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Clinical Pathways

What happens after discharge?

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When is the best time to sell equipment?

How about now?

As Repertoire Editor Mark Thill writes in this month’s cover story:

Traditionally, providers get highly motivated to buy equipment toward the end of their fiscal year, because they don’t want precious budgeted dollars to go to waste. To a large extent, that is still true, according to those with whom Repertoire spoke. Distributors should plan accordingly. But waiting until Q4 is waiting too long.

Yes, budgets play a huge role in the equipment purchasing decision, and selling equipment at the end of the year is something every distribution rep should focus on. However, just as important is an observation I noticed after listening to several top supply chain leaders during The Journal of Healthcare Contracting’s recent IDN West Summit. In fact, every speaker said almost the same thing.

“We are no longer interested in features and benefits, we buy outcomes.”

As the cover story points out, there are several people in the decision-making process. While these supply chain leaders want outcomes, the actual person using the equipment is still interested in features and benefits, and wants ease of use, as well as better patient satisfaction.

By this point you are probably saying “I don’t have the time or capacity for all of this!”

You probably don’t, but your manufacturing partner does. My challenge to you over the last five months of the year is the following: Put your equipment partners to work. Make it a goal to have at least one of them in one of your accounts each week from now until the end of the year. My guess is you will be happy you did.

Please send me (sadams@mdsi.org) some of your success stories as you close big deals by selling outcomes and utilizing your equipment partners.

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McKesson Medical-Surgical chose “Game On” for the theme of its springtime sales meeting in Grapevine, Texas, for two reasons: It signified the kick-off to its fiscal year for the sales team, and it marked the completion of the integration of PSS World Medical and the McKesson Medical-Surgical team. To bring home the point, the company celebrated its annual sales award winners at the Dallas Cowboys’ AT&T Stadium.

More than 1,300 members of the McKesson Medical-Surgical sales team attended, as well as 150 supplier partners.

Almost everyone in the business was involved in the integration of PSS, noted President Stanton McComb in a keynote address. So were McKesson Medical-Surgical’s customers, he said. With the integration complete, the company has already begun refocusing it resources, and customers are responding favorably, as demonstrated by the company’s steadily improving Net Promoter Scores®.

At the meeting, the company introduced its revamped business review tool, McKesson Business Analytics. The online tool allows reps to quickly, and in real time, analyze a customer’s business with the company and put together data to make recommendations for customers based on their patients’ needs and their ordering patterns.

Education sessions had a strong customer focus, designed to provide reps further insight into the everyday challenges facing their customers. And an internal trade-show gave reps face time with many of the McKesson Medical-Surgical teams with whom they interact.

Many members of the sales team were recognized for strong performances in fiscal year 2016. Supplier awards went to:

- **Alere:** Supplier of the Year – Primary Care
- **Drive Medical:** Supplier of the Year – Extended Care
- **Crosstek/SPS Medical:** McKesson Brands Supplier of the Year
- **Welch Allyn:** Supply Chain Partner of the Year
- **Will Sapp, director of distributor sales, Medtronic:** Supplier Contact of the Year
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Rising costs and an increasing emphasis on quality have forced doctors and hospital administrators to question the value of certain time-honored practices, particularly those that may be overused or do not provide meaningful benefit for patients. The result has been nationwide initiatives – such as the American Board of Internal Medicine’s “Choosing Wisely” campaign – to eliminate “low-value” practices.

In 2012, the University of Vermont Medical Center (UVMMC) in Burlington, Vt., took a unique approach to eliminate such practices, inviting its own team members to propose their ideas – based on their own experiences – to reduce harm, cut costs and, more importantly, improve patient care.

‘Agents of change’
The idea to approach bedside physicians for their opinions came from UVMMC Department of Medicine chair Polly Parsons, M.D., who heard of a similar American College of Physicians program in which faculty member Virginia Hood, M.D., professor of medicine in the department’s Division of Nephrology and Hypertension, had participated. From there, Parsons put out a call to unit directors for proposals of ways
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to change what they believed to be low-value practices.

“Within a week, the unit directors had asked their faculty, and already had over 20 ideas,” says Hood. These proposals were then submitted to the UVMMC Department of Medicine Operation Efficiency Committee, which reviewed them and determined which ones to carry forward.

With each faculty member serving as the “clinical champion” of their proposal, “they become agents of change in a collaborative discussion amongst colleagues about utilization,” says Justin Stinnett-Donnelly, M.D., a hospitalist at Central Vermont Medical Center. “It removes the dynamic of the ‘top-down’ approach.”

Hood notes that this program, while designed to change the culture of the medical environment overall, was especially aimed toward influencing the trainees in the College of Medicine – residents, fellows, medical students, etc. “The issue will never be sustained if we don’t have trainees [taking part] at an early stage,” she says.

With this goal in mind, says Stinnett-Donnelly, each clinical champion attached a trainee to their project team, along with a representative of the Jeffords Institute for Quality, which provided data analytics and project management for each project.

**Promoting efficiency**

Focusing on four projects a year, the Department of Medicine has now completed 12 projects, with a forthcoming request for new proposals.

Stinnett-Donnelly notes one that focused on reducing the frequency

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**History of ‘Choosing Wisely’**

In 2010 Howard Brody, M.D., published “Medicine’s Ethical Responsibility for Health Care Reform – The Top Five List” in the New England Journal of Medicine. In the piece, Brody called on U.S. medical specialty societies to identify five tests and treatments that were overused in their specialty and did not provide meaningful benefit for patients.

Shortly after that, the National Physicians Alliance (NPA) piloted the “Five Things” concept through an ABIM Foundation “Putting the Charter into Practice” grant, and created a set of three lists of specific steps physicians in internal medicine, family medicine, and pediatrics could take to promote the more effective use of healthcare resources. These lists were first published in Archives of Internal Medicine.

Building on the work of Brody and NPA, in April 2012 the ABIM Foundation, along with Consumer Reports, formally launched the Choosing Wisely campaign with the release of “Top Five” lists from nine specialty societies. Seventeen additional societies joined the campaign and released lists in February 2013. More than 70 societies comprising over one million clinicians are now partners of Choosing Wisely.

In 2013, the ABIM Foundation received a grant from the Robert Wood Johnson Foundation (RWJF) to advance the Choosing Wisely campaign by funding 21 state medical societies, specialty societies, and regional health collaboratives to help physicians and patients engage in conversations aimed at reducing unnecessary tests and procedures. In 2015, the RWJF awarded a second grant to the ABIM Foundation to continue this work.

**Source:** ABIM Foundation, www.choosingwisely.org/about-us/history
of routine morning chest X-rays. The project, which originated in the medical critical care unit, resulted in cutting the overall frequency of these X-rays by about 75 percent. This has not only saved money, but also improved patient care, as too much movement can be painful for patients and potentially cause ICU delirium. On top of that, the X-rays are often performed as early as 4:30 a.m., interrupting patients’ sleep. Making sure that only appropriate and necessary X-rays are ordered – as opposed to ordering them “reflexively” – helps improve patient experience.

Hood discusses an ongoing project focused on reducing lab test repetition. “Often, physicians don’t know what tests have been done [on the patient] or what the results were,” and consequently order tests that have already been completed. The goal of this project is for hospital systems to be able to recognize and record when a test has been done on a patient, so that, if a physician sends a request for that same test, the laboratory can simply send back the results from the earlier one. This saves money by reducing unneeded testing, but also serves as a model for laboratories in other specialty areas “to look at tests that were replicated when unnecessary,” she says.

**Doing what’s best for the patient**

Though it originated in the Department of Medicine, the administration hopes to extend this faculty-initiated project to other departments within UVMMC, including those of Gynecology, Family Medicine, and Radiology. “This is a hugely collaborative effort,” says Stinnett-Donnelly.

Hood believes that through collaboration among these departments, many low-value practices can be reduced. Ideally, trainees will participate in this inter-departmental collaboration, expanding the important educational component.

