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¹Dr. Alan-Shaun Wilkinson. ASHP 2014 presentation. Towards Extending the Practical Shelf Life (EPSL) or Beyond Use Date (BUD) for hazardous drugs in Preservative Free Single Dose Drug Vials (SDV) using OnGuard™ system.
²Prevention of Hazardous Drug Vapor Release by the Tevadaptor® Vial Adaptor. Third-party lab testing performed at Analyst Research Laboratories, Ltd. Rehovot, Israel, Reference reports 2007-001 Et001C and Nextar Chempharma Solutions, Ltd.
³Minimizing the Risk of Exposure to Potentially Hazardous Drugs, Souraski Medical Center, Tel Aviv, Israel, October, 2010.
⁴Evaluation of a closed-system cytotoxic transfer device in a pharmaceutical isolator. N Vyas, J Oncol Pharm Practice 0 (0) 1-11 2014.
⁵FDA clearance for ONB code: http://www.accessdata.fda.gov/cdrh_docs/pdf14/K141448.pdf

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What Brings Us Together

We are all busier than ever. We receive hundreds of e-mails and texts each day, and rarely get a chance to talk live to our peers. All of this equals activity and a busyness required in order to remain relevant in an ultra-competitive marketplace.

What it does not do is allow us time to reflect and work on our careers and educate ourselves, so we can better serve our customers. That’s why we’re so passionate about Repertoire’s mission within the medical distribution community.

Repertoire is written with one person in mind, the distributor rep. The magazine holds a unique spot in the industry similar to that of a phone call or a handwritten letter. Repertoire is still requested and received by over 95 percent of the industry’s sales reps. Whether delivered in print or digitally each month, it keeps all of us connected to something bigger than our individual accounts or products. We are part of an amazing fraternity tasked with helping America’s caregivers be the best in the world. That task takes education and community.

Are distribution companies as a whole still as valuable to manufacturers given consolidation within health systems and manufacturers?

This is one of the most important questions we are facing today and will continue to face over the coming years. I can’t answer this question, but I know who can. The folks in Columbus, Daytona, Houston, Long Island, Mundelein, Nashville, and Richmond, as well as every regional distributor, and every distribution sales rep in the United States must prove they can continue to deliver value to a manufacturing community seeing providers consolidate every day. Just read the Dail-eNews for a week. We’re constantly reporting on systems being acquired or consolidated.

Our industry is at a crossroads. We need to work together to solve the healthcare debate. Washington cannot do it! Manufacturers and distributors cannot do it alone, but together we can work toward a better healthcare system. The key word in that sentence is together. At some point we have to deliver goods, service accounts, collect payments, and ensure the best products are in the hands of our providers. That sounds like a job for distribution. The question is, can we all start working toward a more collaborative approach where both sides deliver value?

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Editor’s note: Welcome to Practice Points, by physician practice management experts Capko & Morgan. It is their belief – and ours too – that the more education sales reps receive on the issues facing their customers, the better prepared they are to provide solutions. Their emphasis is on helping physicians build patient-centered strategies and valuing staff’s contributions.

I’m writing this in the middle of Q1, a time when physician reluctance to commit to new spending has become remarkably predictable. Although calendar-year budgets are fresh – theoretically opening the door for more investments – there is usually anxiety about whether revenues will materialize as planned.

That’s because most of our clients are dealing with the “January effect” – i.e., the decrease in volume many specialties experience as the year begins. Patients with significant deductibles (these days, that’s most of us) tend to put off all but the most necessary care as the year starts, because they’ll have to pay most or all of the cost themselves. The pinch really hits in February, since January’s revenues are buoyed by insurance claims from December.

Capitalizing on the January effect
The deductible reset makes Q1 a tough time to get new financial commitments, but it’s a wonderful time to work with doctors, who have more openings in their schedules. We aim to capitalize on this by booking a project in the fall (when the client’s cash flow is best) that will be executed in Q1 (when their schedule is lighter). We also find that Q1 is great for access to doctors to discuss longer-range projects (just not for committing the money … yet).

Administrators, on the other hand, are often quite busy in Q1 with year-end analysis and reporting. So we try to be considerate of that, and do our best to stay out of their hair!

Executing projects in Q1 that we booked in the fall is a productive pattern for us, as is targeting that time for more strategic conversations with our physician clients. Booking a big expense in that time period is tougher, even when budgets have restarted. But it’s a good time to discuss the benefits of an investment, and plan for it to be booked later, when the revenue picture is clearer.

Seizing Seasonal Opportunities
Warming up: renewed productivity, planning for fall
For most practices we work with, the deductible bubble bursts by the start of Q2, and practices hit their productivity stride again. Insurance revenues return. With the financial picture clearer, there’s a window when booking business may be easier.

Spring also finds many practices focused on making hay while the sun shines. Summer is just around the corner. Vacations mean short-handedness, and everyone’s workload is increased. It’s harder to get a quorum, so we plant seeds in summer that we hope will bloom into deeper conversations in the fall. When a decision requires multiple players to agree, we have to be more patient about timing.

For most practices we work with, the deductible bubble bursts by the start of Q2, and practices hit their productivity stride again. Insurance revenues return. With the financial picture clearer, there’s a window when booking business may be easier.

Reps may face some of these same challenges, but there are perhaps more opportunities, too. There are many needs to plan for in the spring and summer, and many ways to impress your clients with your attentiveness. Busy juggling staff and physician schedules and focused on optimizing collections, administrators, in particular, may find the summer flies by. Practices may find themselves unprepared for the busiest – and most lucrative – time of year.

Make it easier for practices to order vaccines, supplies, and other essentials – quickly, without hassle – and you’ll be a hero when the busy summer suddenly becomes the even-busier fall and winter. Year-round, by simply understanding the impact of seasonality, you’ll stand out – whether by remembering the necessities your clients might forget, or simply being sensitive to times of extra stress. 

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* U.S. News Best Hospitals 2015-16 Honor Roll

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Manufacturers of innovative medical devices – that is, devices that are too new to attract big GPO contracts or general med/surg distribution contracts – have three choices to get their innovation to market: They can hire a direct sales force, try to contract with a national specialty dealer, or use local or regional specialty dealers, such as those in IMDA, the association for specialty dealers.

Now, a trio of specialty dealers – all IMDA members – have created a consortium to deliver the technical sales expertise and personal relationships of the specialty dealer on a broad geographic scale, offering one point of contact for manufacturers seeking broader representation.

Solutions in Critical Care is the name of the organization, founded by Allendale, N.J.-based Martab Medical; New Orleans, La.-based Medical Specialties and Northridge, Calif.-based SRC Medical.

“We offer a solution to manufacturers that gives them all the benefits of specialty distribution with the ease of working with a national – or near national – supplier,” says John Marmo, president, Martab Medical.

“SICC offers an alternative to the national providers as well as poor performing local sales organizations,” he says. “SICC will offer national coverage with the benefits of local sales organizations. By offering a strategic alliance and taking the best in class from each region, we will be in a position to offer the best solution to our manufacturers, buying groups and our accounts.

“SICC is the best option, because we will offer the benefits of local specialty distribution with the continuity and clarity of a national provider.”

SICC will continue to recruit more “best in class” specialty sales and marketing organizations, he adds.

National strength, local presence

“We offer national strength with a local presence,” says Don Reiter, president,
SRC Medical. “Manufacturers need that local presence, that is, people who know what’s going on in that particular territory, as well as the ease of dealing with just one entity across the country.”

SICC reflects a change in customer base as well, continues Reiter. “Our customers are consolidating – merging, forming coalitions. They are crossing our territories as well. They will look to someone who can bring them that national strength; but when it comes down to the local level, they want local support.”

And despite the national or near-national presence, SICC participants will continue to act as classic specialty dealers, he adds.

“We are our customers’ pre-screeners for innovative products. So when we bring something to them, we have checked it out, market-tested it, and have committed ourselves to it. If we have an opportunity to invest in that manufacturer, whether at the beginning of our relationship or down the line, we want to do that; that’s the level of commitment we bring.”

Adds Marmo, “We do not intend to have 20 product lines, but maybe four or five that we do very well. We’ll be comfortable spending the time and doing due diligence in the field to get the results we all want. And that will lead to longer relationships (with manufacturers of innovative devices).”

“Specialty dealers are the least expensive way for the new technology to be launched,” says Duke Johns, president, Medical Specialties. “We represent the best-of-class in bringing new technology to market. That is what we have been advocating. Now we’re going one step further, combining our strengths and putting some teeth into what we do best.”

“Over the last few years, I have noticed manufacturers going to national providers because they cannot find a specialty dealer in each territory, or the specialty dealer is overstretched and showed poor results,” says Marmo.

“I firmly believe specialty distribution is the best way to market and sell specialty solutions. We are offering manufacturers the best specialty-distribution sales with continuity of messaging and reporting. In short we will offer scale to the marketplace.”

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On a day-to-day basis, our focus is on our customers and responsibilities, which makes it difficult to step back and learn about the healthcare policies developing in states outside our sales territory. Almost every day, new legislation gets introduced across the country on state and local levels that has no immediate impact on the business we conduct in our own regions. However, sometimes an idea can gain traction so quickly that more states pay attention and introduce similar legislation. Some issues even have the potential to rise to the federal level with significant implications for our entire industry.

**Sharps disposal ordinance is potential disrupter for manufacturers, relabelers**

For example, environmental producer responsibility discussions are currently underway in several counties and states, including California. Mandatory collection and disposal programs, or Product Stewardship Programs, are being discussed as a means to remove sharps from the solid waste stream.

The impetus behind the initiative is that many groups are affected by the lack of safe needle disposal programs, particularly individuals who are subject to potential harm by working in jobs where they could come in contact with needles (e.g., landfill workers, hotel employees, police officers). Many states have made it illegal for home injectors to dispose of needles and lancets in the trash, but there is no way to fully police this – another reason why Product Stewardship is being discussed.

Product Stewardship Program participants would be responsible for collecting, transporting, and disposing of sharps under proposed solutions. If implemented, this program would directly affect producers of injectable medications and manufacturers of sharps, since they would be required to pay for initial administrative and operational costs and fees associated with...
getting a program up and running. Distributors who relabel products would also have to account for any new products associated with safe sharps disposal.

