaccine available, depending on age indication, reimbursement differences, and presentation (e.g., multi-dose vial, prefilled syringe, high dose, nasal spray, etc.).

### The CDC provides the following table of licensed influenza vaccines expected

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Trade name</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactivated Influenza Vaccine, Trivalent††† (IIV3), Standard Dose</td>
<td>Afluria*</td>
<td>CSL Limited</td>
</tr>
<tr>
<td></td>
<td>Fluarix*</td>
<td>GlaxoSmithKline</td>
</tr>
<tr>
<td></td>
<td>Flucelvax*§§§</td>
<td>Novartis Vaccines</td>
</tr>
<tr>
<td></td>
<td>FluLaval*</td>
<td>ID Biomedical Corporation of Quebec (distributed by GlaxoSmithKline)</td>
</tr>
<tr>
<td></td>
<td>Fluvirin*</td>
<td>Novartis Vaccines</td>
</tr>
<tr>
<td></td>
<td>Fluzone*</td>
<td>Sanofi Pasteur</td>
</tr>
<tr>
<td></td>
<td>Fluzone* Intradermal§</td>
<td>Sanofi Pasteur</td>
</tr>
<tr>
<td>Inactivated Influenza Vaccine, Trivalent††† (IIV3), High Dose</td>
<td>Fluzone* High-Dose**</td>
<td>Sanofi Pasteur</td>
</tr>
<tr>
<td>Inactivated Influenza Vaccine, Quadrivalent††† (IIV4), Standard Dose</td>
<td>Fluarix* Quadrivalent</td>
<td>GlaxoSmithKline</td>
</tr>
<tr>
<td>Recombinant Influenza Vaccine, Trivalent††† (RIV3)</td>
<td>Flublok*</td>
<td>Protein Sciences</td>
</tr>
<tr>
<td>Live-attenuated Influenza Vaccine, Quadrivalent††† (LAIV4)</td>
<td>Flumist® Quadrivalent††</td>
<td>MedImmune</td>
</tr>
</tbody>
</table>

The 2013-2014 trivalent influenza vaccine is made from the following three viruses:
• A/California/7/2009 (H1N1)pdm09-like virus.
• A (H3N2) virus antigenically like the cell-propagated prototype virus A/Victoria/361/2011.
• B Massachusetts/2/2012-like virus.

Historically, the CDC has found that flu vaccination coverage drops after the end of November. But, it’s not uncommon for flu season to peak in January or February, and extend into May. As long as flu viruses spread and cause illness, vaccination should continue and can provide protection. Even unvaccinated people who already have contracted flu can benefit from the vaccine – particularly since it protects against three flu viruses, and more than one flu virus circulates each season, according to the organization.

Annual vaccination against influenza is imperative, says the CDC. From one season to the next, flu viruses change. And, immune protection from a vaccine declines over time. Given that it takes about two weeks for the vaccine to provide full protection, it simply doesn’t pay for physician customers – or their patients and staff – to wait.

### to be available in the United States for the 2013-2014 flu season:

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Mercury content (mcg Hg/0.5 mL)</th>
<th>Age indications</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5 mL single-dose prefilled syringe</td>
<td>0.0</td>
<td>≥9 yrs.***</td>
<td>IM†</td>
</tr>
<tr>
<td>5.0 mL multidose vial</td>
<td>24.5</td>
<td>≥3 yrs.</td>
<td>IM†</td>
</tr>
<tr>
<td>0.5 mL single-dose prefilled syringe</td>
<td>0.0</td>
<td>≥18 yrs</td>
<td>IM†</td>
</tr>
<tr>
<td>5.0 mL multidose vial</td>
<td>&lt;25.0</td>
<td>≥18 yrs</td>
<td>IM†</td>
</tr>
<tr>
<td>0.5 mL single-dose prefilled syringe</td>
<td>≤1</td>
<td>≥4 yrs.</td>
<td>IM†</td>
</tr>
<tr>
<td>5.0 mL multidose vial</td>
<td>25.0</td>
<td>≥36 mo.</td>
<td>IM†</td>
</tr>
<tr>
<td>0.25 mL single-dose prefilled syringe</td>
<td>0.0</td>
<td>6 through 35 mo.</td>
<td>IM†</td>
</tr>
<tr>
<td>0.5 mL single-dose prefilled syringe</td>
<td>0.0</td>
<td>≥36 mo.</td>
<td>IM†</td>
</tr>
<tr>
<td>0.5 mL single-dose vial</td>
<td>0.0</td>
<td>≥6 mo.</td>
<td>IM†</td>
</tr>
<tr>
<td>5.0 mL multidose vial</td>
<td>25.0</td>
<td>≥18 through 64 yrs.</td>
<td>ID</td>
</tr>
<tr>
<td>0.1 mL prefilled microinjection system</td>
<td>0.0</td>
<td>18 through 64 yrs.</td>
<td>IM†</td>
</tr>
<tr>
<td>0.5 mL single-dose prefilled syringe</td>
<td>0.0</td>
<td>≥65 yrs.</td>
<td>IM†</td>
</tr>
<tr>
<td>0.5 mL single-dose prefilled syringe</td>
<td>0.0</td>
<td>≥3 yrs.</td>
<td>IM†</td>
</tr>
<tr>
<td>0.5 mL single-dose vial</td>
<td>0.0</td>
<td>18 through 49 yrs.</td>
<td>IM†</td>
</tr>
<tr>
<td>0.2 mL prefilled intranasal sprayer</td>
<td>0.0 (per 0.2 mL)</td>
<td>2 through 49 yrs.</td>
<td>IN</td>
</tr>
</tbody>
</table>

Flu vaccines do not – and cannot – cause the flu, say experts. In fact, aside from a bit of soreness at the injection site, the vaccine rarely causes serious problems. Yet, each year, many people put off or avoid being vaccinated for fear it will not be effective or, worse, make them sick. In 2012, CBS ran an online article highlighting 12 myths about flu vaccine.