“What we’re trying to accomplish is to make sure that anyone who has ideas about where we can improve quality and reduce utilization” has the resources to do that, says Stinnett-Donnelly. It will continue to grow – possibly even extending to other institutions outside the university. “We’re learning as we evolve.”

“We see low-value practices as more than just costly practices,” says Hood. “We want to look at practices that actually lead to better patient outcomes and experiences. “We want to make it easier for physicians” to do the job they want to do, she continues. Simply put, that job is “to do what is best for the patient.”

David Thill is a contributing editor for Repertoire.
A major physicians’ group is calling on its members to address a condition that it believes is adversely affecting population health – climate change.

“The evidence for global climate change has been mounting for several decades, but over the past several years we are also seeing the manifestations through untoward health effects,” says Nitin Damle, M.D., MS, FACP, and current president of the American College of Physicians (ACP). “Our members are seeing increased rates of asthma and Chronic Obstructive Pulmonary Disease exacerbations, longer and more severe allergy seasons, effects of heat waves on vulnerable populations, and the spread of tick-borne and waterborne disease.

“As an organization that cares deeply about its patients, we felt it was important to make policymakers, patients, and legislators aware of the consequences and mitigation strategies.”

In its April 2016 position paper from the Annals of Internal Medicine, the ACP declared that it “strongly concurs with the finding of the Intergovernmental Panel on Climate Change (IPCC), which has stated that human influence on the climate system is clear.” Anthropogenic (human-caused) greenhouse gas emissions must be substantially curbed to hold the global average temperature increase under 2 °C (3.6 °F) above pre-industrial levels, as established in the 2015 Paris Agreement under the United Nations Framework Convention.

**Action needed**

Doctors, patients, and suppliers can all play a role in curbing greenhouse gas emissions and avoiding “devastating consequences for public and individual health,” according to the ACP.

For example, physician offices and hospitals can switch to energy efficient building designs, as well as solar and wind-powered energy sources, and reduce fleet emissions. Hospital vehicles can use efficient and alternative fuels. Recycling can help, and doctors can also choose suppliers with efficient or alternate-fuel standards. Patients can become advocates for clean energy and communicate with legislators and policymakers to encourage adoption of mitigation strategies.

Distributors should be aware of efficiency factors in the production and transportation of their products, adds Damle. “Use recycled products and materials, use vehicles with clean emissions, use local suppliers, [and] use waste conservation techniques.”

The ACP ends its position paper by referencing the Lancet Commission on Health and Climate Change, which states that addressing climate change could be the greatest global health opportunity of this century. “The medical profession – by being an objective and trusted source of information about the effect of climate change on health – must be at the fore of this opportunity to make Earth a sustainable home for future generations.”

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**Environmental Approach to Population Health?**

Physician group calls on providers and suppliers to act now in order to mitigate the effects on public health

By David Thill

Patients can become advocates for clean energy and communicate with legislators and policymakers to encourage adoption of mitigation strategies.

(Source: American College of Physicians Annals of Internal Medicine)

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David Thill is a contributing editor for Repertoire.
The American College of Physicians is calling on the healthcare sector to “implement environmentally sustainable and energy-efficient practices and prepare for the impacts of climate change to ensure continued operations during periods of elevated patient demand.”

Repertoire readers can direct their customers to a couple of resources cited by the ACP.

- My Green Doctor, a website supported by the World Medical Association, the Florida Medical Association, and the Florida Academy of Family Physicians, offers physicians free online materials and suggestions to make their offices, staff, and procedures more environmentally conscious, and encourage patients to do the same. These resources include a series of workbooks focusing on topics ranging from energy efficiency to drug disposal to transportation. There are also several resources, including a “sustainability policy” for offices to adopt, a blog on current events in healthcare and sustainable practices, and educational brochures that physicians can print for patients to read in their waiting rooms. (www.mygreendoctor.org)

- In 2014, the U.S. Department of Health and Human Services released “Primary Protection: Enhancing Health Care Resilience for a Changing Climate,” a tool kit for healthcare facilities with guidelines for how to respond to extreme weather. “Disruptions and losses incurred by the U.S. healthcare sector after recent extreme weather events strongly suggest that specific guidance on managing the new and evolving hazards presented by climate change is necessary,” according to HHS. The document provides background information about climate change and healthcare, as well as a five-element framework for healthcare facilities to follow to become resilient to the effects of climate change:

1. **Multi-hazard assessment – understanding climate risk:** Maintain current data on climate hazards and infrastructure vulnerabilities, and prepare infrastructure risk assessments.

2. **Land use planning, building design and regulation:** Understand the building regulatory, design, and land use planning context in which the facility is situated.

3. **Infrastructure protection and resilience:** Invest, design and construct new sustainable infrastructure in appropriate locations and to a higher standard of hazard and climate resilience to withstand future events.

4. **Protect vital facilities and functions:** Understand priority and vulnerable functional needs. (For example, hospitals must be able to provide essential services during and after a disaster.)

5. **Environmental protection and strengthening of ecosystems:** Protect ecosystems and natural buffers to mitigate floods, storm surges and other hazards to which the building, campus or city may be vulnerable.

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As technology and education evolve – particularly with the growing use of the Internet as a vital source of information – the responsibilities of physicians are becoming more complex. They are being asked to play leadership roles in healthcare teams and quality improvement initiatives, and to know more about health than just basic scientific and clinical factors. Economics, social determinants of health, and population health are just a few of the factors that form the basis of a new “third science.” Informally known as “health systems science,” it forms the basis of the new Primary Care-Population Medicine (PC-PM) program at Brown University’s Alpert Medical School in Providence, R.I.

Tomorrow’s leaders

August 2016 marks the one-year anniversary of the implementation of the school’s joint M.D.-ScM degree program. Students in the program learn about health disparities and social determinants of patients’ health, as well as the intersection of population and clinical medicine. Subjects such as advanced biostatistics, epidemiology, and healthcare leadership are integral parts of the curriculum. “These are the skills that are necessary to succeed as a physician in this rapidly evolving healthcare system,” says Paul George, M.D., MHPE, associate professor of family medicine at Alpert.
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Leadership is a core component of the new curriculum. “We hope graduates of the program will be practicing physicians who see patients, but also lead in some way,” says George. These leadership roles could range from leading a community health center, to being the chief medical officer at a large private practice, to leading a city or state public health department. Some graduates might become leaders in health systems science research, and still others may become leaders in education.

To get a taste of leadership, students have the opportunity to teach elective classes in the medical school. George notes that almost all of the PC-PM students will lead these classes at some point during the year. Some of the courses include Health Care in America, which focuses on the United States healthcare system; Leadership in the Health Professions, focusing on working in interprofessional teams; and Sex Ed by Brown Med, a high school sexual education class taught by Alpert medical students.

Population health is a key aspect of health systems science, so PC-PM students also have the opportunity to focus on special populations of their choosing. Paired with faculty mentors who share similar research interests, they are able to work with and learn more about these populations through their work. Some students so far have chosen to work with incarcerated patients, pediatric patients, and patients from the LGBTQ community. “Ideally, the students will be able to continue working with that population in residency and beyond,” says George.

Patient care in the long term
Alpert Medical School is currently piloting its longitudinal integrated clerkship (LIC), a long-term practicum that will eventually become a standard part of medical students’ education in the PC-PM program. According to a paper co-authored by George published in the *Rhode Island Medical Journal*, students in the LIC will have the opportunity to follow up to 30 patients over the course of a year, in each of six core areas: internal medicine, surgery, family medicine, pediatrics, obstetrics and gynecology, and integrated neurology and psychiatry.

By giving students this long-term exposure to patients, faculty hope to promote continuity of care with patients and the integration of population health with clinical medicine. The clerkship culminates in student projects focused on quality improvement, patient safety, and population medicine. According to the Journal article, while most medical students learn only about the care of individual patients, students in the Alpert Medical School LIC will be exposed to the intricacies of panel and population management, as population medicine is a major part of their medical school curriculum.