Although discussions are in early stages, it’s easy to see how broadly our industry would be affected with the passage of any national legislation.

A growing list to follow
Policies unique to one state don’t always remain that way. Before the Drug Quality and Security Act was signed into law in 2013, a patchwork of 29 individual state pharmaceutical pedigree laws existed in competition with each other. HIDA and its members used this disconnect as an advocacy opportunity to strengthen and ensure a secure supply chain for patients and providers.

Shifting focus toward medical products, creating a national uniform medical-surgical wholesaler licensure standard has been a hot topic for more than two years and doesn’t appear to be losing momentum. HIDA has been collaborating with industry stakeholders and cultivating champions on Capitol Hill to introduce legislation which would create a predictable and efficient licensure standard for states to implement. This effort would ensure continuity and enhance security for the medical-surgical supply chain. In fact, lawmakers are working on legislation that is expected to be introduced soon.

Another local example we’re monitoring is in New York, where legislation has been introduced that would require suppliers to issue ten-year warranties on any medical product they produce — from adhesive bandages to MRI machines. While passage of this legislation would affect manufacturers of these products directly, it could have potential spillover effects for distributors carrying these products since they would be required to relabel all of their current inventories.

There are numerous other state and local discussions in addition to these, and it can be difficult to keep up with every new development. This year, HIDA is forming a state legislative workgroup to monitor, pool, and share information among suppliers wishing to take an active role in healthcare supply chain policy. Staying informed of these topics is the first step toward identifying new challenges and possible opportunities for your business and customers.

If you would like more information or to get involved in HIDA’s state legislative workgroup, email us at HIDAGovAffairs@HIDA.org.
Complementary Strengths

Making an effective joint sales demo

Medical products distributors and manufacturers each serve two very unique, yet vital, roles when selling to healthcare providers. If you’re a distributor rep, asking your manufacturer counterpart to join you on product demonstrations is almost always a good idea.

Your results can only improve if you stay committed to building positive relationships with your supplier counterparts.

But conducting a successful joint demo requires close coordination and communication between distributor and manufacturer reps before, during, and even after the call. Here are some considerations to help facilitate these partnerships and push presentations over the top:

• **Know your role.** To create an effective sales demo, first you must clearly define sales rep roles. A good rule of thumb is for distributors to assume the role of ‘customer expert’ – arranging demos, quoting prices, and coordinating product orders or deliveries – while manufacturers position themselves as ‘product experts’ – demonstrating the product or equipment, providing installation or training, and gathering financial or outcomes analysis to justify the product.

• **Test your products.** This may seem like a no-brainer, but it’s crucial that any product you demonstrate is in working order. Usually, manufacturer reps will test a product ahead of the demo, but it could be an added benefit to do this with distributor co-presenters to give a better understanding of the product’s functionality.

• **Work the blueprint.** Distributor reps should open the presentation, and then introduce their counterpart. Manufacturers can then demo product features and benefits, handle customer objections, and answer product questions. Once completed, the distributor should close the call, ideally by obtaining a purchase order and arranging follow-up training or equipment service.

Conducting a successful joint demonstration requires close coordination and communication between distributor and manufacturer reps before, during, and after the call.

If a customer agrees to buy from you after your demo, congratulations! Remember that selling is a continuous process and your results can only improve if you stay committed to building positive relationships with your supplier counterparts. Maintain open communication with your trading partners and seek out new ways to participate in continuing education opportunities like webinars or conferences. This will keep you up to date on the latest supplier offerings and product developments, as well as ensure that your next joint customer demo is even stronger than your last.

By Elizabeth Hilla
Saving customers money is important, but CHAMPS Group Purchasing (Cleveland, Ohio) has discovered it takes much more than that to fill the needs of a growing membership. “We realized many years ago that it isn’t enough to simply save members money if you are not working closely with them to identify their organizational goals,” says Yolandi Myers, vice president. “Our organization has changed vastly over the years, including the way we collaborate with our membership. Our Client Services team acts as an extension of the member’s purchasing department, consulting and collaborating with them to perform data analytics that guide them to savings opportunities; resolve connection, communication and pricing issues with suppliers; and help them achieve their organization’s supply chain goals.”

Repertoire spoke with Myers about the group’s evolution over the years, how CHAMPS works to successfully service its members and its direction moving forward.

Repertoire: When was CHAMPS started and what has been its mission?

Yolandi Myers: The Greater Cleveland Hospital Association started in 1916. In 1918 these Cleveland hospitals decided to work together to acquire supplies, and our GPO efforts were born. While our membership has changed tremendously, our mission remains the same: to help members coordinate purchasing and contracting efforts in order to save money.

Repertoire: How has CHAMPS grown since it was started?

Myers: Over the past ten years, CHAMPS membership has evolved from a local collaborative to now serving the 7,000+ healthcare provider locations in all 50 states participating in our GPO. We actively recruit new members every day and continue to bring value to them, as well as to our existing members. Each time our membership base grows, the savings opportunity does as well. Because of our ability to aggregate our collective members’ spend, we are able to work with our supplier partners to drive down cost. This is a vital advantage, enabling our members – especially critical access and rural hospitals – to access higher contract tiers, which deliver higher discounts and lower cost.

Because of our ability to aggregate our collective members’ spend, we are able to work with our supplier partners to drive down cost. This is a vital advantage, enabling our members – especially critical access and rural hospitals – to access higher contract tiers, which deliver higher discounts and lower cost.

Repertoire: How has being part of a regional purchasing coalition enabled your members to leverage their buying power?

Myers: Since the majority of our members are not part of large healthcare systems, they understand the value of participating in a collaborative that concentrates their purchasing power and enables them to maximize their GPO discount structure.

Repertoire: How much savings did the coalition achieve in the first year, and how has that increased since?

Myers: Member savings vary greatly between classes-of-trade through the continuum of care and are also very dependent on the provider’s previous GPO. Typical savings for an acute care facility joining CHAMPS range between six and 10 percent, but in the non-acute market we frequently see savings of over 20 percent.
**Repertoire**: Can you explain the process whereby your supply chain executives meet and make their decisions?

**Myers**: Since our membership is spread across the country, in-person group meetings are not common. Our national account managers are specialized by class of trade and bring virtual collaboration efforts to reduce costs to the membership for decision-making and implementation.

**Repertoire**: How do you co-exist with your national GPO?

**Myers**: We are extremely involved with our national GPO partner, Premier healthcare alliance, so the majority of agreements accessed by CHAMPS members are in the Premier portfolio. The value that CHAMPS adds is to provide access to lower costs through spend aggregation. Additionally CHAMPS itself negotiates a portfolio of contracts that is designed to supplement the Premier portfolio. Through careful selection of suppliers – in some cases, regional ones – we drive value in our portfolio, as well as what we offer through Premier. CHAMPS truly is an extension of Premier to provide value for our members, as well as market share for the suppliers and manufacturers. CHAMPS builds upon this relationship, developing custom GPO contracts that complement the Premier portfolio. This helps us live out our mission of providing low-cost contracts for high quality supplies and services, while helping healthcare providers maximize their supply chain efficiencies.

**Repertoire**: How do you ensure that the interests of each of your facilities are considered and that each facility’s needs are met?

**Myers**: CHAMPS has a unique service model. Because of the diversity of our membership, we have built a model where account management experts work directly with members on a customized plan to identify savings and implement GPO pricing. Each new member has a dedicated account manager, and we build strategic partnerships and shared goals with each facility or group. Our supplier-relations initiatives include working directly with our GPO-contracted suppliers to provide additional value (not just price) to each class of trade and to membership as a whole.

**Repertoire**: How difficult is it to get buy-in to the coalition’s contracts from each of your facility’s physicians and staff?

**Myers**: This is a challenge. Physicians and other providers in the post-acute market are busy. Their patient loads are heavy and they are looking to cut costs anywhere they can. When we meet with them, they have limited time and often it is clear that the person in charge of purchasing also wears many other hats. That is why we have created systems to help with GPO contract management, electronic price activation and identification of top contract savings opportunities. Our account management team uses these systems to consult with the members on their best options and handle the contract connection process for them, minimizing the time it takes the members to manage their own GPO spend.

**Repertoire**: Other than cost-savings your coalition has achieved through greater volume purchasing, what has been the greatest benefit of the coalition to its members?

**Myers**: The support members get from CHAMPS as a free service to their hospitals, practices and skilled nursing facilities always gets high praise. CHAMPS works to ease the burden of contract management and local negotiation, giving supply chain executives and staff the ability to focus on broader goals.

**Repertoire**: How do you envision your purchasing coalition in the next several years?

**Myers**: There will continue to be growth in our membership and in savings to providers, as well as value to supplier partners. CHAMPS has a collaborative approach, so we will continue to explore new areas for group effort and will provide more support to our membership through evolving technology solutions and contracting strategies. We strongly believe that the ability to move market share is imperative in a sustainable model, so we will continue to progress in this area. I envision intense collaboration and solid partnerships in our future, which will sustain and support members as they learn to prosper under new care models.
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At $10 billion or so a year, some question the value of annual physicals

Today, as healthcare providers – and consumers – preach the importance of preventive healthcare and population health, why would anyone diss the annual physical? An annual rite of passage for as many as one-third of U.S. adults, the physical is coming under attack from some providers, who question its value and its cost. Many consumers are left wondering what to do.
In September 2013, the Society of General Internal Medicine, as part of the Choosing Wisely initiative of the ABIM Foundation, recommended against routine health checks for asymptomatic adults, and suggested that such checks can actually lead to more harm than good.

“In contrast to office visits for acute illness, specific evidence-based preventive strategies, or chronic care management such as treatment of high blood pressure, regularly scheduled general health checks without a specific cause, including the ‘health maintenance’ annual visit, have not shown to be effective in reducing morbidity, mortality or hospitalization, while creating a potential for harm from unnecessary testing,” wrote the Society.

Poorly defined

Two years later, in an October 2015 editorial in the New England Journal of Medicine, two physicians – Ateef Mehrotra, M.D., MPH, and Allan Prochazka, M.D. – continued the attack.

“[We, like many colleagues, view the routine (although not necessarily annual) well-patient visit as a mainstay of the physician–patient relationship.”

– David U. Himmelstein, M.D., and Russell S. Phillips, M.D.

“But by no means was that editorial the last word on the subject.