**Myth: Flu shots can cause the flu**
Flu vaccines contain only inactivated flu viruses. As such, they are unable to cause infection. In studies comparing flu shot recipients to people who get saltwater placebo shots, the only difference between the two groups is that the flu shot recipients experience redness at the injection site and arm soreness. They are not reportedly more likely to experience body aches, fever, cough, runny nose, or sore throat.

**Myth: Late flu shots don’t help**
Some people believe it makes no sense to get a flu shot after November. But, because flu season varies from year to year, experts say it can be helpful to get a vaccine as long as flu viruses are circulating. Though seasonal influenza usually peaks in January or February, some people get the flu as late as May.

**Myth: Flu shots protect for years**
Flu vaccine must be updated yearly as well. Flu viruses change from year to year, and last year’s vaccine won’t necessarily protect against this year’s viruses.

**Myth: Flu shots make other precautions unnecessary**
Even with a flu shot, government researchers say it’s a good idea to take everyday steps to prevent the spread of germs and viruses, including those that cause influenza. Simple precautions include covering one’s mouth and nose when coughing or sneezing; staying away from people who are sick; washing one’s hands often, either with soap and water or an alcohol-based hand sanitizer.

**Myth: It pays to wait**
Some people believe they need a flu shot only if the people around them come down with the flu. Because it takes about two weeks for the flu vaccine to provide full protection, however, by waiting until others get sick, it likely will be too late to protect against flu.

**Myth: Babies should get flu shots**
Although children under six months of age are at risk for influenza, they are too young to get a flu shot. The best way to protect them against flu is to make sure other members of the household get vaccinated, along with their caregivers.

**Myth: Flu shots aren’t very effective**
True, the flu vaccine doesn’t work all the time. Still, studies show that it can reduce the chances of getting the flu by up to 90 percent. The vaccine is a bit less effective in old people and young children, but getting vaccinated can help them avoid serious complications of flu even if it doesn’t prevent the illness itself.

**Myth: Everyone should get a flu shot**
Flu shots are now recommended for everyone over the age of six months – except for people who have a severe allergy to chicken eggs or other substances in the vaccine or who have sustained a serious reaction to previous flu shots.

**Myth: Flu shots cause autism**
Some flu vaccines contain thimerosal, a mercury-containing preservative that has been blamed for health problems, including autism. But studies have shown that low doses of thimerosal are harmless, causing nothing more than redness and swelling at the injection site. Many studies have shown no link between thimerosal exposure and autism.

**Myth: One flu shot isn’t enough**
Most people need to get vaccinated only once. Children between the ages of six months and eight years who have never gotten a seasonal flu vaccine should get two doses of vaccine spaced at least four weeks apart.

**Myth: Antiviral drugs make flu shots unnecessary**
Antiviral pills, liquids and inhaled powders are available to treat flu symptoms. But, these prescription-only products – Tamiflu and Relenza – are considered a second line of defense against the flu. And, they tend to work only if they are taken within the first day or two of coming down with influenza.

**Myth: Flu shots are the only option**
For needle-phobic patients, a nasal spray flu vaccine is available and can be safely used by healthy people between the ages of two and 49 years, as long as they are not pregnant.

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Ultrasound Screening Debate

State laws regarding breast density notification may lead to increased ultrasound usage

Should women with dense breasts – estimated to be anywhere from 40 percent to 50 percent of the female population – receive a screening ultrasound following mammography? Radiologists and OB/GYNs might argue the point. But a growing number of states are passing legislation that might lead to more ultrasound, regardless of clinicians’ beliefs.

“Density of breast is related to hormonal stimulation,” says Eva Chalas, MD, FACOG, FACS, and chair of District II of the American Congress of Obstetricians and Gynecologists. “Thus a significant proportion of women who are young will have dense breasts. As a woman approaches menopause, hormonal levels fall and then the breast tissue becomes less dense. Overall, between 40 percent and 50 percent of women who get screening mammograms have dense breasts.”

State laws

Verbiage in the Alabama law, signed in May and effective July 2014, offers an example of today’s breast-density-notification legislation: “If the mammogram of a patient demonstrates dense breast tissue, the physician issuing the report of the mammography results shall provide notification to the patient that includes, but is not limited to, the following statement: ‘Your mammogram shows that your breast tissue is dense. Dense breast tissue is very common and is not abnormal. However, dense breast tissue may make it harder to find cancer on a mammogram and may also be associated with an increased risk of breast cancer. This information about the result of your mammogram is given to you to raise your awareness. Use this information to talk to your doctor about your own risks for breast cancer. At that time, ask your doctor if more screening tests might be useful, based on your risk. A report of your results was sent to your physician.’”