Leading change in education
Working in the American Medical Association’s “Accelerating Change in Medical Education” consortium “has been a very unique and wonderful opportunity,” says George. “We’ve been able to work with other schools to learn best practices about how to integrate cutting edge curriculum [components] into our own.”

George and his Brown colleagues recently co-authored a chapter in the “first textbook on health systems science,” written collectively by the consortium schools, a book they hope will be used at medical schools throughout the country. “Without the grant,” he says, “we wouldn’t have this collective expertise coming together … to change how we educate students for the better.”

David Thill is a contributing editor for Repertoire.
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Repertoire readers may be familiar with clinical pathways in the hospital – that is, well-researched, well-documented paths to providing care that result in optimum outcomes. But what about clinical pathways for patients following their hospital stay? When should that patient be discharged? And to what kind of facility, or perhaps home? For how long? And then what?

These are significant questions for payers, providers and distributors, as reimbursement methods change and post-acute-care costs continue to rise.

Post-acute spending is estimated to exceed $200 billion per year and is growing at approximately 6 percent annually, according to Cardinal Health. Proper discharge planning and post-acute care coordination reduces overall cost and variance in the healthcare system, which is important to providers and health plans participating in value-based payment models, including bundled-payment initiatives, the company says.

That’s one reason that naviHealth Inc., a Cardinal Health company, recently acquired Curaspan Health Group Inc., a provider of care transition tools for hospitals and post-acute-care providers.

Cardinal Health isn’t new to post-acute care. In 2013, for example, the company acquired AssuraMed, a provider of medical supplies to patients in the home. The company continues to operate through two separate businesses: Edgepark, a mail-order, direct-to-home provider of disposable medical supplies; and Independence Medical, a wholesale medical supplies distributor providing services to home health agencies, providers, retailers, and home medical equipment customers.
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In August 2015, Cardinal Health acquired a majority stake in naviHealth, a Nashville, Tenn.-based company that manages the post-acute-care segment of the care continuum for health plans, health systems and providers. naviHealth uses evidence-based protocols and technology to help optimize care plans and align all stakeholders, including providers and patients, according to Cardinal Health. At the time of the acquisition, naviHealth served 2 million health plan members and more than 75 hospitals and physician groups.

Four months later, in December 2015, naviHealth acquired RightCare Solutions, a healthcare decision support software service provider specializing in hospital discharge planning software and readmissions management. RightCare's software is powered by evidence-based decision-support technology developed in conjunction with the University of Pennsylvania School of Nursing, according to the company. RightCare licenses its software to hospitals and health systems to assess patients for post-acute care needs, determine risk of readmission, and coordinate patient discharges to post-acute care providers. The company also licenses its software to post-acute-care providers, allowing them to automate many of the administrative tasks involved in accepting referrals.

Curaspan, which Cardinal Health acquired in June 2016, is designed to automate transitions of care, create workflow efficiencies, reduce variation and optimize collaboration among providers as patients move from one site or mode of care to another.

The system is installed in more than 600 hospitals and has more than 8,000 post-discharge customers, including skilled nursing facilities, home health agencies, long-term acute-care hospitals, dialysis centers, durable medical equipment distributors, hospice providers, transportation companies and other post-acute-care organizations.

**Safe Transition Home**

Los Angeles-based Cedars-Sinai has teamed up with HomeHero, a non-medical homecare provider, to help discharged patients stay on a healthy path and, if possible, avoid readmission.

The joint program, called Safe Transition Home, aims to address transitional care challenges by providing licensed and trained homecare professionals as a post-acute extension of Cedars-Sinai’s healthcare continuum.

HomeHero’s caregivers, referred to as “Heroes,” provide assistance with activities of daily living, such as personal care, housekeeping and medication management. Safe Transition Home covers additional services, including transportation to and from follow-up appointments with the patient’s physicians.

The program is funded through a combination of private clients and Cedars-Sinai.

Approximately four out of 10 Medicare patients – and about a third of all hospitalized patients – require some form of post-acute care. That can take place in skilled nursing facilities, at the home, or in more intensive settings, such as inpatient rehab facilities and long-term acute-care hospitals.

— Clay Richards, CEO of naviHealth

**Attacking variation**

Approximately four out of 10 Medicare patients – and about a third of all hospitalized patients – require some form of post-acute care, says Clay Richards, CEO of naviHealth. That can take place in skilled nursing facilities, at the home, or in more intensive settings, such as inpatient rehab facilities and long-term acute-care hospitals.

“Often, these patients bounce from one facility to another and back again,” says Richards. “Costs go up and there is no correlation to better outcomes. That’s why post-acute care has become such a focus for the
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Keeping tabs on patients after their discharge is the key to comprehensive, effective post-acute care. In fact, in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress declared a national objective to achieve widespread exchange of health information through interoperable certified electronic health record (EHR) technology nationwide by Dec. 31, 2018.

Providers are moving toward interoperability, but their path has been uneven.

National rates of hospitals’ electronically sending, receiving and finding information to and from providers or sources outside their hospital system increased between 2014 and 2015, reports the Office of the National Coordinator for Health Information Technology (ONC), the principal federal entity charged with coordinating nationwide efforts to implement and use advanced health information technology and the electronic exchange of health information.

Some highlights from the ONC report:

- Hospitals’ rates of electronically exchanging laboratory results, radiology reports, clinical care summaries, or medication lists with ambulatory care providers or hospitals outside their organization doubled since 2008, when 41 percent of all hospitals electronically exchanged health information with outside providers.

- The percent of hospitals electronically sending, receiving, finding and integrating key clinical information grew between 2014 and 2015, from 23 percent to 26 percent.

“Interoperability: You can’t have a continuum without it”
Forty-six percent of hospitals in 2015 had necessary patient information electronically available from providers or sources outside their systems at the point of care, compared to 41 percent in 2014.

About one-third of hospitals (36 percent) reported their providers “rarely” or “never” use patient health information received electronically from outside their hospital system when treating their patients. Fewer than one-fifth (18 percent) of hospitals reported their providers “often” use patient health information received electronically from outside their hospital system when treating their patients. And 35 percent reported their providers “sometimes” use patient health information received electronically from outside their hospital system when treating their patients.

Among hospitals that rarely or never used patient health information electronically received from outside their hospital system, 53 percent said the information is not available to view within the EHR; 45 percent indicated that they experienced difficulty integrating the information in the EHR; and 40 percent indicated the information was not always available when needed.

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Rising Acuity Levels

By Gina Smith, CMRP, AMS, Director of Business Development, Health Industry Distributors Association

Rising acuity levels are driving cost increases at long-term care facilities, according to HIDA’s most recent Extended Care Market Survey. The number of facility administrators reporting higher acuity since last year reached 82 percent, a 9 percentage point increase from the 2015 survey.

The survey found:

**Nearly 80 percent of respondents cite higher acuity as a primary cost driver.** Additionally, the majority of executives surveyed (73 percent) predict further patient acuity increases over the next two years. A slight majority (53 percent) anticipate their medical supply budget will grow.

**Average lengths of stay are holding or increasing.** Approximately 32 percent of 2016 respondents report lengths of stay remained the same while 16 percent say it increased, up from 24 percent and 10 percent, respectively, for 2015. Overall, occupancy is the second leading challenge for providers, after attracting talented personnel.

**Hospital partnerships become increasingly essential.** Long-term care facilities see numerous advantages to partnering with hospitals. About 80 percent of respondents say they are partnering with hospitals to reduce readmissions, while 74 percent list hospitals as a primary referral source. A slight majority (51 percent) cite geographic practicality as a reason for hospital partnership.