In a January 2016 Annals of Internal Medicine editorial, David U. Himmelstein, M.D., and Russell S. Phillips, M.D., punched holes in the “evidentiary support” for recommendations against the annual physical, particularly a study published in 2012 referred to as the “Cochrane review.” That study – conducted by the Cochrane Collaboration, a global, independent network of researchers, professionals and others interested in health – concluded that regular health checks failed to reduce morbidity or mortality.

Reducing the number of physicals could also free up primary care providers’ time, they argue. “Approximately 10 percent of all visits with primary care physicians are for annual physicals, which might be crowding out visits for more urgent health issues,” they say. “Poor access to primary care has been cited as one reason why patients seek care in emergency departments for low-acuity conditions.”

On the other hand…

“One of the difficulties in assessing the role of the annual physical is that its content is poorly defined and its focus has evolved over time,” they write. “The potential components of the annual physical include history taking, screening questions designed to uncover undetected illness or risk factors such as smoking, counseling to address those risk factors, a full physical exam, ordering of recommended preventive services, and routine testing (e.g., complete blood counts, electrocardiograms, and urinalyses) in asymptomatic patients. Many of these components are included because of billing regulations established by health plans and Medicare.”
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The Cochrane review was full of flaws, according to Himmelstein and Phillips. It encompassed mostly outdated studies conducted in settings where control patients had frequent primary care visits and faced few access barriers, and the interventions assessed were not part of a 21st-century wellness visit.

“[W]e, like many colleagues, view the routine (although not necessarily annual) well-patient visit as a mainstay of the physician–patient relationship and worry that abandoning it risks undermining proven benefits of primary care, including better patient outcomes and attenuation of disparities,” write Himmelstein and Phillips. “In our experience, such visits have led to new diagnoses of melanoma, colon and breast cancer, alcohol abuse, opiate addiction and depression – diagnoses that would otherwise have been delayed or missed.”

What’s more, vulnerable patients – particularly low-income people who have little access to primary care physicians and little money to pay them – could suffer the most if the annual physical is eliminated, they say. “Without solid evidence, affluent, well-educated patients with unfettered access to care might reasonably choose longer intervals between routine visits. However, for vulnerable patients and groups at high risk for intercurrent illness (such as the elderly), regular, even annual, visits may be appropriate.”

Some resolutions
In their editorial, Mehrotra and Prochazka offer three solutions that might appease both sides:

• Create a new type of visit whose exclusive function is to establish relationships. “The majority of patients who receive a physical every year have established relationships with their physicians and come to the practice regularly for other reasons,” they write. “For those who have not seen a primary care physician recently, valid arguments can be made that a physical serves as a mechanism for establishing a relationship.”

• Change the methods by which primary care providers ensure that patients’ preventive care is up to date. “[P]assively waiting for patients to come in for physicals has not been an effective strategy, as

“Though on a per-visit basis, the annual physical is not costly, it is the single most common reason that U.S. patients seek care.”

– Ateef Mehrotra, M.D., MPH, and Allan Prochazka, M.D
evidenced by the low rates of receipt of preventive care in the United States,” they say. “We believe that the emphasis in a practice needs to shift from such passivity to active engagement of the patient population,” including automated methods of screening, such as online health risk assessments, questionnaires delivered in the waiting room, and delivery of preventive care at any type of health-care encounter. Payers could encourage such a shift by using pay-for-performance incentives.

- Payers should stop reimbursing providers for annual physicals or using the incidence of such physicals as a measure of health care quality.

“Many private health plans have created a financial incentive for physicians to provide annual physicals by reimbursing for them at a higher rate than for other office visits. Eliminating this reimbursement differential would be an important step.”

“These payment changes would not eliminate all annual physicals,” write Himmelstein and Phillips. “Physicians would, in many cases, substitute regular office visits, but they would reduce their prevalence. Any savings achieved could be invested in other aspects of primary care, such as remote chronic care management or health coaching – care that’s typically not reimbursed but that has been shown to improve outcomes.”
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Diagnostics

Patient safety: Front and center

Editor’s note: Last month, Repertoire interviewed Jennifer Lenoci-Edwards, patient safety director, Institute for Healthcare Improvement, about patient safety in the primary care office. This month, we talk to Rahul Nayak, M.D., MBA, who, while serving as Kaiser Permanente Georgia’s physician program director for patient safety, attended IHI’s Patient Safety Executive Development Program. Part of Kaiser Permanente’s program involves a systematic approach to critical abnormal labs.

Repertoire: You received a master’s degree in business administration while working on your M.D. degree. What were your thoughts and goals at the time?
Rahul Nayak: During my third year of clinical rotations, I was struck by how often finances and financial concerns drove healthcare decisions outside of the academic environment. I evaluated the various courses of study that would prepare me to advocate for my patients and for my profession; an MBA seemed to be the most practical and high yield.

Repertoire: Why did you join Kaiser Permanente in Georgia?
Rahul Nayak: I ask one question when evaluating a good or service: “How does this company make money?” I want the answer to that question to be aligned with my needs and interests. The way that Kaiser Permanente makes money makes sense to me – we make money by keeping people healthy and getting them over illness as quickly as possible. Kaiser Permanente also values my expertise in performance improvement, and I have opportunities to apply that knowledge to benefit my patients and the organization.

Repertoire: Why did you attend the IHI Patient Safety Executive Development Program?
Rahul Nayak: I had a portfolio of work around patient safety and risk mitigation, but I needed a patient safety “boot camp.” IHI offered the most robust and well respected example. The experience and passion of the faculty, including some from Kaiser Permanente, is unmatched.

Repertoire: The IHI program must have struck a chord with you, because you worked on patient safety initiatives for close to a year before being named Kaiser Permanente of Georgia’s Physician Program Director for Patient Safety in May 2011. What were the key insights you gained from it?
Rahul Nayak: IHI provides the core set of skills necessary for any professional in the safety space. It offers an approach to data, root cause analysis, change management, and leadership/structure development. One

“Safety, efficiency, great outcomes, great service and affordability are all manifestations of the way that we do our work.”

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of the highlights was the opportunity to closely interact with the faculty as well as the other leaders who were participating in the program. The fundamental systems approach and the application of scientific method to safety has influenced all of my subsequent work.

**Repertoire:** How does Kaiser Permanente Georgia’s “centralized safety net” project relate to patient safety and critical abnormal labs?

**Rahul Nayak:** Centralized Safety Net was developed by Kaiser Permanente in Southern California and deployed successfully across that region. In a root cause analysis of an event, we concluded that we needed a more systematic approach to critical abnormal labs. Connections I had made at IHI with other safety leaders at Kaiser Permanente led us to contact the Southern California team responsible for their safety net, which is a powerful concept. The “safety net” system accepts that no one is perfect and provides a way to back up both our patients and our providers. Our success was measured in lives saved and a better night’s sleep for our providers – and we actually won an award for our adoption of their work.

**Repertoire:** Kaiser Permanente Georgia has multiple sites and hundreds of clinicians. Talk about the challenge of building a patient safety program in multiple sites.

**Rahul Nayak:** We have many advantages by being a large system with many shared services. This allows us to test and refine improvements in a small unit and then scale those changes across the entire region. The biggest challenge for outpatient safety is the geographic and temporal spread. This differs from a hospital setting, where there is a well-defined amount of time from admission to discharge, one building, and a great deal of focus and regulation.

**Repertoire:** What is the most difficult part of sustaining a culture of patient safety, day after day, month after month, year after year?

**Rahul Nayak:** The challenge is that there is a great deal of energy focused on safety after an adverse event, which tapers off over time. Keeping safety front and center is often difficult, if it is separated from your other organizational goals. We believe that safety, efficiency, great outcomes, great service and affordability are all manifestations of the way that we do our work, so it is linked as one of the desired and measured outcomes.

**Repertoire:** You stepped down as program director for patient safety in January 2015. What’s next for you?

**Rahul Nayak:** There are many challenges ahead of us in healthcare. Right now, I am interested in helping develop the model of care that will take us into the future. The U.S. healthcare system is not sustainable in the long term, and recent changes in legislation have opened up opportunity for different models of healthcare delivery. As much as I enjoyed the work that I did in patient safety, it always felt as though I was helping steer a fire truck from the back – able to nudge and influence, but not really picking the direction. The fact remains that safety, service, and efficiency happen at the front line of care delivery, and working in that space is my next challenge.
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Anesthesiologists, surgeons, nurses, respiratory therapists, physical rehabilitation specialists and others are starting to look at the perioperative process in a new way. Instead of viewing it as a series of disconnected snapshots, they are choosing to treat it as one continuous movie, beginning weeks before surgery and not concluding until 30, 60 or even 90 days after discharge.

The concept is being embraced by the American Society of Anesthesiologists who, with the help of Premier Inc., gathered 44 healthcare organizations from across the country to refine what they call the Perioperative Surgical Home – a patient-centered, team-based practice model of coordinated care that guides patients through the entire surgical experience, from the decision to undergo surgery to discharge and beyond.

The ASA is so enthusiastic about the program that at press time it was recruiting healthcare organizations to participate in the next round of the PSH Learning Collaborative, in conjunction with Premier. Round Two is expected to run through March 2018.

New payment models
The Perioperative Surgical Home can lead to better patient care, faster recovery times and lower overall costs, according to proponents. That’s because it will encourage surgeons to collaborate to develop clinical pathways and agree on physician preference items, such as orthopedic implants.

It is an approach that is right for the times, says Michael Schweitzer, M.D., an anesthesiologist and medical director of the Perioperative Surgical Home Collaborative for the American Society of Anesthesiologists. He was recently named chief medical officer of bundled payments for Premier.

Last year, Congress passed the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) in order to make it easier for healthcare providers to take part in two of the Centers for Medicare & Medicaid Service’s quality programs:
• The Merit-Based Incentive Payment System (MIPS), which combines parts of the Physician
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Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier) and the Medicare Electronic Health Record (EHR) incentive program into one program based on quality, resource use, clinical practice improvement and meaningful use of EHR technology.

- Alternative Payment Models (APMs), including accountable care organizations, patient-centered medical homes and bundled payment models. APMs call for lump-sum incentive payments for participating healthcare providers as well as increased transparency of physician-focused payment models.