Nevada’s law, signed in June and set to go into effect in January 2014, includes the following verbiage: “The State Board of Health shall prescribe by regulation the notice to be included in a report pursuant to subsection 1. The notice must include: (a) A statement regarding the benefits, risks and limitations of mammograms; (b) A description of factors that may affect the accuracy of a mammogram, including, without limitation, the density of breast tissue or the presence of breast implants; (c) A statement that encourages the patient to discuss with his or her provider of health care the patient’s specific risk factors for developing breast cancer; and (d) A statement that encourages the patient to discuss with his or her provider of health care...”

At press time, breast density notification laws had either passed or were pending in an estimated 20 states. Connecticut was reportedly the first state to pass such a law, in 2009. These laws require the radiologist to either advise a woman with dense breasts that she should speak to her OB/GYN or other physician about additional screening, or simply to inform all women about dense breasts and associated issues.

Dense breast tissue is comprised of less fat and more connective tissue, which appears white on a mammogram, according to Are You Dense Inc., a nonprofit patient group. Cancer also appears white on a mammogram, hence the concerns that tumors might be hidden behind the dense tissue.
whether the patient should adjust his or her schedule for mammograms or consider other appropriate screening options as a result of the patient’s breast density.

**Is screening necessary?**
Clinicians are divided on the necessity of a screening ultrasound following mammography on women with dense breasts.

The American College of Radiology neither supports nor disagrees with the state density laws, says Debra Monticciolo, MD, FACR, chair of the American College of Radiology’s Commission on Quality and Safety, and Section Chief of Breast Imaging at Texas A&M University College of Medicine. “Our position is, if patients are better informed, we are in favor of that.”

That said, some of the legislation is very prescriptive, verging on forcing clinicians to recommend a screening ultrasound or MRI for women with dense breasts, says Monticciolo. “But there’s no mandate to pay for that,” she says.

More to the point, she is concerned that such laws might cause women to get additional tests that are of little value to them. It’s true that mammography can miss 40 percent or more of cancers in women with dense breasts, says Monticciolo. “But there’s no mandate to pay for that,” she says.

More to the point, she is concerned that such laws might cause women to get additional tests that are of little value to them. It’s true that mammography can miss 40 percent or more of cancers in women with dense breasts. But studies have shown that screening ultrasound following mammography only catches from two to four additional cancers per thousand women. What’s more, 90 percent or more of biopsies performed as a result of screening ultrasound turn out to be negative.

“Everyone wants to find more positives,” says Monticciolo. “But at what cost? We are in favor of women being well-informed. But we have to be careful about how these laws are being applied.”

“Ultrasounds should be performed at the discretion of the radiologist who reads the mammogram,” says Chalas. “If they feel the test is inadequate – they cannot see an area well enough to be sure there are no lesions present – then they should be able to perform an ultrasound to help assess the area in question.”

But ACOG would prefer that legislators stay out of the discussion, she continues. “Radiologist are not allowed – by law – to self-refer, that is, order a test such as breast ultrasound, if the ordering OB/GYN requested a mammogram. Thus, they request that we prescribe the ultrasounds, even when doing so, we are having to rely on their judgment that it is needed. The new legislation essentially regulates the previous law, which limits the radiologist from using his/her judgment about which test will provide the most accurate answer. Clearly, this is a total catch-22.”

“The reading of ‘dense breast’ on a mammogram is somewhat subjective, which may add a further layer of complexity to the situation,” she adds.
More than three years after the United States Preventive Services Task Force (USPSTF) recommended against routine mammogram screening for women between the ages of 40 and 49, a study from Brigham and Women’s Hospital found that mammogram rates in the United States have not declined in that age group, or any other. The study results were published in the April 19, 2013, online edition of the journal Cancer.

The American College of Radiology and the Society of Breast Imaging said they were encouraged by the study’s findings, as it reinforces their recommendation that women begin getting annual mammograms at age 40.

“If the USPSTF recommendations had been widely adopted, we would have expected to see a significant decline in mammography rates among women in their 40s,” said the study’s lead author, Lydia Pace, MD, MPH, a global women’s health fellow in the Division of Women’s Health at Brigham and Women’s. “However, this study demonstrates that younger women are continuing to get mammograms.”

Researchers analyzed data from nearly 28,000 women who were asked about their mammography use during the 2005, 2008 and 2011 National Health Interview Survey, a federally sponsored household interview survey. They found that among all women, mammography rates rose at a slight but statistically non-significant rate between 2008 and 2011, from 51.9 percent to 53.6 percent. Among women in the 40 to 49 age group, mammography rates also rose at a slight but statistically non-significant rate between 2008 and 2011, from 46.1 percent to 47.5 percent.

“Our research does not explain the reasons why mammography rates did not decline, but it is worth noting that several prominent professional and advocacy organizations continue to recommend mammography screening for women between the ages of 40 and 49,” said Pace. “Providers may disagree with the USPSTF recommendations or they may not have the time or the tools needed for discussions with patients about the relative benefits and harms of mammography. Patients may also disagree with the recommendations and may still be requesting annual mammograms or self-referring to mammography facilities.”