Sales data can be anywhere from 45 days to 2 years old. To provide suppliers with the most up-to-date information, HIDA has created MarketPULSE to gather patient utilization data directly from providers. Subscribers receive this data within three weeks after the end of the quarter, making it one of the fastest views available in the market.

The information is delivered in a quarterly subscription report for four major markets: acute care, extended care (primarily SNFs), primary care, and laboratory (hospital and POLs). HIDA’s Extended Care MarketPULSE is the first to launch, released this July.

In addition to the national overview of patient activity, survey response data is sorted into six geographic regions, as well as by bed size, allowing subscribers to track regional and facility trends. Subscribers also can compare the present quarter to the previous quarter, the present quarter to the same quarter a year ago, and year over year.

Annual subscriptions and the Extended Care MarketPULSE report are now available at www.HIDA.org/MarketPULSE. For additional information, please call Gina Smith at 703-838-6116 or email GSmith@HIDA.org.
Distributors Educate Lawmakers at Washington Summit

A record number of HIDA member executives converged on Capitol Hill last month to educate lawmakers about key issues impacting healthcare suppliers and providers. More than 60 executives participated in over 100 meetings with members of Congress, their staff, and federal agency leaders during HIDA’s annual Washington Summit.

Participants reported productive discussions with congressional leaders and their staff from committees that influence the healthcare supply chain, including the Senate Finance and Senate HELP (Health, Education, Labor, and Pensions) committees, as well as the House Ways and Means and House Energy and Commerce committees.

Meetings centered on key industry issues including emergency preparedness, the value of laboratory diagnostics, the competitive bidding program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), wholesaler licensing standards, and the medical device tax.

Focus on emergency preparedness
Pandemic preparedness was a key topic at the Summit. The Ebola crisis in 2014 strengthened distributors’ relationships with government agencies, including the Department of Health and Human Services and the Centers for Disease Control. This allowed both industry and government leaders to learn and adapt ahead of the current Zika outbreak.

Senator Richard Burr (R-NC) and Health and Human Services Deputy Assistant Secretary Ed Gabriel, both speakers at the event, encouraged participants to continue to collaborate with government leaders to improve the nation’s readiness for epidemics.

Value of laboratory diagnostics
Members educated congressional representatives on the importance of lab diagnostics in combating the spread of infectious diseases like Zika. They highlighted the role of diagnostics in mapping and responding to an infectious disease outbreak, and in overall population health.

Upcoming changes to the clinical lab fee schedule could deter physicians from using these critical resources, participants said. They explained that these changes could result in significant reimbursement cuts for providers.

DME competitive bidding
Members also encouraged lawmakers to support the Patient Access to Durable Medical Equipment Act (PADME) of 2016 which would delay certain cuts to durable medical equipment (DME) reimbursement rates under Medicare’s competitive bidding program. Those cuts took effect July 1; the bill would retroactively delay their rollout in non-competitive bidding areas by 12 months.
The legislation would also require the Centers for Medicare and Medicaid Services to gather input from stakeholders and take into account travel cost, volume, and information on the number of providers serving bid areas as part of rate-setting activities.

By the time the Summit concluded, the House was considering legislation to implement this act, but key details, including the length of the proposed delay, varied substantially between the House and Senate versions. HIDA Government Affairs is following this legislation closely and will offer further analysis as this issue develops.

Medical device tax
HIDA members thanked legislators for the moratorium on the Affordable Care Act’s 2.3% excise tax on medical devices, and asked them to make it permanent. Participants explained that the potential re-introduction of the tax has held down investment and hiring.

Wholesaler licensure standard legislation
HIDA members also called on legislators to implement a uniform national standard for licensing wholesale distributors of prescription medical devices. Specifically, they sought legislation that allows individual states to continue to license wholesale distributors and not require a separate prescription device license if the wholesaler has a pharmaceutical wholesaler license pursuant to the Drug Supply Chain Security Act (DSCSA).

Key takeaways
On the second day of the Summit, lawmakers and experts shared perspectives on key policy issues. Among the takeaways:

Hospitals are experiencing an uptick in bad debt, due in part to the growing popularity of high-deductible health plans. These plans have grown tremendously since the Affordable Care Act was implemented, speakers noted.

Shawn Martin, American Academy of Family Physicians, suggested that payment models that involve two-sided risks to providers, like capitation, could return as payers seek to hold down costs.

Trent Haywood, Blue Cross Blue Shield, observed that care will continue its shift to the outpatient setting, especially as new technology strengthens smaller facilities’ capabilities.

HIDA continues to advocate on behalf of distributors through meetings with lawmakers and regulators and other efforts. Still, Summit speakers stressed that advocacy visits to Capitol Hill are the most powerful way to advance key issues because they allow lawmakers to understand the human side of each issue.
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Equipment Sales

Follow your customers’ signs for successful equipment selling
It may be challenging, but for the distributor sales rep, some simple truths remain fixed.

Ben Mosley, director, vendor marketing and programs, NDC, says the successful distributor equipment salesperson:
- Shows up
- Follows up
- Earns the trust of the customer

KC Meleski, national sales manager, Claflin Medical Equipment, believes that the successful rep is:
- Intelligent
- Meticulous
- A good communicator (both written and spoken)
- Motivated
- Personable

And Cindy Juhas, chief strategy officer for Claflin Medical Equipment, says the successful equipment rep has:
- Attention to detail
- Mental acuity
- Drive

**First step**

Taking the time to research and understand the customer’s needs is the first step in successful equipment selling, according to those with whom Repertoire spoke.

“To sell equipment in today’s healthcare, you can’t just present features and benefits,” says Matt Bourne, vice president of medical sales for Midmark. “You can’t just present it as a return on investment. You really have to embrace the strategy of that customer you’re working with. You have to understand what they’re going to need in the next three to five years to drive the measures they have put in place to be successful.”

Your customers’ needs are changing – rapidly. So is the way they are buying equipment.

“As a great deal of medical spend has moved to the large health system, many times we are dealing with multiple influencers and stakeholders when it comes to equipment purchasing habits or preferences,” says Dick Moorman, vice president of distribution relations for Midmark. “We are seldom dealing with a single decision-maker like we did in the single practitioner’s office. Each of those influencers will have different wants and needs. We need to know and understand what those are.

With today’s educated and diverse buyers, reps must be able to justify the solutions they are proposing, he continues. And those solutions must address three things:
- Does the equipment improve the patient experience?
- Does it lead to better outcomes?
- Does it result in a lower cost to serve?

More and more hospital systems are standardizing what they purchase, says Juhas. “Consumables and high ticket items have been standardized for years, but equipment was usually a crapshoot of sorts. Now, every system seems to be focusing on standardizing equipment.”

Nor is price their only consideration, she continues. “They look at longevity, patient and staff satisfaction, safety, quality, accuracy (if it is measuring something), conductivity (if applicable) and logistics (how much extra will the logistics cost). The price of some equipment includes a hefty logistics fee that needs to be considered in the overall cost of the equipment.”

**IDN-owned practices**

The landscape for equipment buying and selling is changing as physician practices get acquired by health systems, says Juhas. “Independent physicians are either buying nothing or used equipment first. Some groups do some investing, but they are usually the bigger ones. Hospital systems are looking at two-tiered standards, in some cases: one standard for the hospital and another for their non-acute facilities. If hospitals do buy a practice, they usually refresh the office and standardize certain pieces of equipment.”
Mosley agrees that the acquisition of physician practices by health systems has had a dramatic effect on equipment selling. “This evolution has moved the purchase decision up the corporate ladder, which has added complexity to sign a purchase order,” he says.

“Economies of scale come into play, because hospitals and health systems have increased opportunities for added value than a single physician-owned practice. Larger entities can leverage economies of scale with equipment standardization for volume purchases, improved cross-utilization and shortened learning curves for staff. On top of the internal benefits, the hospital or health system may have access to more favorable contract pricing and/or direct manufacturer access.”