No place like home
Using the words “surgical” and “home” to describe the new care delivery model isn’t so far-fetched, says Schweitzer. “First, patients would rather be in their homes than in the hospital or nursing home. That’s why the goal is to get patients back to their own homes as soon as possible. Second, we wanted to use the successful elements and attributes of the patient-centered medical home – which has been around much longer – and build on them.”

A key attribute of the patient-centered medical home is team-based care, says Schweitzer. That means a full team of providers – including physicians, physician assistants, nurse practitioners, diabetes educators, care managers and others – coordinate their efforts to treat the patient. The patient-centered medical home also employs a technique called risk stratification; the primary care team identifies those patients at highest risk of complications and seeks to address those risks in a timely manner in order to avoid negative consequences later.

Similarly, in the Perioperative Surgical Home, “We want to identity high-risk patients and focus on them with a full team of providers who can work with those patients to improve their health, get them through the surgical process and back to their desired functional state,” he says. “It involves a lot of teamwork.”

Difference to the patient
Patients will notice the difference.

“Even as recently as a few years ago, and still in too many locations across the country, the whole surgical process has been totally disconnected,” says Schweitzer. “You have silos of care that don’t communicate with each other, and too often, patients slip through the cracks.”

A case in point might be a total joint procedure (on which the Perioperative Surgical Home Collaborative has focused most of its efforts thus far).

Traditionally, the surgeon and patient meet and set a day for surgery, which could be six weeks hence. “What happens then is essentially nothing,” says Schweitzer. “Then, two or three days before surgery, there is a flurry of activity,” such as lab tests, consults, etc. But two or three days doesn’t give providers enough time to identify and optimize conditions such as anemia or poorly controlled blood glucose levels.

In the Perioperative Surgical Home, on the other hand, “you start implementing a process as soon as a shared decision to have surgery is made,” says Schweitzer. The clinical team might enroll an anemic patient in an anemia clinic long before surgery, and the diabetic patient in a diabetes care program. If the surgical patient’s nutritional habits are poor, the team can identify that and work with that person long before surgery to improve his or her state of health. “And then, you work as a team, with a consistent pathway and goal, so the patient doesn’t slip through the cracks,” he says.
“We are redesigning or re-engineering the whole delivery-of-care process. We look at it from the patient’s point of view. How do we prepare him for surgery? How do we optimize his medical condition prior to coming to the hospital? If we can do that, his physical status will be better after surgery, and he will have a clearer understanding of his own responsibilities after discharge.”

In the Perioperative Surgical Home, the perioperative team helps set the patient’s expectations well before surgery, adds Schweitzer. For example, the physical therapist meets with the patient and instructs her on the exercises she will have to do after discharge. The case manager inquires whether the patient’s home has stairs or rugs, or if she is a fall risk. Does she have someone at home to help her navigate those stairs, rugs and the bathroom in the first days after surgery, or will she need someone from the community to call on her daily? “It is best to coordinate all these things weeks before the surgery, rather than have the care manager in the hospital go over these concerns three or four hours before discharge,” he says.

**Making it work**
Health system administrators recognize that narrow margins necessitate taking a fresh look at processes, including surgery, says Schweitzer. True, they may have a difficult time seeing how the health system can benefit by working with a patient weeks before and after the inpatient surgical procedure. “But when they understand there will be savings, fewer complications, fewer ED visits and fewer readmissions, they will get on board.”

The Perioperative Surgical Home also requires a surgeon champion, anesthesiologist champion, perhaps a hospitalist or internal medicine champion, and others, he continues. Working with the C-suite and project manager, these champions lead the redesign process. Other surgeons and anesthesiologists help design care protocols and guidelines, and are held accountable for following them.

Suppliers can help the clinical team keep down the costs of the Perioperative Surgical Home. Implants represent roughly 40 percent of the cost of the in-hospital portion of joint replacement surgery, says Schweitzer. “And the cost goes beyond the implant,” and includes pharmaceuticals, durable medical equipment, and other supplies.
Ever since the Institute of Medicine published its landmark report, *To Err Is Human: Building a Safer Health System*, in 1999, the public, clinicians and suppliers have focused on one of healthcare’s greatest secrets: Healthcare providers make mistakes, and patients – as many as 100,000 a year – die because of them. Largely because of that report, “patient safety” has become a well-recognized term among the healthcare community and the public at large.

One aspect of error has been relatively underreported, however, and it is one of the most basic: diagnostic error. That is no longer the case, given the National Academy of Sciences’ newest report, *Improving Diagnosis in Health Care*, published in September 2015.

“The data on diagnostic error are sparse, few reliable measures exist, and often the error is identified only in retrospect,” says the NAS committee that wrote the report. “Yet the best estimates indicate that all of us will likely experience a meaningful diagnostic error in our lifetime.”

The committee defines diagnostic error as the failure to 1) establish an accurate and timely explanation of the patient’s health problem(s), or 2) communicate that explanation to the patient. Either way, such errors constitute a “blind spot” within the healthcare system, one that has persisted for decades.

“Improving the diagnostic process is not only possible, but also represents a moral, professional, and public health imperative,” says the NAS. “Achieving that goal will require a significant re-envisioning of the diagnostic process and a widespread commitment to change among healthcare professionals, healthcare organizations, patients and their families, researchers, and policy makers.”

The committee’s recommendations address eight goals to improve diagnosis and reduce diagnostic error.

**Goal 1: Teamwork**

Healthcare organizations should ensure that healthcare professionals have the appropriate knowledge, skills, resources, and support to engage in teamwork in the diagnostic process, says NAS. To accomplish this, they should facilitate and support collaboration among pathologists, radiologists, other diagnosticians, and treating healthcare professionals.

What’s more, patients and their families contribute valuable input that can facilitate the diagnostic process and ensure shared decision-making about the path of care, according to NAS. Accordingly, the committee recommends that providers:

- Provide patients with opportunities to learn about the diagnostic process.
- Create environments in which patients and their families are comfortable engaging in the diagnostic process and sharing feedback and concerns about diagnostic errors and near misses.
- Ensure patient access to electronic health records (EHRs), including clinical notes and diagnostic testing results, to facilitate patient engagement in the diagnostic process and patient review of health records for accuracy.
- Identify opportunities to include patients and their families in efforts to improve the diagnostic process by learning from diagnostic errors and near misses.

**Goal 2: Education and training**

Getting the right diagnosis depends on all healthcare professionals getting involved in the process, and receiving appropriate education and training, according to the NAS committee. Feedback – or information about the accuracy of a clinician’s diagnosis – is essential for improved diagnostic performance.

The committee made two recommendations:

- Educators should ensure that curricula and training programs address performance in the diagnostic process, including areas such as clinical reasoning; teamwork; communication with patients, their families, and other healthcare professionals; appropriate use of diagnostic tests and the application of these results on subsequent decision-making; and use of health information technology.
- Healthcare professional certification and accreditation organizations should ensure that healthcare professionals have and maintain the competencies needed for effective performance in the diagnostic process.
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Goal 3: Health IT
Health IT has the potential to improve diagnoses and reduce diagnostic errors by facilitating access to information; communication among healthcare professionals, patients, and their families; clinical reasoning; and feedback and follow-up, says the NAS committee. However, many experts are concerned that health IT is failing to effectively facilitate the diagnostic process and may even be contributing to errors. The committee made three recommendations:

- Health IT vendors and the Office of the National Coordinator for Health Information Technology (ONC) should work with users to ensure that health IT used in the diagnostic process demonstrates usability, incorporates human factors knowledge, integrates measurement capability, fits well within clinical workflow, provides clinical decision support, and facilitates the timely flow of information among patients and healthcare professionals.
- ONC should require health IT vendors to meet standards for interoperability among different health IT systems to support effective, efficient, and structured flow of patient information across care settings by 2018.
- The Secretary of Health and Human Services should require health IT vendors to routinely submit their products for independent evaluation and notify users about potential adverse effects on the diagnostic process related to the use of their products.

Goal 4: Identifying, learning from, and reducing errors
Due to the difficulty in identifying diagnostic errors and competing demands from existing quality and safety improvement priorities, very few healthcare organizations have processes in place to identify diagnostic errors and near misses (i.e., failures in the diagnostic process that do not lead to diagnostic errors), says the committee. The committee recommends:

- Accreditation organizations and the Medicare conditions of participation should require that healthcare organizations have programs in place to monitor the diagnostic process and identify, learn from, and reduce diagnostic errors and near misses in a timely fashion.
- Healthcare organizations should monitor the diagnostic process and identify, learn from and reduce diagnostic errors and near misses as a component of their research, quality improvement, and patient safety programs; and implement procedures and practices to provide systematic feedback on diagnostic performance to healthcare professionals, care teams, and clinical and organizational leaders.
- The Department of Health and Human Services should provide funding for a subset of healthcare systems to conduct routine postmortem examinations on a representative sample of patient deaths.
- Healthcare professional societies should identify opportunities to improve accurate and timely diagnoses and reduce diagnostic errors in their specialties.

Goal 5: Work system and culture
The culture and leadership of healthcare organizations are key factors in ensuring continuous learning in the diagnostic process. The committee recommends that healthcare organizations:

- Adopt policies and practices that promote a non-punitive culture, which values open discussion and feedback on diagnostic performance.
- Design the work system in which the diagnostic process occurs to support the work and activities of patients, their families, and healthcare professionals, and to facilitate accurate and timely diagnoses.
- Develop and implement processes to ensure effective and timely communication between diagnostic testing healthcare professionals and treating healthcare professionals.

Goal 6: Reporting environment
Conducting analyses of diagnostic errors, near misses, and adverse events presents the best opportunity to learn from such experiences and implement changes, according to the NAS committee. But the environment must be safe – without the threat of legal discovery or disciplinary action. The NAS recommends:

- The Agency for Healthcare Research and Quality (AHRQ) or other appropriate agencies or independent entities should facilitate the voluntary reporting of diagnostic errors and near misses.
- AHRQ should evaluate the effectiveness of patient safety organizations (PSOs) as a major mechanism for voluntary reporting and learning from these events.
- States, in collaboration with other stakeholders (healthcare organizations, professional liability insurance carriers, state and federal policy makers, patient advocacy groups, and medical malpractice plaintiff and defense attorneys), should promote a legal environment that facilitates the timely identification, disclosure and learning from diagnostic errors. Specifically, they
should encourage the adoption of communication and resolution programs with legal protections for disclosures and apologies under state laws; and conduct demonstration projects of alternative approaches to the resolution of medical injuries, including administrative health courts and safe harbors for adherence to evidence-based clinical practice guidelines.