The research was supported by the Global Women’s Health Fellowship at the Connors Center for Women’s Health and Gender Biology at Brigham and Women’s Hospital.

The state of New York – where Chalas practices – passed legislation in 2012 that says patients with dense breasts must be told that their mammograms may be difficult to interpret and that additional tests might be needed. “This has resulted in additional ultrasounds or MRIs,” she says. “One reason we object is this: We’re not looking at the picture. We don’t know how to interpret them. We don’t know the next best test. We rely on the radiologist, and that may result in overordering of tests.”

The big question is, how many tests are too many tests? If the link between breast density and breast cancer were firmly established and high enough, then perhaps there is no such thing as too many tests. But Chalas questions that link. “If there is science showing a connection between dense breasts and an increased incidence of breast cancer, that would be one thing,” she says. “But there is no such science.”

More than 80 percent of breast biopsies performed are benign, she adds. However, other studies show that the risk of breast cancer is four to five times greater in women with mammographically dense breasts compared with women of similar age with less or no dense tissue. And the Centers for Disease Control and Prevention list breast density as one of several risk factors for breast cancer. However, increased breast density has not been linked with mortality from breast cancer.

The bottom line is, patients who get a notice such as that prescribed by the New York legislation are, understandably, panic-stricken, says Chalas. “They think they have breast cancer, even though the lesions are benign. It is resulting in a lot more phone calls and concerns.”

Patients tend to believe that every test they receive is 100 percent accurate, she continues. “But there’s no such thing.” That said, 3D mammography is becoming more widespread, as doctors believe it can eliminate some of the guessing game.
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The Need to Breathe

The importance of testing for COPD

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With an emphasis on preventive care, catching, diagnosing and treating disease states as early as possible is critical to improved outcomes. This is especially the case with chronic obstructive pulmonary disease (COPD), a progressive disease that makes it hard to breathe, according to the National Heart, Lung and Blood Institute. COPD can cause coughing that produces large amounts of mucus, wheezing, shortness of breath, chest tightness, and other symptoms. COPD is slow developing, but has very serious health implications. Consider the following:

• COPD is the third leading cause of death in the United States.
• The National Heart, Lung and Blood Institute estimates that 12 million adults have COPD and another 12 million are undiagnosed or developing COPD.
• COPD kills more women than men each year. In 2006, COPD killed more American women than breast cancer and diabetes combined.
• Every four minutes an individual dies of COPD.

Questions to ask

Reps should approach their physician customers with the following questions:

• Do you currently perform spirometry? If so, how many patients do you see a week that complain of SOB or have a history of smoking?
• What do you do with these patients? If you refer out, have you considered treating and diagnosing those patients here?
• Are you aware you can perform spirometry on patients that have SOB and bill for it?

If the physician's volume is greater than five patients per week, or if they were to include testing on patients with a pulmonary Hx, Cardiac Hx, or SOB, then reps could ask:

• Are you aware that there is a fully portable PFT system that performs spirometry, DLCO and nitrogen washout that will allow you to better differentiate between an obstructive or restrictive lung process, a cardiac component or a diffusion disorder?
• Are you also aware this additional testing only takes about five minutes, and reimbursement increases significantly? In fact, you only have to test five patients per week to pay for the unit in a year.

Treatment and monitoring

Lung function tests such as spirometry and lung diffusion capacity are used to diagnose and monitor COPD. According to the NHLBI, lung function tests measure:

• How much air you can take into your lungs. This amount is compared with that of other people your age, height, and sex.
• How much air you can blow out of your lungs and how fast you can do it.
• How well your lungs deliver oxygen to your blood.
• The strength of your breathing muscles.

Doctors use lung function tests to help diagnose conditions such as asthma, pulmonary fibrosis, and COPD. Lung function tests also are used to check the extent of damage caused by conditions such as pulmonary fibrosis and sarcoidosis. Also, these tests might be used to check how well treatments, such as asthma medicines, are working.

Editor's note: Repertoire would like to thank ndd Medical Technologies for its assistance with this article.
How to Diagnose and Manage COPD and Asthma

Your choice is an EasyOne® for prompt, easy and accurate testing

Improve efficiency and quality of care by providing complete lung function testing on site

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Portable single breath DLCO device allowing physicians to provide their patients with prompt, accurate diagnosis and treatment.

EasyOne Pro® LAB
All the benefits of the EasyOne Pro plus multiple-breath nitrogen washout to obtain complete lung volumes, FRC and LCI measurements.

EasyOne® Plus
True portability for testing anytime, anywhere.
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- Instant results
- Powered by 2 AA batteries

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- Real time curves

nedd Medical Technologies, Inc., Two Dundee Park, Andover, Massachusetts 01810
Phone: 877-934-0090 www.nddmed.com
HOW MUCH BUSINESS
CAN YOU GET DONE IN 2½ DAYS?