Internet and the competition

Steve Ervin, national sales manager for Henry Schein Medical’s equipment specialist team, believes the growth of the Internet has had a significant effect on medical equipment selling.

Today’s online equipment buyer can scrutinize equipment options from many suppliers, he says. It’s up to the equipment rep to emphasize to his or her accounts the hidden costs associated with online purchases, such as delivery, installation, service and training. “Oftentimes, these things aren’t disclosed upfront [on the Internet], nor are they asked about.”

As physician practices continue to get acquired by health systems, physicians and their office staff may need guidance or key information from their equipment rep, continues Ervin. They need to know, for example, if the equipment they are buying is interoperable with the practice’s – or health system’s – electronic health record system. Data collection and the transferring of data are crucial in the changing health environment.

As more decision-makers are involved in the budgeting and buying process, the rep may need to help the recently acquired practice obtain and review the details of the equipment being purchased, such as shipping, service and warranty information or specification sheets, says Ervin. The rep also needs to share with office managers and doctors the existing standardization decisions that may have occurred regarding equipment as they work through the budgeting process.

The GPO: Partner or not?

Group purchasing organizations play a big role in equipment buying today, according to observers.

“I would believe that equipment sold through GPO contracts has increased over the last five years based on the growth of GPOs,” says Mosley. “As GPO membership has increased and the drive for GPO compliance has increased, this would drive equipment as well. I have also seen support for this observation based on input from equipment manufacturers.”

Says Moorman, “I believe it is obvious that [GPO involvement] has increased, and increased dramatically. The biggest change for a distributor rep is that price is transparent and no longer an advantage. That requires a very different approach to the customer.”

Juhas says that Claflin has also found that customers’ reliance on GPO contracts is increasing. “We align ourselves with the GPO reps in all of our major accounts. They are part of the supply chain in our world and are part of that team for the customer.”

“Consumables and high ticket items have been standardized for years, but equipment was usually a crapshoot of sorts. Now, every system seems to be focusing on standardizing equipment.”

— Cindy Juhas

“Consumables and high ticket items have been standardized for years, but equipment was usually a crapshoot of sorts. Now, every system seems to be focusing on standardizing equipment.”

— Cindy Juhas
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“There is a greater amount of interest from the customer in trying to be GPO-compliant,” says Scott Manecke, vice president, capital equipment group, Henry Schein Medical. “We continue to see the percentages of our overall customer base increase as far as those tied to GPOs.”

That is particularly true for larger health systems and physicians whose practices are owned or affiliated by them, he says. “They are more interested in ensuring GPO compliance, and oftentimes, that philosophy is being driven down from the corporate office of the IDN.”

“Our reps are encouraged to take advantage of local GPO partners when making their sales calls,” says Ervin. GPOs can play a critical role in the construction and furnishing of new offices, he adds. “I’ve seen more contracts for equipment from GPOs than I have in the past. They are a new partner to work with and to help us attract new customers.”

**Caveats**

No one said selling equipment is easy. Mistakes will be made.

“Probably the biggest mistake made by distributor reps is not focusing on solving the customers’ needs or problems,” says Mosley. “Capital equipment can be a solution for many needs, from patient care, patient satisfaction, or financial benefits. Equipment can serve all of these needs, but addressing the most salient needs makes it easier for the customer to make the purchase decision.”

Moorman believes that selling categories of products can take the distributor’s focus away from the customer’s true equipment needs.

“Distributor salespeople have been trained to sell categories of products,” he says. “Virtually all of distribution has category managers, who are responsible for various manufacturers’ product lines.

“The reason for category management is certainly understood, and it is not an easy job for a distributor category manager to manage multiple manufacturers. That being said, what a distributor brings to a customer should be the best possible solutions with a manufacturer who truly understands the medical space they play in. One who can really deliver to the end user the solutions they need.”

Says Juhas, “Many of today’s distributor reps don’t have the technical expertise nor do they have the time to spend on the extra detail required to do equipment selling right.” Successful equipment reps are hands-on, savvy about technology, and pay a great deal of attention to detail, she says.

Juhas recalls one competitor who gave a customer a quote for an exam table – but neglected to include the upholstered top. Not surprisingly, its bid came in lower than that of Claflin. “Once we pointed that out to the end user, they sent an email out to all of their peers and told them to use us for this kind of equipment in the future. We knew what we were selling!”

Successful reps need to be independently motivated and willing to attack the market, says Ervin. But lone wolves aren’t wanted.

“Healthcare has become so complex that going it alone oftentimes means you’ll overlook opportunities, under-penetrates the customer, or quote pricing too soon,” he says. “At times, you may only be talking to the office manager, but there may be three or four other decision-makers you weren’t even aware of.”

“The team selling concept is something we strive for,” he says. “Our specialists assist the traditional sales rep, and together they help the customer make the most sound purchasing decision.”

Equipment reps – like their med/surg counterparts – need to transition from the transactional approach of selling to a more consultative approach that builds trust and provides value to customers, adds Manecke. “There will always be those transactional opportunities, where the rep walks in and the customer says, ‘I need an EKG machine.’ But at Henry Schein, our strategy is to educate the sales team on how to be a trusted advisor so that our customers can rely on us to offer a broad portfolio of solutions that help meet individual practice needs.”
Traditionally, providers get highly motivated to buy equipment toward the end of their fiscal year, because they don’t want precious budgeted dollars go to waste. To a large extent, that is still true, according to those with whom Repertoire spoke. Distributors should plan accordingly. But waiting until Q4 is waiting too long.

“The smart salesperson knows when all his/her customers’ year-ends are and starts six months ahead of time to create needs for capital equipment,” says Midmark Vice President of Distributor Relations Dick Moorman.

Steve Ervin, national sales manager for Henry Schein Medical’s equipment specialist team, points out that physician practices are so preoccupied throughout the year with their day-to-day patients, practice operations and professional conferences, that they have little time to think about year-end equipment purchases and tax implications…until year-end. “If our sale reps have done their due diligence in providing equipment solutions, [physician practices] will start to make those decisions about what equipment to invest in and how to get it in the practice before the end of the year.”

Says Scott Manecke, vice president, capital equipment group, Henry Schein Medical, “When mid-November approaches, it’s often a race to the finish, as practice owners have a heightened awareness of the tax-saving benefits, which results in a greater impact on equipment purchases in the fourth quarter.”

The fourth-quarter budget crunch continues, says Ben Mosley, director, vendor marketing and programs, NDC. “For the owner/operator who has tax planning or Section 179 incentives, they have to get the equipment in use before year end. For the larger corporate entities, there is incentive to spend budgeted dollars before year end.”

Section 179
Section 179 – that part of the IRS code that allows businesses to deduct the full purchase price of qualifying equipment (up to $500,000) in the year it is put into service – remains a motivator for many equipment purchasers, especially those in physician practices.

“Section 179 and [disabled access tax credit] Code 44 are still effective selling tools to the right audience,” says Moorman. “That being said, a salesperson needs to qualify their statements by saying something on the order of, ‘Consult your tax advisor before taking action on any advice given around Section 179 and Code 44.’ No salesperson should be seen as giving tax advice to their customer.

“Keep in mind no one cares how much something costs, nor about the tax savings possible, until they have decided if they want it or need it. Creating ‘the want’ or ‘the need’ is a much more effective selling proposition.”

The Section 179 deduction is not much of a selling tool for Claflin Medical Equipment, says Cindy Juhas, chief strategy officer. “We typically work with medical systems and IDNs. They buy equipment because they are expanding, remodeling or building something new. The dollars are budgeted and part of their growth strategy.”

Says Mosley, Section 179 continues to be an effective selling tool for the customer who is a practice owner. “This deduction offers tremendous benefits, but it has been around so long that it may not offer the urgency to ‘buy now’ as it once had. The $500,000 deduction limit has been in place since 2010, so telling your customer that it may not be available next year may not be the best strategy.”