- Professional liability insurance carriers and captive insurers should collaborate with healthcare professionals on opportunities to improve diagnostic performance through education, training, and practice improvement approaches.

Goal 7: Fee-for-service payment

Fee-for-service reimbursement lacks financial incentives to coordinate care among clinicians. However, as long as fee-for-service remains the predominant payment mechanism, the NAS recommends that the Centers for Medicare & Medicaid Services and other payers:

- Create current procedural terminology (CPT) codes and provide coverage for additional evaluation and management activities not currently coded or covered, including time spent by pathologists, radiologists, and other clinicians in advising ordering clinicians on the selection, use, and interpretation of diagnostic testing for specific patients.
- Reorient relative value fees to more appropriately value the time spent with patients in evaluation and management (E&M) activities.
- Modify documentation guidelines for evaluation and management services to improve the accuracy of information in the electronic health record and to support decision-making in the diagnostic process.
- Assess the impact of payment and care delivery models on the diagnostic process, the occurrence of diagnostic errors, and learning from these errors.

Goal 8: Dedicated funding

The NAS recommends that the federal government pursue and encourage opportunities for public–private partnerships among a broad range of stakeholders, such as the Patient-Centered Outcomes Research Institute, foundations, the diagnostic testing and health information technology industries, health care organizations, and professional liability insurers to support research on the diagnostic process and diagnostic errors.

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• A conservative estimate found that 5 percent of U.S. adults who seek outpatient care each year experience a diagnostic error.
• Postmortem examination research spanning decades has shown that diagnostic errors contribute to approximately 10 percent of patient deaths.
• Medical record reviews suggest that diagnostic errors account for 6 to 17 percent of hospital adverse events.
• Diagnostic errors are the leading type of paid medical malpractice claims, are almost twice as likely to have resulted in the patient’s death compared to other claims, and represent the highest proportion of total payments.

Source: Improving Diagnosis in Health Care, Sept. National Academies of Sciences, Engineering and Medicine

The good news about new payment models

New payment models probably will have an impact – a positive one, at that – on diagnostic processes, says the National Academies of Science, Engineering and Medicine in its report, Improving Diagnosis in Health Care.

Global payment, capitation, per-member-per-month
Definition: A single per-member-per-month payment is made for all services delivered to a patient, with payment adjustments based on measured performance and patient risk.
Potential impact on diagnosis: Broader adoption could enhance provider activities that improve diagnostic accuracy and reduce diagnostic errors, because the capitated, at-risk organization bears the cost of diagnostic error if there are immediate costs associated with the error.

Accountable care organizations (ACOs)
Definition: Groups of providers that voluntarily assume responsibility for the care of a population of patients.
Potential impact on diagnosis: The quality of care in accountable care organizations (ACOs) is assessed through a set of quality measures, though none of them involve accuracy or timeliness of diagnosis. Even so, ACOs have the potential infrastructure to provide a base of activity to improve diagnostic accuracy for their constituent or affiliated clinicians.

Bundled payment or episode-based payment
Definition: A single “bundled” payment, which may include multiple providers in multiple care settings, is made for services delivered during an episode of care related to a medical condition or procedure.
Potential impact on diagnosis: By definition, bundled payment would seem to apply mostly to well-established, “correct” diagnoses, for which efficiencies of care can be further gained. However, bundled payment remains volume-based, that is, the financial incentive is to produce more, efficiently provided episodes. This raises the importance of addressing appropriateness of the bundled episode procedure being performed. Appropriateness is relevant to the topic of diagnostic error in the sense of needing to determine acuity of the condition as part of the diagnostic process.

Pay-for-performance, or value-based purchasing
Definition: Physicians receive differential payments for meeting or missing performance benchmarks
Potential impact on diagnosis: The effects of pay-for-performance on outcomes remain unsettled, with concerns about the effects on important elements of care that are not being measured. Current pushes for account-
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ability neglect performance measures for diagnosis, and that is a major limitation of these approaches.

**Patient-centered medical homes**

**Definition:** A physician practice or other provider is eligible to receive additional payments if medical home criteria are met.

**Potential impact on diagnosis:** A well-functioning medical home – with teamwork, longstanding relationships with patients as the center for care and care coordination, and improved electronic health records and interoperability of patient information – has the potential to improve diagnostic performance. There are concerns, however, that medical home performance will be assessed using measures that do not include those related to diagnostic performance, although it is known that diagnostic error is a significant problem in primary care.

**Shared savings**

**Definition:** A payment strategy that offers incentives for providers to reduce healthcare spending for a defined patient population by offering them a percentage of net savings realized as a result of their efforts.

**Potential impact on diagnosis:** There are no direct incentives to focus on improving diagnostic accuracy. The impact depends largely on the objectives of the underlying organization to which the payment is being applied. For example, shared savings has become the primary method for rewarding ACOs for spending less than a target spending amount. Theoretically, at least, the ACO should be interested in diagnostic accuracy if by getting the diagnosis correct, the ACO can reduce spending. So the focus would be on efforts to make correct diagnoses of acute, urgent presentations of illness in emergency departments and primary care practices and for commonly misdiagnosed conditions, such as stroke and congestive heart failure. Conversely, based on incentives alone, the organization might be less interested in efforts to make accurate and timely diagnoses of conditions whose costs would not be borne for many months or years. To date, little attention paid seems to be paid to diagnostic accuracy as a mechanism for achieving savings.

**Source:** Improving Diagnosis in Health Care, National Academies of Sciences, Engineering and Medicine
Screening mammography is effective in reducing deaths due to breast cancer among women ages 40 to 74 years, per the final recommendations on the subject published in January by the U.S. Preventive Services Task Force. But the greatest benefit of screening mammography occurs in women ages 50 to 74 years, and these women get the best balance of benefits to harms when screening is done every two years.

For women in their 40s, the Task Force found that mammography screening every two years can also be effective, and recommends that the decision to start screening should be an individual one, taking into account a woman’s health history, preferences, and how she values the potential benefits and harms. Women in their 40s who have a mother, sister, or daughter with breast cancer may benefit more than average-risk women by beginning screening before age 50.

While the Task Force noted that screening mammography is effective in reducing deaths from breast cancer for women in their 40s, the likelihood of benefit is less than for older women and the potential harms proportionally greater. The most serious potential harm of mammography screening is unneeded treatment for a type of cancer that would not have become a threat to a woman’s health during her lifetime; the most common is a false-positive test result, which often leads to additional tests and procedures and may lead to anxiety and stress.

The Task Force identified a number of areas where additional research is needed to better understand how screening might reduce breast cancer deaths. Specifically, the Task Force concluded that evidence is insufficient to determine the balance of benefits and harms in three areas:

- The benefits and harms of screening women age 75 and older.
- Adjunctive screening in women with dense breasts.
- The effectiveness of 3-D mammography for the detection of breast cancer.

The Task Force does not make recommendations for or against insurance coverage; coverage decisions are the responsibility of payers, regulators and legislators. Legislators recently extended a guarantee that women who have private insurance, beginning at age 40, will not have a co-pay for their screening mammogram.

The Task Force – an independent, volunteer panel of experts in evidence-based medicine – conducted a review of the science on the benefits and harms of screening mammography, and reviewed input received from the public and healthcare professionals on its 2015 draft recommendation. It examined the evidence on women who were not known to be at increased risk of breast cancer. The recommendation statement was published in Annals of Internal Medicine.
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As the role of nursing homes grows, so too does the need for infection prevention in post-acute healthcare. Over 3 million Americans receive care in U.S. nursing homes each year, according to the Centers for Medicare & Medicaid Services (CMS). The agency estimates that:

- Between 1 to 3 million serious infections occur every year in these facilities.
- Common infections include urinary tract, diarrheal diseases, antibiotic-resistant staphylococcal infections and other multi-drug-resistant organisms.
- Infections are a major cause of hospitalization and death; as many as 380,000 people die from infections in nursing homes each year.

These facts – and the recent U.S. experience with Ebola – have highlighted the importance of infection prevention programs in protecting both healthcare personnel and patients, notes CMS. “Translating lessons learned from the Ebola outbreak, including the importance of core infection prevention practices, to every setting where individuals receive healthcare is a significant opportunity to increase the safety of U.S. healthcare facilities,” it states. With funding from the Centers for Disease Control and Prevention (CDC), CMS has begun a three-year pilot project to meet identified joint priorities related to assessing the continuum of infection prevention efforts between hospitals and nursing homes, in order to prevent transmission of infections in both settings.

**Pilot surveys to assess LTC compliance**

CMS plans to use a national contractor to perform educational pilot surveys designed to assess the continuum of infection prevention efforts spanning hospitals and nursing homes. While no citations...
will be issued, if an immediate Jeopardy deficiency is noted, a referral to the CMS Regional Office will be made, according to the agency.

“The surveys will provide nursing homes and hospitals with guidance on improving infection prevention within their catchment area,” CMS states. “Starting in fiscal year 2016, a pilot nursing home surveyor infection control worksheet (ICWS) and pilot survey process, in collaboration with CDC, will better assess compliance with long-term-care facility infection control requirements that CMS published in 2015 in a Notice of Proposed Rule-Making. To the extent that such requirements are published in final form, we believe that these educational surveys will help the nursing homes become more prepared and help CMS and the CDC develop training materials for both nursing homes and surveyors.” In 2017, CMS anticipates the educational surveys will be conducted in both hospitals and nursing homes.

Once the survey findings have been determined, a team of infection prevention professionals will use that to develop an action plan for improvement, as well as organize on-site technical assistance. When necessary, there will be follow-up visits for technical assistance, and the long-term impact may be measured using CDC’s National Healthcare Safety Network data, says CMS, adding that its long-term goal is “improved surveyor infection control tools and survey processes to optimize infection control.”

CMS expects to communicate regularly with the CDC and state survey agencies throughout the three-year pilot. At press time, CMS had yet to identify the facilities selected to participate in the program.