Provider Insights

Kenneth Grant
The Johns Hopkins Hospital and Health System

Thomas Terry
Bassett Healthcare

Martin Basso
Suburban Hospital Healthcare System

John Carrico
Fairview Health

Robin Norman
Virginia Hospital Center

Les Bucker
ProMedica

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Innovators

Ryan Estis
Business Performance Expert

Thomas J. Williams
Healthcare Leader

Jim Dover
Hospital Strategist

Ron Lee
ION Sales Expert

Roger Benz
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Stanton McComb
McKesson Medical Surgical

299

distributor companies attended in 2012 including all of the top 30 distributors in the U.S.

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scheduled meetings occurred during the 2012 Streamlining Healthcare Conference.

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# Conference Schedule

**Subject to change • All events take place at the Gaylord National Resort and Convention Center**

## Tuesday, September 24

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00am – 5:00pm</td>
<td>Suites Meetings</td>
</tr>
<tr>
<td>11:00am – 3:00pm</td>
<td>PWH Annual Meeting (members only)</td>
</tr>
<tr>
<td>6:30 – 9:00pm</td>
<td>Chairman’s Dinner (by invitation)</td>
</tr>
<tr>
<td>9:00 – 10:00pm</td>
<td>Gather for Networking in the Belvedere Lobby Bar</td>
</tr>
</tbody>
</table>

## Wednesday, September 25

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 – 8:00am</td>
<td>Networking Breakfast on the Show Floor *</td>
</tr>
<tr>
<td>8:00 – 10:00am</td>
<td>Opening General Session • <em>Stories and Strategies from the Business of Sports</em> • <em>Next Level Leadership: Managing for Breakthrough Performance</em></td>
</tr>
<tr>
<td>10:00am – 1:00pm</td>
<td>Show Floor Open *</td>
</tr>
<tr>
<td>10:00am – 1:00pm</td>
<td>Leaders in Healthcare Amphitheater Sessions on Show Floor</td>
</tr>
<tr>
<td>10:00am – 5:00pm</td>
<td>Suites Meetings *</td>
</tr>
<tr>
<td>1:00 – 4:00pm</td>
<td>Executive Business Exchange *</td>
</tr>
<tr>
<td>1:00 – 4:00pm</td>
<td>Operations Business Exchange *</td>
</tr>
<tr>
<td>1:00 – 4:00pm</td>
<td>Category Management Business Exchange *</td>
</tr>
<tr>
<td>1:00 – 5:00pm</td>
<td>C-Suite Selling Seminar New!</td>
</tr>
<tr>
<td>5:00 – 6:00pm</td>
<td>Cocktail and Networking Reception on the Show Floor *</td>
</tr>
<tr>
<td>6:00 – 9:00pm</td>
<td>Open Time for Networking Dinners *</td>
</tr>
<tr>
<td>9:00 – 11:00pm</td>
<td>PWH/HIDA After Party</td>
</tr>
</tbody>
</table>

## Thursday, September 26

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 – 8:00am</td>
<td>Networking Breakfast on the Show Floor *</td>
</tr>
<tr>
<td>8:00 – 10:00am</td>
<td>Voice of Customer Sessions</td>
</tr>
<tr>
<td>8:00 – 8:55am</td>
<td>IDN Supply Chain Leaders</td>
</tr>
<tr>
<td>9:05 – 10:00am</td>
<td>Case Studies in Streamlining Healthcare</td>
</tr>
<tr>
<td>8:00am – 5:00pm</td>
<td>Suites Meetings *</td>
</tr>
<tr>
<td>10:00am – 1:00pm</td>
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<tr>
<td>1:00 – 3:00pm</td>
<td>Category Management Business Exchange *</td>
</tr>
<tr>
<td>1:00 – 3:00pm</td>
<td>Sales Rep Rotations</td>
</tr>
<tr>
<td>3:00 – 5:00pm</td>
<td>Closing General Session • <em>Healthcare Transformation: The CFO’s Perspective</em></td>
</tr>
<tr>
<td>5:00 – 10:00pm</td>
<td>Open for Networking Dinners *</td>
</tr>
</tbody>
</table>
HOW MUCH INSIGHT CAN YOU GET IN 2½ DAYS?

Opening General Session

Stories and Strategies from the Business of Sports

Sean McManus
• Chairman of CBS Sports
• Executive Producer for Inside the NFL
• Helped create CBSSports.com
• Under McManus, CBS has won more major awards than any other network’s news division

Next Level Leadership: Managing for Breakthrough Performance

Ryan Estis
• Former Chief Strategy Officer, McCann-Erickson World Group Advertising, People Marketing Division
• Business Performance Guru
• Expert on Innovation, Adapting to Change, and Leadership

Leadership is all about helping others stretch to achieve their potential. Top-rated speaker and strategist Ryan Estis offers a compelling crusade on corporate culture, communication, collaboration, brand ambassadorship, change and preparing leaders to thrive in the ultra-competitive, hyper-connected business environment we now know as the new normal. Estis will challenge conventional thinking with emphasis on innovation and strategy that offer leaders actionable content to accelerate breakthrough performance.
HOW MUCH INSIGHT CAN YOU GET IN 2½ DAYS?

Closing General Session

Healthcare Transformation: The CFO’s Perspective

If you really want to understand what’s driving a healthcare organization – or any business – talk to its CFO. In this session, you’ll get to hear from a panel of them, to truly get a clear picture of the challenges facing healthcare systems.