Manecke says, “Now that a definitive amount – $500,000 – has been implemented and hopefully will stay in place for many years to come, we’re hopeful that will eliminate the fourth-quarter rush.” No longer will buyers be kept in suspense until mid-year or later to find out whether the deduction will be in place, and if so, at what dollar limit. “People were hesitant to go down this road [of making equipment decisions] because of the uncertainty,” he says.
Effective procedure lighting is a critical component of a well-functioning medical environment. To see clearly and correctly, the lighting needs to be intense, uniform, and close to white as possible to show the subjects true color. Additionally, a quality light will offer dimming and a large enough diameter LED array to provide exceptional shadow control. Your lighting needs to perform all these functions without generating too much heat that can effect tissue and make the surgery team uncomfortable.

The aim of procedure lighting is to better illuminate a procedure area, and give you and your medical staff a greater sense of confidence. With adequate procedure lighting, you can be assured that your vision will be clear, and that you will be better able to avert costly and potentially dangerous medical errors.

Lighting evolution
As technology has evolved so has lighting. Older lighting options consisted of halogen lamps, these lamps typically emitted lower color temperatures, (which is measured in Kelvin°) than the modern LED lights. Many consumers believed that the color temperature is somehow related to the brightness of a lamp. This is not the case. In fact, color temperatures is a measure of the color of a light’s output. LED lights typically emit much higher color temperatures. This affords a much more accurate tissue rendition and does so without color filters, or the other external color correction devices.

How to choose
Needs may vary by practice and procedure. If you are considering new lighting, here is a checklist to help you navigate your lighting choice.

✓ Intensity
• In the world of LED medical lighting, Intensity means Brightness and is measured in LUX or Foot-candles
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• Intensity increases and decreases based on the distance from the procedure site. The industry standard distance for measuring intensity is at 1 meter. Beware of companies who measure their light intensity at a shorter distance to increase their LED light intensity

✓ Color
  • The color of the LED light output is measured in degrees KELVIN (K)
  • Lower the degree of Kelvin = pink or red hue
  • Higher the degree of Kelvin= a blue tint
  • All Bovie MI LED lights are 4300°K, which is similar to daylight and offers a pure white light for superior visibility.

✓ Heat Generation
  • LED lighting radiates virtually no heat
  • Improving surgeon and patient comfort during procedures

✓ Shadow Reduction
  • A surgeon cannot be working on a patient, moving instruments and inhibited by shadows in the surgical site

✓ Positioning
  • Perfect positioning is important to any doctor and is a great engineering achievement
  • Bovie’s MI LED lights offer a 4 ½ foot radius and utilizes a compression spring arm to adjust to the perfect positioning

✓ Pattern
  • Pattern relates to the diameter and focal range at the surgery or procedure site.

Bovie Medical has many cost effective high quality lighting options that will illuminate your needs from: Family Practice, Dermatology, Plastic Surgery, Urgent Care, OB/GYN, Surgery Centers and Small Operating rooms.

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Scales are a necessary piece of equipment for all medical facilities. These silent workhorses sit in the hallways and corners of every medical office and every hospital department, and they are used by nearly every patient as part of their intake and daily care.

A patient’s weight is vital information for detecting fluid retention, calculating proper medication dosages and screening for malnutrition. Yet, healthcare professionals sometimes overlook the importance of accuracy and safety, methodically recording readings without a second thought. Outdated, unsafe scales can lead to falls and injuries for both patients and healthcare professionals. Improperly calibrated or inaccurate scales can lead to incorrect treatment or inconsistencies across a health system. In fact, recent studies show that many medical scales are troublingly inaccurate. It’s time to weigh the risks posed by your physician and hospital customers’ scales and take steps to protect their patients, their employees and their bottom line.

Higher weights, lower accuracy
As the obesity epidemic grows, medical professionals are seeing heavier patients. According to the National Council on Strength and Fitness, 3.8 million Americans weigh over 300 pounds, and 400,000 weigh more than 400 pounds. Many scales have high capacities, but they are not accurate at higher weights. As a patient’s weight increases, the accuracy of many scales decreases. The results can mean inconsistent readings, leading to an inaccurate representation of a patient’s weight over time. Healthcare standards recommend that scales be precise to 1 pound per 150 pounds of weight to ensure accurate dosing and treatment. However, a recent study of scales in Kansas City-area health facilities found average inaccuracies ranging from 1.3 pounds at 100 pounds of weight, to 3.8 pounds at 250 pounds of weight. As the test weights increase, more scales were found to be inaccurate. When tested at 200 pounds, the study found that 15.1 percent of scales were off by more than 6 pounds – or one Body Mass Index (BMI) unit. At 250 pounds, the percentage of inaccurate scales increased to 20.8 percent. Since many physicians use a patient’s BMI as a critical measure for planning treatment and care options, this inaccuracy can lead to over- and under-treatment, denial of proper treatment or ill-informed guidance.

The risks — and cost — of inaccuracy can be substantial. For a patient undergoing treatment, inaccuracy can mask a weight gain or loss that signals health changes. According to a study by Nursing, a heart patient with a weight variance as small as 3 pounds requires assessments for peripheral edema jugular venous distension, dyspnea or abnormal lung sounds. Similarly, patients with renal failure or some cancers typically receive medication doses based on their current weight. To ensure accuracy across a variety of patient weights, scales should be calibrated regularly, particularly because in the course of daily usage, scales are bumped or jarred, which can affect their accuracy.

A study by the UK’s National Health Services found that 22 percent of scales were not set to zero, and a third
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of all scales tested were inaccurate. The study, which examined 7,875 scales at more than 200 hospitals, noted that while small inaccuracies may not be important when monitoring obese adults, inaccurately weighing oncology patients, children or infants to determine medication doses could be dangerous. For instance, the Pennsylvania Patient Safety Authority surveyed four years of state health event reports and found 479 instances of medication errors stemming from inaccurate patient weight. Of these incidents, 67% resulted in a patient receiving an incorrect dose, with 1.3% of cases causing enough harm to warrant additional treatment.

According to the Pennsylvania Patient Safety Authority, in one state:
- 479 medication errors were caused by inaccurate patient weight.
- 67 percent of these incidents resulted in a patient receiving an incorrect dose.

**Standardization matters**

Many hospital systems or IDNs have not made scale standardization a priority, with most systems using four or more scale brands throughout their organization’s facilities. This requires staff to be familiar with multiple scales’ operation and can lead to variances in the weight results. Standardization across a hospital system or network benefits both patients and staff. By using standard scales and calibration procedures, a patient’s weight variation across several locations within the network becomes more meaningful. With newer scales that integrate with a facility’s electronic medical record system, weight readings are automatically added to a patient’s record, reducing the risk of transcription error on date or weight. Additionally, staff working in multiple locations across a hospital system can apply the same best practices when using standardized equipment. Overall, standardizing across the continuum of care helps staff provide a consistently high level of patient care while reducing costs to an organization.

**Next steps**

Your hospital customers can start by taking an inventory of every scale in their facility or network.
- How many are there?
- Where are they located?
- Who’s using them, and how often?
- Do they have rail supports or low platforms, particularly in departments that see more elderly and frail patients?

Next, hospitals and IDNs should evaluate accuracy across the entire range of use. They should verify when they were last calibrated, their maximum accurate weight and how often they are calibrated. Is someone at the IDN responsible for calibrating scales, and are users trained to zero them out between patients? Particularly in larger facilities or IDNs, responsibility for scales can be centralized. They should develop standards for usage and establish maintenance procedures and schedules to help ensure that accuracy does not lapse. Then, they should train staff to use the scales properly and empower them to point out when something doesn’t seem right. The patients’ health — and the provider’s bottom line — depends on it.

**About Health o meter® Professional Scales**

Health o meter® Professional Scales is the market leader in medical scales in North America and has been supplying leading technologies to the healthcare industry since 1919. Visit homscales.com or call (800) 815-6615 to learn how Health o meter® Professional Scales can meet all of your medical weighing and measuring needs. We make things “Weigh Easier.”