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Infections are a major cause of hospitalization and death; as many as 380,000 people die from infections in nursing homes each year.
Eight years ago, the University of Alabama at Birmingham’s School of Business began its Medical Equipment and Supplies Distribution track – a unique opportunity for future distributor sales reps to learn skills for success. (See July 2008 Repertoire.) Since then, the program has evolved to become even more relevant to today’s medical sales industry.

“Many companies that did not typically hire college graduates are finding that the graduates from our medical distribution program are just as effective as those with [professional sales] experience,” says Thomas E. DeCarlo, PhD, Ben S. Weil Endowed Chair in Industrial Distribution.

In 2013, UAB created a two-course sequence that pairs sales distribution students with biomedical students. In the first semester, students work to enhance and develop medical products and devices. During the second semester, they develop marketing and sales strategies for those products.

“These are real products that have been developed at UAB,” says DeCarlo, adding that eventually the school hopes to obtain patents on the products. “These courses extend our students’ expertise beyond the classroom or into getting a basic understanding of what it takes to develop and launch new products.”

Distribution Program Manager Kristen Craig adds that this course sequence allows students the opportunity to develop a solution that is “real-time,” rather than a case study or retrospective look at what a company did to solve a problem. The students get to work with actual clinicians to solve real issues, she says.

Simulated OR

Last year, the medical distribution program formed a partnership with UAB’s Office of Interprofessional Simulation for Innovative Clinical Practice (OIPS) to offer students hands-on learning and actual marketing experience. OIPS is an enterprise-wide umbrella organization at UAB that oversees, develops, and supports interprofessional clinical simulation experiences. OIPS partners with practicing clinicians in the hospital, as well as with faculty in all schools across campus to develop interactive learning experiences, hands-on training, immersive simulations, and a variety of other educational modalities to foster an environment of safe-learning in the simulated setting.

Simulated OR allows UAB students to take a dry run at medical sales

By David Thill

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The goal of the new partnership is threefold, says DeCarlo. First, it provides a setting—other than the high-pressure OR or physician’s office—in which distributor reps can demonstrate new products and technologies to doctors, nurses, and other medical professionals. Second, it gives medical distribution students a chance to see “firsthand, how those presentations change based on the audience.” And third, it provides students an opportunity to set up visits to the lab by medical distributors and manufacturers. “We hope it will provide opportunities for students to build relationships with company representatives,” he says.

Dr. Marjorie White, the director of OIPS and the vice president for simulation in the UAB Health System, adds that “the partnership with the medical distribution program helps us to bridge the gap between our mission of providing state-of-the-art simulation-based learning for UAB’s healthcare providers and cutting-edge medical device companies.” Simulation labs have often been used as a place for product testing and demonstrations, and UAB’s simulation labs are no stranger to that. So this was a very organic symbiotic relationship.

“Many companies that did not typically hire college graduates are finding that the graduates from our medical distribution program are just as effective as those with [professional sales] experience.”

– Thomas E. DeCarlo, PhD, Ben S. Weil Endowed Chair in Industrial Distribution

Craig points out that while simulated settings have long been used to train healthcare professionals, “when you integrate [our medical distribution] students, it grounds their education in one more concrete way.

“These are the unique opportunities that make the young professionals qualified, which in turn makes companies more likely to hire them,” she says. “It is a transformation [in the] training of young professionals.”

Craig says that the simulation experience will serve as a training ground and a new line of communication between distributor reps and manufacturing reps. “It is a great synergy between the manufacturer and distributor,” she notes, as the manufacturer trains the distributor in the use of the product, and the distributor in turn demonstrates the product’s use to the doctors and other professionals.

Currently, the lab re-creates the OR and the clinical lab environment, says DeCarlo. In the future, it will be modified to depict other aspects of the typical acute-care and non-acute-care facility, from surgery and clinical work to purchasing and billing.

“Think of how unique it would be [for students] to have the opportunity to interact with purchasing agents” in a simulated setting, says Craig. By doing so, students will get to see “what it takes to get a sale through…to have that holistic perception of what they would be facing in the industry.”

In short, says DeCarlo, the medical distribution track’s partnership with OIPS provides for better training: “for better opportunities to learn by doing.”

Companies interested in learning more about partnerships with the UAB Office of Interprofessional Simulation should contact Dr. White (mlwhite@uab.edu), or Dr. DeCarlo (tdecarlo@uab.edu).
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The year 2015 ended on a bright note for manufacturers of medical products and equipment, as President Obama signed into law the Protecting Americans from Tax Hike (PATH) Act of 2015.

Provisions of special interest to the supply chain community include:
• A two-year moratorium of the 2.3 percent medical device tax.
• Extension of bonus depreciation through 2019.
• The permanent extension of the $500,000 expensing deduction per Section 179.

Repertoire asked a handful of manufacturers and distributors for their reactions to PATH. Responding were:
• Cindy Juhas, chief strategy officer, Hospital Associates, a division of Claflin Medical Equipment.
• David Bussa, executive vice president, The Brewer Company.
• John J. Greisch, president and CEO, Hill-Rom.
• Heather Llorca-Kropp, vice president of marketing communications and channel management, DUKAL.

Repertoire: Please talk about the effect the medical device tax had on your company since it went into effect Jan 1, 2013. How has it affected you and your end-user customers?

Cindy Juhas: Unfortunately, many of the manufacturers already raised prices to account for that tax. I doubt very much they will go ahead and lower prices. So I don’t see much of a benefit for distribution or end-users. Manufacturers can now start innovating again, because many said this tax crunch affected their R&D.

David Bussa: The device tax had a significant impact on the entire medical device manufacturing community. It required cost reductions to offset the costs it imposed. One of the fundamental challenges it presented was that it was revenue-based. Regardless of a corporation’s profitability, it was obligated to pay the tax. Startups were especially hard-hit, but established manufacturers also were impacted as new product design budgets had to accommodate the expense in their modeling. In addition, price increases to offset the tax were not accepted and the manufacturers solely bore the costs.
Heather Llorca-Kropp: The implementation of the medical device tax only affected certain products in our product line; however, the products in question were highly commoditized and contracted, which impacted our margins on those products. DUKAL did not pass this tax on to our customers, so it did not impact our top-line business – only our bottom line. It was unfortunate that the tax was so widespread and encompassing of products like ours, which carry low margins. This was not well thought out; at other companies in our industry, many good people lost their jobs who had a higher percentage of product impacted.

Repertoire: How do you plan to take advantage of the two-year moratorium, which began Jan. 1, 2016, and ends Dec. 31, 2017?

Bussa: We will reinvest the funds into new product and program innovations.

John Greisch: Our work to develop new technologies depends on our ability to take calculated risks and make strategic investments – efforts challenged by the medical device excise tax, which stifles innovation and reduces our ability to invest in R&D. Hill-Rom and Welch Allyn are grateful that Congress passed a two-year reprieve. On behalf of the patients we serve, the providers who care for them, and the distributors who serve the industry, thank you to our friends in the U.S. Congress for taking the lead and ensuring this tax is no longer an impediment to developing important new medical technologies. We look forward to continue working together to permanently repeal this onerous tax.

Llorca-Kropp: The tax was not drastic enough for us to change any future business practices based on the savings – and the moratorium will just normalize our margins to where they should be. Our customers will not see any changes from us, since we opted not to adjust their pricing during the tax and we shouldered the cost.

Repertoire: Do you see any downside to the two-year moratorium?

Bussa: We don’t see any downside to the moratorium. The uncertainty of reinstatement is a concern, however. Therefore, we expect manufacturers to be very conservative when it comes to adding cost to their businesses to avoid having to make cuts again in the future.

Repertoire: What will be the impact of the extension of bonus depreciation through 2019?

Juhas: The 50 percent bonus depreciation part of the bill should help our customers immensely, especially those that depreciate all of the new equipment they are putting into their new facilities.

Repertoire: Regarding the permanent extension of the $500,000 limit in Section 179, what impact – if any – do you expect it to have on equipment sales?

Juhas: The Section 179 deduction should promote equipment purchases this year. So, if a customer takes advantage of these aspects of the bill [i.e., the bonus depreciation and Section 179 provision], it could promote increased purchases of equipment. I think this is a big year for construction in the medical marketplace, and customers either have budgets for growth and remodels, or they don’t. I don’t think this will affect the overall growth, but it certainly will help those organizations that are growing.

Bussa: As with the uncertainty in the duration of the device tax moratorium, the lack of confidence in Section 179 being extended had a negative impact on year-end spending. The extension is very positive for us and should help drive the purchase of capital goods in the future.

Repertoire: How can distributors use the PATH Act to increase their sales or improve their service to customers?

Bussa: Distributors can now educate their customers on the certainty of the 179 depreciation. It will make it easier for end users to make buying decisions. Again, with the moratorium on the device tax, distribution should see an uptick in product and program innovations from manufacturing, which will translate into new sales opportunities.
Suppliers were pleased with the two-year moratorium on the 2.3 percent medical device tax, a key provision of the PATH Act. How about buyers?

*Repertoire* asked Cathy Denning, RN, MSN, senior vice president, sourcing operations, Vizient Inc., for her take on it. Vizient is the name of the healthcare company and GPO(s) formerly known as VHA, UHC, Novation and MedAssets’ Spend and Clinical Resource Management.

*Repertoire*: Since Jan. 1, 2013, manufacturers of medical devices have been paying a 2.3 percent excise tax on their sales. Has this affected contracting pricing, if at all?  

**Cathy Denning:** Vizient’s position was, and continues to be, that paying the excise tax is the responsibility of the device manufacturer, not the device purchaser. When the excise tax was initially passed, many medical device manufacturers tried to pass it through to customers. Some manufacturers tried to add language into contracts up for bid to cover the tax. Others tried to lump it in with sales tax, which is collectible. We even had one manufacturer send a letter directly to customers who were utilizing a Vizient contract stating this was a required tax and they would begin adding it, as they do sales tax, to the negotiated price.

We were able to mitigate these tactics through our regular negotiation and contracting practices, which include fixed pricing over the term of the contract, an offer evaluation process that includes bid-to-bid and bid-to-market review, and the addition of language to our contract terms and conditions that explicitly states that sales tax is the only tax that may be collected from customers served under the Vizient contract.

*Repertoire*: The PATH Act put a two-year moratorium on the medical device tax beginning Jan. 1, 2016, and ending Dec. 31, 2017. What impact – if any – do you expect that to have on pricing?  