Marty Basso
Senior Vice President, Finance and Treasurer, Suburban Hospital Healthcare System
Acute care, medical-surgical hospital featuring all major services except obstetrics. Serves as the designated regional trauma center for Montgomery County, one of nine regional trauma centers in Maryland. Affiliated with National Institutes of Health and many other local healthcare organizations.

Robin Norman
Chief Financial Officer, Virginia Hospital Center
342-bed, $150 million state-of-the-art facility. Named one of the Nation’s Top 100 Hospitals by Truven Health Analytics. Only hospital in Northern Virginia to receive the 2013 Everest Award.

Voice of the Customer Education Sessions

IDN Supply Chain Leaders

Supply chain executives from three of the nation’s leading healthcare organizations give candid answers to your most important questions.

Kenneth Grant
Vice President for Supply Chain Management, The Johns Hopkins Hospital and Health System
Baltimore, Maryland
World renowned academic health system. Four hospitals plus the largest primary care group practice in Maryland.

Thomas Terry
Senior Director, Corporate Supply Chain Management, Bassett Healthcare, Cooperstown, New York
One of the top 50 health networks in the nation. Six hospitals, home care, primary care, and more.

John Carrico
System Director of Supply Chain Operations, Fairview Health Services Minneapolis, Minnesota
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New! C-Suite Selling Seminar

Healthcare consolidation is pushing many sales interactions to a higher level. Instead of calling on physicians and practice managers, you and your team must be prepared to talk to top corporate officers in health systems, medical groups, and other healthcare networks in order to win the business. In this new program, gain the specific skills and knowledge you need to talk to C-suite healthcare leaders about the issues that matter most to them.

Curriculum

- Top 10 things you need to know about selling in the C-suite
- How IDNs and hospitals define and measure value
- Understanding the C-suite mindset
- Tailoring your message for the C-suite executive’s attention span
- The C-suite’s involvement in the buying process
- Five approaches to gaining access
- C-suite sales calls: preparation and execution
- Metrics that matter and providing proof

Expert Faculty

**Thomas J. Williams**
Managing Director, Strategic Dynamics Inc.
More than 35 years’ experience in sales, marketing, and operations with medical device manufacturers and medical service organizations. Served as CEO managing two specialty hospitals.

**Jim Dover**
Senior Consultant, Strategic Dynamics Inc.
37-year background in the development and operation of healthcare facilities. Experience with Riverside Healthcare Association, Hospital Corporation of America, Greenville Hospital System, and Kindred Healthcare.

**Ron Lee**
Senior Consultant, Strategic Dynamics Inc.
Managing principal of Aegis HC, LLC, an entrepreneurial healthcare-focused organization. Works with C-level executives managing multi-million dollar hospital projects throughout the US.

**Patrick Sweeney**
President, Caliper Corporation
Expert in personality assessment and performance development.

The C-suite Selling Seminar is free with your registration to the Streamlining Healthcare Conference. To sign up visit [www.HIDA.org/Conference](http://www.HIDA.org/Conference) and enter promo code CSUITE during the registration process. If you are already registered for the conference and would like to attend the C-suite Selling Seminar, contact Cindy Chen at [chen@hida.org](mailto:chen@hida.org) or 703-838-6114. Earn 4 Accredited in Medical Sales (AMS) points by attending the entire program.

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- Answers to Your Questions about Government Affairs Issues
- Long-term Care Reimbursement and Regulatory Update
- Talking to Customers about Distribution Value
- Using Data to Identify Sales Opportunities
- Market Trends You Can Harness for Sales Growth
- Qualifying Leads in Today’s Digital World
- Helping Your Customers Reduce Readmissions
- Selling the Value of POL Testing at the Corporate Level
- Talking with Customers about the Issues that Matter Most
- Responding to an RFP
- Working with Hospital Committees

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BD
Beckman Coulter Inc.
Bionix Medical Technologies
Bovie Medical
Brewer
Cardiac Science / Criticare Systems
Covidien
Dukal Corporation
GE
Georgia-Pacific Professional
Globe Medical - Surgical Supply Co.
GOJO Industries, Inc.
Grove Medical Inc
Henry Schein, Inc.
Hospital Associates
Kreisers, Inc.
Laboratory Supply Company (LABSCO)
McKesson
Med Care Associates
Med Tech Associates
Medline Industries
Mercedes Medical
Midland Medical Supply Company
MMS - A Medical Supply Company
Moore Medical
ORION Medical Supply
Owens & Minor
Patterson Medical
PharMedCorp
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Professional Hospital Supply, Inc.
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And More! See full list at www.HIDA.org/Conference

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Beckman Coulter Inc.
Bionix Medical Technologies
Bovie Medical
Brewer
Cardiac Science / Criticare Systems
Covidien
Dukal Corporation
GE
Georgia-Pacific Professional
Getinge USA, Inc.
Global Healthcare Exchange
HORIBA Medical
Independent Medical Co-op, Inc.
Kimberly-Clark Corporation
MDSI
Midmark Corporation
National Distribution & Contracting, Inc.
Nestle Health Science
PDI
Professional Hospital Supply, Inc.
Professional Women In Healthcare (PWHI)
Quidel Corporation
Roche Diagnostics
SCA Personal Care/Div of SCA North America
Sekisui Diagnostics, LLC.(Formerly Genzyme Diagnostics)
Sempermed USA, Inc.
Smith & Nephew
TIDI Products LLC
ValueCentric
Welch Allyn, Inc.
And More! See full list at www.HIDA.org/Conference