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**Notes:**


REDUCING OCCUPATIONAL RISK
for Caregivers in Ambulatory Care Settings

CHALLENGE
Caregivers working in healthcare facilities are one of the most at-risk professions for musculoskeletal disorders (MSDs), including back injuries and other strains and sprains.

Exam tables in ambulatory settings typically have a fixed height of about 33 inches, requiring caregivers to assist or lift patients with mobility limitations onto the tables, placing caregivers at risk for injury.

When patients are unable to get onto exam tables, it may inhibit the exam process, lower quality of care provided and diminish desired outcomes.

GOAL
Midmark partnered with Guy Fragala Ph.D., PE, CSP, CSPHP, to examine the occupational risk reduction that might be achieved by using height-adjustable exam tables in the ambulatory care setting.

The goal was to consider the risk caregivers encounter when assisting limited mobility patients onto fixed-height exam tables – and then determine if and how that risk might be reduced with a height-adjustable exam table.
RESEARCH APPROACH

The study measured caregiver subjective physical exertion required to help a patient up and onto an exam table. A 10-point scale ranging from 0 (no exertion) to 10 (extremely hard exertion) was used.

Two different tasks for assisting a 235-pound patient with limited mobility:

**Task 1**: traditional fixed-height exam table with 33.38-inch surface height

**Task 2**: height-adjustable exam table with lowest height of 18 inches

Thirty-two recorded trials with the patient were completed, with each task performed by one individual caregiver. Immediately after each task, caregivers completed a data sheet, indicating perceived physical exertion** for each body part considered.

### Table: Mean Perceived Physical Exertion

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Fixed-Height</th>
<th>Adjustable</th>
<th>% Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder</td>
<td>5.29 +/- 2.98</td>
<td>.28 +/- .49</td>
<td>95%</td>
</tr>
<tr>
<td>Upper Back</td>
<td>5.23 +/- 3.39</td>
<td>.13 +/- .28</td>
<td>98%</td>
</tr>
<tr>
<td>Lower Back</td>
<td>5.73 +/- 2.98</td>
<td>.20 +/- .46</td>
<td>97%</td>
</tr>
<tr>
<td>Whole Body</td>
<td>6.00 +/- 2.77</td>
<td>.19 +/- .35</td>
<td>97%</td>
</tr>
</tbody>
</table>

In eight of the 32 trials run, caregivers determined the task of helping the patient onto the fixed-height table to be unsafe since the exertion required would be extremely hard.

Caregivers reported dramatically less perceived physical exertion when using a height-adjustable exam table versus a fixed-height table. Results showed a 95 to 98 percent reduction.

This reduction translates into less force exerted on the musculoskeletal structure and a lower risk of injury to caregivers.

“The exam table is the central and most important furnishing in the ambulatory care clinic. This research demonstrates that employing height-adjustable, accessible exam tables can improve the environment of care by significantly reducing occupational risk to caregivers while improving quality of care for patients.”

- Dr. Fragala

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Rely on our expertise and experience in the medical space.

At Midmark, we know that managing diverse patient volumes and needs can be tough. Your customers are tasked with improving care and maximizing efficiency, all while trying to reduce costs and stay under budget. With these challenges come new opportunities for you.

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Many of us in the business world use LinkedIn every day to find information about the people at companies with which we work. Rest assured that customers and prospects use it to check you out as well.

Why is that important? It means we all need to think about the impression a customer will get when they look us up. Do they see:

- Someone who’s proud of their current organization and the value they provide?
- Someone who appears to be trolling for their next job?

If you want customers to be more inclined to buy from you, make sure it’s the former.

Social media expert Jan Beery of KBK Communications pointed this out on a HIDA webinar last year, and it really stuck with me. She recommended emphasizing customer-focused areas of expertise, so your profile lets current and prospective clients know how they can benefit from working with you.

Which of the following would make a better impression on you, if you were the customer?

“John Salesguy is a results-oriented healthcare sales rep with a proven track record of making quotas and closing sales. He is an expert at finding new prospects, cold-calling, and growing revenue.”

Or,

“John Salesguy serves as a resource to healthcare providers, offering product and service solutions designed to help organizations save money and improve efficiency. His areas of expertise include logistics, low-unit-of-measure programs, and value analysis.”

I hope you picked the second one.

Profile pointers

If I’ve convinced you that it’s time to update your profile, here are a few tips:

- Consider selecting “Hospitals and Health Care” as your industry, rather than “Medical Devices” or “Wholesale” so you’re in the same category as your customers.
- Take time with your “Summary.” This is where you spell out your areas of expertise.
- Tell what’s great about your company. A good place to do this is in the “Description” field for your current position.
- Choose a professional photo. Pictures really do say a thousand words.
- Make sure it’s grammatically perfect. Typos and poor writing detract from your professional image. (Most salespeople weren’t English majors, so ask for help if you need it.)
- Consider making some of your contact information public. If you’re afraid to put your email address public and risk getting a barrage of junk mail, consider at least including your work phone number so that prospects can contact you.

Also, remember to update your profile when your role changes. Good luck and smart selling! 🍀

Use Your LinkedIn Profile to Market Your Expertise, Not Your Resume

By Elizabeth Hilla, Senior Vice President

SMART SELLING DISTRIBUTOR SALES STRATEGIES FROM HIDA
Long-term care facilities are concerned about avoidable readmissions. Help them do something about it, with rapid point-of-care testing from Abbott. The i-STAT® System and Piccolo Xpress® Chemistry Analyzer deliver lab-accurate results for a wide range of tests in just minutes.

- Help clinicians make informed patient care decisions quickly, without waiting for an outside lab
- Broad menu of CLIA-waived assays, including Basic Metabolic Panel, Comprehensive Metabolic Panel, Liver Panel, Lipid Panel, Hematocrit, and Hemoglobin
- Simple, intuitive operation

CUSTOMERS CONCERNED ABOUT READMISSIONS? LET’S TALK TO THEM ABOUT POINT OF CARE TESTING.

To learn more, contact your Abbott Point of Care or Distribution Representative, or visit www.abbottpointofcare.com
MIR, Medical International Research, is a global medical device company founded in 1993 and today is present in over 93 countries worldwide. For more than 20 years the company has been internationally recognized as a leader in the Spirometry, Oximetry and Telemedicine markets for its award winning, innovative designs.

In addition to connecting to PC-Windows via USB and Bluetooth®, MIR provides the ability to connect to Tablets and Smartphones. This makes MIR the ideal solution for your customers who wish to use these technologically advanced devices combined with our diagnostic instruments.

The cornerstone of our Spirometry technology is the FlowMIR®, which is the first and only internationally patented Disposable Turbine. The FlowMIR® comes pre-calibrated, eliminating the need for daily calibration as required by other devices requiring the use of a pneumotach. Each turbine has its own cardboard mouthpiece and has been factory tested on a computerized system. FlowMIR® is an inexpensive alternative to costly reusable devices and replaces the worry of cross contamination or the use of expensive filters.

Our entire product line interfaces with our proprietary software program Winspiro Pro® to provide a comprehensive report to the clinician. In addition, the Spirobank II® Smart will also interface via Bluetooth® with your Apple iPad. So as you can see, MIR has something for each of your customers in every price range. All MIR products are tested on the latest ATS Curve Generator to insure impeccable accuracy and repeatability.

In their determination to continue to be a market leader, MIR will be introducing some new products in the near future that will also help your clinicians to provide better treatment to their patients providing better outcomes. In addition, MIR has a team of over 20 Spirometry Sales Specialists who are here to assist your team in meeting their goals.