**Denning:** We are not anticipating manufacturers will voluntarily lower prices to reflect the tax moratorium. We will continue to expect the best contract value for members, and at a minimum, expect they will use those dollars to invest in product and service enhancements that benefit providers and the patients they serve.

*Repertoire*: Regarding the permanent extension of the $500,000 limit in Section 179, what impact – if any – do you expect it to have on contracting for capital equipment?  

**Denning:** Capital budgets continue to be impacted by the pressures of healthcare reform. Members are more conservative with their money, so the Section 179 deduction on qualifying purchases of capital equipment should bring some relief, especially for small to mid-size facilities.

Since 2005, Vizient has worked with contracted capital equipment suppliers to offer members quarterly savings opportunities via our national group buy program. In 2015, the average savings opportunity offered by participating capital equipment manufacturers was 40 percent off list price on specified products purchased within the quarter. Over the 10 years the program has been in place, these “group buys” have delivered $1 billion in savings to members on a wide range of capital equipment, including angio/cardiovascular equipment, CT equipment, MRI systems, patient monitors and ultrasound equipment. Combining the savings offered through Vizient’s group buys with the Section 179 deduction will enable more hospitals to invest in the capital equipment they need this year rather than delaying purchase to 2017.
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Top picks

The Wall Street Journal has introduced its top picks from the 2016 Consumer Electronics Show. The list includes:

HP EliteBook Folio G1. The Windows 10 laptop is said to be slimmer than Apple’s MacBook. HP’s newest business-targeted laptop squeezes a 12.5-inch screen into an aluminum shell that’s 0.47 inches thick — reportedly trimmer than an AA battery, and slightly thinner than the 12-inch MacBook’s 0.52-inch-thick body. And, while Apple has only one USB-C port for both power and wired connections, HP features two ports. The Folio can swing open 180 degrees, and HP claims its battery should last over 10 hours if the user selects the model with the HD screen. The device is scheduled to be available in March, starting at $999.

GreatCall Lively wearable. A wearable fitness and safety monitor for seniors, the Lively is designed to help both seniors and their families by combining Fitbit-like fitness

Quicks Bytes

Technology news

Put a ring on it

Neyya, a digital companion smart ring, offers women a mix of practical and fun. The smart ring allows the user to access her devices, such as a laptop or phone, with a simple tap and swipe. For instance, Neyya:

• Buzzes on the user’s finger to notify her of important calls or texts.
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The ring is available in Titanium (US $139) and Gold (US $179), in a variety of sizes. For more information on neyya and the neyya smart ring visit www.myneyya.com.
tracking with an always-on emergency service. Worn on the wrist or as a necklace, it pairs with a smartphone to gauge and report activity. A companion app offers daily challenges and virtual rewards for goals, and shares updates with family members. With a press of Lively’s emergency button, a service called 5Star responds. The device can also make a call if it senses a fall. The waterproof Lively reportedly lasts up to six months on a charge and costs $100, plus $15 a month for emergency service. greatcall.com

**SensorWake.** An olfactory alarm clock, the clock’s alarm is a little hatch that spritzes fragrance until one shuts it off. SensorWake’s makers say their scents wake 99 percent of sleepers in two minutes, the key being pleasant yet jarring fragrances such as peppermint, chocolate and coffee. SensorWake is now working with Swiss fragrance manufacturer Givaudan on the hyper-concentrated scents. A two-scent pack costs $10.90, and is good for 60 wake-ups. SensorWake is taking pre-orders for $109, and intends to ship in June. sensorwake.com

**4Moms Car Seat.** A self-installing baby seat, 4mom’s smart car seat is designed for babies weighing 4 to 30 lbs, and features dual LCD screens and speakers in the seat, to help guide one through the installation process. Once the base is connected to the car’s metal clips, it automatically levels itself and audibly confirms that all is safe and sound. The seat includes a peekaboo canopy, a pop-up sun shade and an adjustable headrest. It is expected to be available in June for $500. 4moms.com

**PetChatz HD With PawCall.** A two-way video-conferencing system for pets, the PetChatz HD camera has two-way video chat and an app-controlled treat dispenser. Recently the manufacturers added the PawCall accessory, which lets one’s pet initiate the call. When the pet-safe button is pressed, the owner receives a request on his or her smartphone or computer for a quick woof or meow! The PetChatz HD system is costs $380, and PawCall is available for an additional $100. petchatz.com

**Digitsole Smartshoe.** By pairing a smartphone with Digitsole’s Smartshoe, one can wirelessly control the temperature of the insole, adjust the shoe for a snugger fit and even turn on a built-in flashlight. The shoe tracks the user’s step count to calculate calories burned and distance walked. In addition, it offers built-in wireless charging. Even when the user is away from the charging mat, the smartshoe reportedly works for multiple days on a charge. Smartshoe is expected to be available by the fall of 2016 for $450 a pair. digitsole.com

**Fitbit Blaze.** A fitness-focused smartwatch, Blaze combines the company’s workout tracking with smartwatch features, including a high-resolution color touchscreen, continuous heart-rate tracking and on-screen workouts from FitStar. (It relies on the user’s smartphone for GPS tracking.) Fitbit is promising up to five days of battery life, all at a cost of $200. fitbit.com

**Bartesian Cocktail Machine.** A pod-based mixed-drink maker, Bartesian works much like a Keurig coffee maker. Users pop in a capsule and select a desired strength, and the robot bartender prepares one of potentially hundreds of cocktails. The Bartesian draws on four containers filled with rum, vodka, tequila and gin. The capsules, which come in such flavors as Cosmopolitan and Zest Martini, contain the bitters, juices and other flavors needed to complete the cocktail. No shaking or stirring is required. Bartesian costs $300, plus $20 for a mixed pack of 12 capsules, and is expected to ship in the spring. bartesian.com

**Lego Education WeDo.** Lego Education WeDo 2.0 – a wireless update to a system that launched in 2009 – is designed to teach children to build tiny robots, while challenging them to solve real-world science problems with coding and bricks. The system includes an electronic building brick, a motion sensor and a motor, as well as a wireless hub. Projects are open-ended. For instance, children are asked to design a device that could mitigate devastation in a storm-damaged region. Unlike Lego Mindstorms, which are designed for middle schoolers, WeDo aims at younger children aged 7 and 8. While $160 kits are targeted for schools, they are available to families as well. education.lego.com

**Variowell smart bed.** A mattress that responds to one’s fitness tracker? With Variowell’s smart bed, the mattress connects to smartwatches and fitness trackers, and adjusts its firmness based on the user’s real time sleep stage. In light sleep, it firms up. In deep sleep, it softens to make sure the user is most comfortable. Before one wakes up, it becomes firm again. If the user prefers, he or she can adjust the firmness manually, using a smartphone app. The system is scheduled to be available in May. variowell-development.com

For more information on top picks from the 2016 Consumer Electronics Show visit www.wsjonline.com.
The rule of thumb that traditionally has banned politics from the workplace appears to be wearing down, according to a Chicago Tribune column by Rex W. Huppke. So, given this is a campaign year, don't be surprised if a debate finds its way into your office.

But, that's not to say the office climate should or will heat up, notes Huppke. If colleagues remain respectful of one another, there's little reason this topic needs to remain taboo. In fact, “If you can't have a tough conversation with a co-worker, how are you going to have tough conversations with clients or customers?” he points out. He references a book written by longtime mediators, Louise Phipps Senft and William Senft – Being Relational: The Seven Ways to Quality Interaction & Lasting Change. The authors believe that, contrary to traditional beliefs that certain topics should be considered off-limits in polite conversation, “We need to talk about these topics and learn how to do it well, without having it become a problem.”

As with many behaviors that don't come naturally, the more we do it, the better we get, note the authors. “Having these conversations with people who work together will make their ability to deal with issues at work much easier,” say Senft and Senft.

Huppke speaks to the authors about the best approach co-workers should take when approached by a colleague who wishes to talk about the presidential campaign. First, determine whether the setting is right for the discussion at hand. Can you give the topic your full attention and completely engage your colleague? “Set the stage for a quality conversation,” the authors point out. “A discussion on a controversial subject can't just be a couple of comments in the hallway,” adds Huppke. “You need time to listen to each other and show an interest in what the other person is saying.” If that's not possible, Senft and Senft recommend meeting over lunch to continue the discussion.

Being truly engaged in a discussion calls for “a little bit of generosity and humility and a willingness to be attentive to the other person, and hope that they're attentive to you,” says Huppke, paraphrasing the authors. This means being open to the possibility that we are not always right. According to the authors, “You are really trying to look hard at your own assumptions and beliefs and [ask] yourself, ‘Do I really know that to be true? How do I know that? Could there be information that I don't have that I need to be more informed?’”

It's important to remember that this is a conversation or friendly discussion, not a competition, note the authors. “Quality dialogue is not a competitive process,” they say. “That doesn't mean you give up on persuading other people. It means you're being open and generally willing to consider other people's arguments.

While there’s no guarantee that a political discussion will end well, following the authors’ suggestions at least presents a possibility for a positive outcome, notes Huppke. In fact, he points out, you might even learn something.

For sales reps who make it their business to listen and learn from their customers, that's not a bad approach. [Source: Chicago Tribune, December 7, 2015.]
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Chances are you spend a lot of time in your car. Here’s something that might help you appreciate your home-away-from-home a little more.

Automotive-related news

Driverless Cars
Car makers and suppliers appear to be committed to putting more autonomous – or driverless – cars on the road. Recently, chip maker Nvidia Corp. made an announcement about deepening its commitment to driverless vehicles. The company said it has built a new computer for autonomous cars that has the computing power equivalent to 150 Apple MacBook Pro laptops, and is about the size of a lunch-box. The new computer is required to process the massive amount of data coming through sensors on autonomous vehicles. In other news, Toyota is building a 200-person company designed to advance automated driving and other artificial intelligence. The new company may seek to commercialize products outside of autos that relate to artificial intelligence. In fact, the word is that Toyota plans to introduce an autonomous highway-driving system around 2020, although it hasn’t committed to a fully autonomous vehicle usable in all conditions. At the same time, Tesla Motors chief executive Elon Musk has tried to recruit software engineers to work on autonomous vehicles, and Ford Motor Co. said it plans to triple the number of autonomous Ford Fusion sedans it is testing. Ford also announced it is implementing a new advanced laser range finder from supplier Velodyne Acoustics, which can be hidden in side-view mirrors. General Motors Co. said it has a partnership with Mobileye NV, a maker of a camera-based vision system for lane and object detection used in autonomous vehicles. GM vehicles, which are connected to servers through its OnStar system, can feed information about roadways and traffic back to Mobileye, which can then constantly create new maps that are then sent back to autonomous vehicles to help them navigate the world. Google Inc., meanwhile, has been working on autonomous driving systems since 2009.