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4. Pavilion
5. Ad Hoc Meeting Space
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7. General Session Stage, C-Suite Selling Seminar and Voice of Customer Session

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Does eating fish protect against cancer?
Fish is a rich source of omega-3 fatty acids. Studies in animals have found that these fatty acids may stop cancer from forming or slow its growth, but it is not clear if they can affect cancer risk in humans. Eating fish rich in omega-3 fatty acids is linked with a reduced risk of heart disease, but some types of fish (such as swordfish, tuna, tilefish, shark, and king mackerel) may contain high levels of mercury, polychlorinated biphenyls (PCBs), dioxins, and other pollutants. Some studies have also shown that farm-raised fish may carry more of these harmful substances than fish caught in the wild.

What are folate and folic acid, and can they lower cancer risk?
Folate is a B vitamin naturally found in many vegetables, beans, fruits, whole grains, and fortified breakfast cereals. Some studies from the 1990s suggested that a lack of folate might increase the risk of colorectal and breast cancers, especially in people who drink alcohol. But since 1998, enriched grain products in the United States have been fortified with folic acid, a manmade form of this vitamin, so most people get enough folate in their diet. Some studies suggest that folic acid supplements may increase the risk of prostate cancer, advanced colorectal polyps, and possibly breast cancer. Because of this, and the fact that most people get enough folate in their diet, the best way to get folate is by eating vegetables, fruits, and enriched or whole-grain products.
Can garlic lower cancer risk?
There have been claims of health benefits of the Allium compounds found in garlic and other vegetables in the onion family. Garlic is now being studied to see if it can reduce cancer risk, and a few studies suggest that it may reduce the risk of colorectal cancer. However, there currently is not much evidence that Allium compound supplements can lower cancer risk.

What are genetically modified foods, and are they safe?
Genetically modified or bioengineered foods are made by adding genes from other plants or organisms to increase a plant’s resistance to insects, slow spoilage or to improve flavor, nutrient content or other desired qualities. In the United States, most soybeans and corn are grown from seeds that have been modified to resist herbicides and, in the case of corn, to make a natural insecticide. There is no proof at this time that genetically modified foods currently available on the market are harmful to human health or that they would increase one’s risk of cancer. However, because these foods have been around for a fairly short time, the possible long-term health effects are not known and their safety should continue to be assessed.

Should I avoid processed meats?
Some studies have linked eating large amounts of processed meat to increased risk of colorectal and stomach cancers. This link may be due in part to nitrites, which are added to many lunch meats, hams and hot dogs to maintain color and to prevent bacterial growth. Eating processed meats and meats preserved using smoke or salt increases exposure to potential cancer-causing agents and should be reduced as much as possible.

Do non-nutritive sweeteners or sugar substitutes cause cancer?
There is no proof that these sweeteners, at the levels consumed in human diets, cause cancer. Aspartame, saccharin, and sucralose are a few of the non-nutritive sweeteners approved for use by the FDA, and studies in humans show no increased cancer risk. People with the genetic disorder phenylketonuria, however, should avoid aspartame in their diets.

Aspartame, saccharin, and sucralose are a few of the non-nutritive sweeteners approved for use by the FDA, and studies in humans show no increased cancer risk.

Does being overweight increase cancer risk?
Yes, being overweight or obese is linked with an increased risk of cancers of the breast (among women after menopause), colon and rectum, endometrium, esophagus, kidney, pancreas and likely cancer of the gallbladder as well. It may also be linked with increased risk of cancers of the liver, cervix, and ovary, as well as non-Hodgkin lymphoma, multiple myeloma, and aggressive forms of prostate cancer.

Does olive oil affect cancer risk?
Although consuming olive oil is linked with a reduced risk of heart disease, it is most likely neutral with respect to cancer risk.

Are foods labeled “organic” more effective in lowering cancer risk?
The term “organic” is widely used to describe foods from plants grown without adding artificial chemicals, and foods from animals raised without hormones or antibiotics. At this time, there is no evidence that such foods are more effective in reducing cancer risk or providing other health benefits than similar foods produced by other farming methods.

Do pesticides and herbicides in foods cause cancer?
Pesticides and herbicides can be toxic when used improperly in industrial, farming or other workplace settings. At this time there is no evidence that residues of pesticides and herbicides at the low doses found in foods increase the risk of cancer. Still, fruits and vegetables should be washed thoroughly before eating, not only to lower exposure to these compounds but also to limit the risk of health effects from germs.
Recent studies suggest that eating more vegetables and fruits may also help lower the risk of developing obesity, and thus is likely to have an indirect effect on cancer risk.

Can increasing physical activity lower cancer risk?
Yes, people who get moderate to vigorous levels of physical activity are at a lower risk of developing several cancers, including those of the breast, colon, and endometrium (lining of the uterus), as well as advanced forms of prostate cancer.