Vegan cars?
Tesla’s luxury electric vehicles are considered an eco-conscious choice for car buyers – or are they? For some, the leather in the seats and steering wheel requires slaughtering animals. Yet, the cloth substitute doesn’t quite measure up for a vehicle that can cost more than $100,000. In response, Tesla has introduced synthetic leather seats and steering wheels in its the new Model X sport utility vehicle. The carmaker is not alone. In recent years, BMW, Mercedes-Benz, Lexus and Ferrari have begun offering models with faux leather seating, and Volvo and Ford have increasingly emphasized the use of more natural components, such as soy foam, in their seats. Still, as the push to reduce carbon dioxide emissions leads to the use of new energy sources, it may become increasingly difficult to avoid animal products. Biofuels aimed at reducing carbon dioxide emissions (such as those United Airlines announced last year it would start using) are sometimes...
derived from animal fats. And the use of animal-based food waste to make electricity and fuel is on the rise in

**Mainstream electric**

General Motors recently introduced its Chevrolet Bolt at the Consumer Electronics Show in California — the automaker's latest electric vehicle aimed in part at making inroads with the brand in California and urban areas. GM has positioned the Bolt — which reportedly has a range of 200 miles — as a mainstream electric vehicle that will further the automaker’s technological bona fides. GM has said in the past that the car would be priced roughly at $38,000 and cost owners around $30,000 after the federal $7,500 income-tax rebate for electric car purchases. The car features one-pedal driving mode and saved settings for multiple drivers controlled through their smartphones. GM has stated that looming uncertainty over the direction of fuel prices, and stringent U.S. regulations calling for automakers to eventually sell vehicles together averaging nearly 55 miles a gallon, underpin the company’s bet on the Bolt. In addition, California requires automakers to sell so-called zero-emissions vehicles.

**Collision course**

Federal auto safety officials in Detroit, Mich., recently indicated the National Highway Traffic Safety Administration (NHTSA) agency is willing to allow auto manufacturers to detour U.S. motor vehicle laws and regulations, particularly for unproven robot cars. At press time, NHTSA was expected to announce an industry-government consortium aimed at putting safety breakthroughs into production faster than would happen through the traditional rule-making process. Not everyone was pleased with the prospect. Non-profit citizen organization Consumer Watchdog said it would be a “wrong turn.” Given the multiple instances of deadly defective cars, the number of recalls, the recent Volkswagen scandal and the recent report that Google’s robot cars have had hundreds of near misses, it’s imperative that the National Highway Traffic Safety Administration maintain its responsibility to enforce auto safety through binding safety rules, notes Harvey Rosenfield, founder of Consumer Watchdog. Consumer Watchdog and other leading consumer safety advocates have formally petitioned NHTSA to issue a safety rule requiring auto companies to install new braking technologies as standard equipment. In addition, the consumer advocates caution that autonomous (driverless) vehicles pose unprecedented safety, privacy and ethical questions.

**Safe phoning**

The 2017 Hyundai Elantra will be compatible with Apple CarPlay and Android Auto™. Both smartphone integrations will be available on the 2017 Elantra’s seven-inch Display Audio touchscreen system, with rearview camera and Hyundai’s eight-inch touchscreen navigation system, which includes voice texting, access to music stored on the phone and third-party audio apps. CarPlay support is designed to enable drivers to make calls, get directions optimized for traffic conditions, listen to music and access messages. With CarPlay, Siri provides drivers an eyes-free experience by responding to requests through voice commands accessed through the steering wheel’s voice button. Using a Lightning connector, CarPlay works with iPhone 5 and current models running the iOS 7.1 or higher operating systems. (Elantra provides an available second USB port for charging.) Elantra is also compatible with Android Auto for seamless and intuitive operation of commonly used smartphone functions, including navigation with Google Maps™, streaming audio, voice-controlled search capabilities and over 40 approved smartphone apps. Android Auto is compatible with Android phones running Android 5.0, Lollipop or higher.
When Monty Wallin joined the medical products sales profession 38 years ago, the industry looked nothing as it does today. “When I started, we were trained differently than today,” he explains. “Nothing was automated. We hand-wrote our orders. Inventory was kept in a ‘cardex system,’ which was also managed manually. Technology today provides reps so much data that was not available to us back then. It’s simply a different environment.”

Not only that, disposable products were a novelty, group purchasing organizations had yet to define themselves and a multitude of medical products distributors populated the healthcare landscape, he points out.

A college graduate with a degree in education, Wallin’s decision to forego teaching for a sales position was a leap of faith. “I found healthcare interesting, and I applied to a few hospitals for materials jobs,” he says. A friend who worked in distribution got him an interview at American Hospital Supply (now Cardinal Health), and he joined the company in September 1977. “There were very few disposable products at that time,” he recalls. “Exam and surgeon gloves were washed, powdered and sterilized. We sold glass syringes and reusable needles that had to be sharpened by hand when they got dull. Surgical drapes and gowns were reusable and had to be washed, de-linted and sterilized.”

Wallin spent much of the next four decades adapting to continuous changes in healthcare, from growth in technology to industry regulation and consolidation. “We saw the real birth of group purchasing organizations and watched as Diagnosis Related Groups (DRGs) changed the way hospitals were reimbursed,” he says. “Margins were driven down to all-time lows, even while customers expected the same excellent service they were used to.”

“There are far fewer distributors now, due to increased consolidation,” he continues. “Manufacturers, too, are consolidating and becoming increasingly larger. Cardinal Health is a unique company in that we are both a distributor and a manufacturer. Of course, it is extremely important for us to maintain strong relationships with our vendor partners despite these ongoing changes.” In fact, while the Internet, email and social media have made it easier for reps to communicate with customers, they also have led to a decrease in face-to-face contact with physician and hospital customers – something he considers essential to building strong relationships.

Being a successful sales rep is about meeting challenges head on and learning from those challenges, Wallin points out – something that has “helped me become the customer-focused sales professional and partner I am today.”

A humbling experience

In 1989, Wallin and his wife, Nyla, took their healthcare connection to a new level and began mission work in Haiti, followed by 12 years of missions in Jamaica. In 2003, they joined a ministry called Savior’s Tear – an organization that provides free medical care to underprivileged people in Nicaragua.
“We bus people to our clinic location and provide free medical care, medicine, glasses and food to everyone who comes,” he says. “Over the years, we’ve had hundreds of volunteers join our teams and have provided care to thousands of needy families.”

Each trip is eight days long, including a day of travel at the beginning and end of the trip. Wallin and his wife partner as team leaders. “We make all of the travel arrangements, book the hotel and organize our ground transportation during the stay. I order all of our medical supplies and pharmaceuticals for the trip, as well as make arrangements for the two to three tons of food we give away every year.

A typical clinic day runs from 8:30 a.m. until 5:30 or 6 p.m. The last few years, we’ve been fortunate enough to have three doctors go with us, as well as four to five nurses. The rest of our team includes volunteers from all walks of life.

On a typical day, we will see about 300 patients, which can vary from newborns to elderly.

“We host the clinic for five days and end the trip with a free day to relax and enjoy the local environment,” he says. “We stay in a nice hotel where the food is good, because the days are very long and very hot. Thus, it’s helpful to have a nice place to unwind, regroup and prepare to serve the next day.

“There is no describing the blessings we receive as team volunteers when we organize these trips. It can literally change a person’s life.”

Regional Territory Sales Representatives Wanted

Hemosure, Inc. is a privately held company headquartered in CA; we are dedicated to saving lives and educating patients on the importance of getting screened for colorectal cancer.

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If you are interested in this opportunity submit your resume to: hr@hemosure.com or give us a call at (626) 443-8480.
Court Square Capital Partners gains equity interest in NDC
Silver Oak Services Partners LLC (Evanston, IL) completed the sale of its equity interest in NDC (Nashville, TN) to Court Square Capital Partners (New York, NY), a private equity firm. NDC is a healthcare supply chain company and distributor of consumable medical supplies. It has more than 180 employees and operates distribution centers in Tennessee and Nevada. Details of the transaction were not disclosed.

Abbott to acquire Alere for $5.8B
Abbott (Abbott Park, IL) and Alere Inc (Waltham, MA) formed a definitive agreement whereby Abbott will acquire Alere. Under the terms of the agreement, Abbott will pay $56 per common share for a total expected equity value of $5.8 billion. The combined business will offer a broad point-of-care menu of infectious disease, molecular, cardiometabolic and toxicology testing, expanding Abbott’s platforms to include benchtop and rapid-strip tests. Upon completion of the transaction, Alere will become a subsidiary of Abbott. Alere’s net debt, currently $2.6 billion, will be assumed or refinanced by Abbott. The transaction has been approved by the boards of directors of Alere and Abbott and is subject to the approval of Alere shareholders and the satisfaction of customary closing conditions, including applicable regulatory approvals.

DUKAL Corp acquires select Albahealth products
DUKAL Corporation (Ronkonkoma, NY) acquired Albahealth LLC (Rockwood, TN) dressings. Under the agreement, DUKAL will own the Albahealth-branded product line to include Petroleum Gauze, Oil Emulsion Dressings, Xeroform Gauze, and Packing Strips. DUKAL will retain the Albahealth brand name on the product line in the short term. Terms and financial details of the transaction were not released.

Alfa Wassermann announces 2015 President’s Club winners
Alfa Wassermann Diagnostic Technologies (West Caldwell, NJ), announced its 2015 President’s Club winners. Business Development Managers Jennifer Kennedy of the West region, John Husted of the Midwest region, and Frank Pollock of the Mid-Atlantic region, have all received the President’s Club Award. President’s Club is the highest honor awarded to the top sales representatives in the 2015 calendar year.
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