Does sugar increase cancer risk?
Sugar increases calorie intake without providing any of the nutrients that reduce cancer risk. By promoting obesity, a high sugar intake may indirectly increase cancer risk.

Do trans fats increase cancer risk?
Trans fats are made when vegetable oils are hydrogenated to create oils such as margarine or shortening, which are solid at room temperature. Trans fats raise blood cholesterol levels and increase heart disease risk, but their relationship with cancer risk has not been determined.

Will eating vegetables and fruits lower cancer risk?
Yes, the overall evidence suggests some lowering of risk for several types of cancer, including cancers of the lung, mouth, throat (pharynx), voice box (larynx), esophagus, stomach, colon, and rectum. Recent studies suggest that eating more vegetables and fruits may also help lower the risk of developing obesity, and thus is likely to have an indirect effect on cancer risk.

Clinic in a Can
When an EF-5 tornado touched down in Moore, Okla., in May, medical assistance wasn’t far behind. One person on the scene early was Michael Wawrzewski, a physician’s assistant and founder of Clinic in a Can, who brought with him one of his organization’s 20-foot shipping containers, modified to serve as a portable medical clinic. The clinic, which features equipment and supplies donated by a number of medical suppliers, including Midmark and Welch Allyn, was located temporarily at a Home Depot parking lot, then moved to a Walgreens lot. The unit has its own generator and water supply.

new products

Terumo announces FDA 510K clearance of SurGuard®3 safety hypodermic needle
Terumo Medical Corporation announced the new SurGuard®3 Safety hypodermic needle featuring 3 modes of activation – thumb, finger or hard surface is in stock at all distributors’ warehouses. Terumo SurGuard®3 safety hypodermic needle will be available in sizes ranging from 18-gauge to 30-gauge and incorporate Terumo’s proprietary T-sharp Technology. On average, Terumo needles with T-Sharp™ Technology are 10 percent sharper than similar products from the market leader, according to a study. “Terumo’s innovative SurGuard3 safety hypodermic needle offers exceptional performance and safety for the healthcare professional and is the one needle that fits every nurse’s style,” said Steve Omiecinski, Director of Marketing for Terumo Medical Corporation. “Furthermore, SurGuard3’s 3 modes of activation offer significant clinician flexibility. Our deeper understanding of industry needs allowed us the insight to specifically design SurGuard3 so that we can help our clinicians reduce needlestick injuries, improve patient satisfaction and feel confident as they pick how they click.” For more information on SurGuard®3 Safety Hypodermic Needle, contact your Terumo Representative at (800) 888-3786 or email TMSupport@terumomedical.com.

Parker Laboratories announces re-designed THERMASONIC® Gel Warmers
Parker Laboratories announced three, completely re-designed THERMASONIC® Gel Warmers; a single bottle gel warmer, a three-bottle gel warmer with preset temperature options and LED indicators; and a three-bottle gel warmer with LCD readout and temperature adjustment in one degree increments, in either Fahrenheit or Celsius. The units have been completely redesigned with microprocessor control, a powerful heating element, and higher sidewall heat exchangers to rapidly heat gel and consistently monitor temperature. From basic, single bottle warming to degree-specific, three bottle temperature controls with JCAHO compliant temperature indicator, there is an option for most any healthcare setting. All units contain hospital grade plug and power cords and are complete with a 2-year warranty. www.parkerlabs.com
Fed up with declining reimbursements and rising red tape, a small but growing number of doctors are opting out of the insurance system completely, reports CNN. How is it working out for them? Pretty well for Doug Nunamaker, who set up a membership-based practice called Atlas M.D. (yes, in honor of Ayn Rand’s Atlas Shrugged). Patients pay a flat monthly fee (kid’s $10 a month, adults $40-50, seniors $100), and the office has negotiated deals for services such as lab and MRIs. Nunamaker’s patient base went from 2500-400 to 400-600, but he told CNN it’s minus the headaches cause by dealing with insurers and he is comfortable with the salary he’s making.

Right now, the cash-only model hasn’t caught fire, but it’s a trend worth watching in the next year. It’s believed that only a small number of doctors have switched to a cash-only model, according to the report. The American Academy of Family Physicians said about 4% of respondents to a 2012 survey reported taking only cash, up from 3% in 2010. A Medscape survey found 6% of physicians in the cash-only business in 2013, up from 4% in 2012.

$128 Question

Repertoire’s $128 Question for each month is available on our Facebook page, Twitter, and Blog.RepertoireMag.com.

In June we asked:

What former Major League Pitcher ranks in the top ten in all-time wins for a left-hander, but is probably better known for a ligament procedure named after him that prolonged his career?

Answer: Tommy John

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Any company can claim to be the best. We prefer to let our industry-leading range of products and technology do the talking.

When it comes to helping customers manage consolidation and change, improve staff productivity and satisfaction, and enhance patient outcomes, it’s important to be able to back up your talk. That’s why Welch Allyn maintains over 80 EMR provider relationships, a service support program and a dedicated team for ongoing interface development and testing to provide seamless, customized connectivity solutions. So if your customers are looking to achieve true standardization across entire care networks, Welch Allyn allows you to offer something the competition can’t—proof.

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