The MIR Family of products includes:
- FlowMIR® disposable Turbine
- Spirolab® All in One portable Spirometer
- Spirodoc® 4 in One Spirometer
- Spirobank II® Family of hand-held Spirometers
- Minispir® & Minispir Light® PC system
- Spirotel® Telemedicine Spirometer & eDiary
- Winspiro Pro® & Winspiro® Net Software
- Winspiro Light® Software
- iSpirometry® & iOximetry®

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Minispir® & Minispir Light®

PC Based Spirometers with Oximetry option

Switch to the Best Innovation in Spirometry Oximetry & Telemedicine

For more information: contact your MIR representative or visit www.spirometry.com
It can be difficult to keep on top of nutritional guidelines. Further, while men and women often share similar concerns when it comes to maintaining a healthy diet, dietary recommendations don’t always apply across the sexes. However, guidelines provide encouragement and advice for following healthier eating habits. It’s left to each of us to pick and choose.

For men
Every five years, the U.S. Department of Agriculture releases its Dietary Guidelines for Americans. Katherine McManus, director of the Department of Nutrition at Harvard-affiliated Brigham and Women’s Hospital, recommends paying particular attention to four areas from the guidelines:

**Vary your food choices.** Adopt a varied eating pattern; try different foods from different cultures. Variety exposes one to an assortment of micronutrients, including a broad array of minerals such as calcium, zinc, magnesium, iron and selenium, as well as key vitamins. Micronutrients, in turn, work individually and together to help protect against heart disease, increase bone health and maintain smooth functioning of many of the body’s systems. Men over 50 years require certain amounts of micronutrients daily; however, their diets do not meet these requirements. In fact, the USDA reports that only seven percent of older men receive the recommended daily amount of calcium and vitamin D. The key is to expand one’s palate to different foods, according to McManus. Focus on nutrient-dense foods, such as whole fruits.
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Gina Marchese  
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Attending the HIDA Streamlining Healthcare Conference?  
Visit HMMC at Booth # 220
and vegetables, but mix it up. For instance, try a different colored fruit or vegetable each week, she suggests. Experiment. Even go meatless for one or two meals each week!

**Rethink fats.** Whereas previous guidelines recommended that men limit their fat intake to 30 percent of their total calories, the current thinking is that it’s less important how much fat they consume, and more important what types of fat they consume. McManus still recommends limiting saturated fats, such as those found in red meat. At the same time, though, they should not avoid healthier fats, such as monounsaturated (e.g., olive oil, canola, peanut oil and nut fats) and polyunsaturated fats (e.g., safflower, sunflower and soybean oils), including omega-3s (e.g., found in fatty fish, such as salmon, tuna and sardine, as well as in walnuts). Healthy fats protect against heart disease and may improve cognitive function as well, she points out.

**Curb those sweets!** The current guidelines are clear: Everyone should cap his sugar at 10 percent of his total calories. On average, men consume about 12 percent of their calories from sugar — most of it coming from such drinks as soft drinks, flavored coffee and energy/sports drinks, as well as cookies, candy and cake. For instance, the American Heart Association recommends that men should have no more than nine teaspoons — or 36 grams — of sugar each day; however, a 16-ounce cola has 41 grams of sugar.

**Cut sodium — not potassium.** While it’s important for many men to limit their sodium intake to protect against high blood pressure, the USDA notes that less than 3 percent of men get adequate potassium. Potassium aids in the function of healthy cells, and low amounts can cause muscle weakness and irregular heartbeats, according to McManus. Potassium-rich foods include cantaloupe, honeydew and kiwi, as well as such vegetables as winter squash, broccoli, tomatoes and most greens.

**For women**

There are no single nutrients or vitamins designed to make women healthy, according to Harvard Health Publications, Harvard Medical School. But together, certain food types can dramatically reduce their risk for heart disease. The consensus is that women should eat more fruits and vegetables, whole grains, fish and seafood, vegetables oils, beans, nuts and seeds. At the same time, they should consume less whole milk and other full-fat dairy foods, red meat, processed meats, highly refined and processed grains and sugars, and sugary drinks.

And, they should drink more water! An online study (The Journal of Human Nutrition and Dietetics, February 22, 2016) examined the dietary habits of over 18,000 adults. The findings: Those who increased their daily intake of plain water reduced their total daily calorie intake as well as their consumption of saturated fat, sugar, sodium and cholesterol. According to University of Illinois researcher Dr. Ruopeng An, “Water helps increase feelings of satiety, which can help avoid overeating, as well as replace high-calorie beverages that have added sugar.”

In other research, a team of German researchers analyzed data from over 90,000 women enrolled in the Women’s Health Initiative (WHI), who were between 50 and 79 years when they entered the study. Participants completed the WHI Food Frequency questionnaire at the onset, and each one’s diet was identified as being most similar to the Mediterranean Diet, the Healthy Eating Index 2010, the Alternative Healthy Eating Index 2010 and the Dietary Approaches to Stop Hypertension. During a median follow-up time of 15.9 years, women whose diets most closely paralleled the Mediterranean Diet (e.g., vegetables, fruits, whole grains, nuts/seeds, vegetable oils and some fish or poultry) had marginally lower risk for hip fractures compared to those who adhered to healthy other diets.

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Healthcare Manufacturers Management Council (HMMC), a non-profit industry association, brings together senior-level executives and ‘early professionals’ from medical products manufacturers. As the industry’s only association for manufacturers, membership in HMMC provides the perfect forum to

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It’s time…

It’s time to take advantage of the great outdoors, says Casio America, Inc., a company that features timepieces designed to track data and navigate outdoor adventures. From seasoned enthusiasts to casual hobbyists, Casio’s PRO TREK series includes the following:

- **PRO TREK PRG300.** The watch features Triple Sensor Version 3 Technology, said to offer more accurate data readings to help navigate through any adventure. The timepiece includes a direction sensor and pressure sensor for compass capabilities as well as altimeter/barometer readings, enabling the user to easily check and record necessary information on outdoor conditions. In addition, the Tough Solar Power technology enables users to charge the timepiece in low or fluorescent light, eliminating the need for continuous battery replacement. The device powers down when not exposed to light for a certain period of time to conserve energy.

- **PRO TREK PRW3500.** Based on Casio’s PRW-3000, which has a digital display and is water resistant up to 100 meters, the 200-meter water-resistant PRW3500 permits outdoor enthusiasts to take their adventures to new heights – and depths. The device is equipped with Triple Sensor Version 3 Technology and Multi-Band 6 Atomic Timekeeping technology, and automatically synchronizes with atomic clocks in the U.S., Germany, the UK, China and two clocks in Japan, based on the user’s home city setting. In addition, the PRW3500 features large buttons, non-slip surfaces and a register ring that has been shaped for easy gripping for easy operation, even if the user is wearing gloves.


**Freebie**

Or rather, a FreeMo. FreeMo (www.getfreemo.com) is an Android mobile screensaver app that uses targeted advertising to eliminate consumers’ cellphone bills by passing those costs on to advertisers. It is available for Android devices on Google Play, as well as on the GetFreeMo.com website. Let’s face it: The average smartphone user’s cellphone bill has skyrocketed to $100 or more each month. FreeMo suggests that consumers, who supply valuable marketing data to advertisers when using their cellphones, deserve to be compensated for this data in the form of free or drastically reduced monthly cellphone bills.

**Editor’s note:** Technology is playing an increasing role in the day-to-day business of sales reps. In this department, *Repertoire* will profile the latest developments in software and gadgets that reps can use for work and play.
drastically reduced monthly cellphone bills. The screensaver app reportedly displays full-screen, high quality advertisements and local deals on users’ lock screens when the phone is locked. The ads displayed on each user’s screensaver are specifically targeted to that user. (The user chooses from several preference-based categories in the app to ensure he/she receives more relevant ads.) Downloading and maintaining the app on their smartphone entitles users to an automatic $5 credit off their bill every 30 days. Users get another $5 credit for every person they refer that downloads and keeps the app on their phone. FreeMo works with all carriers, from pre-paid services like Boost, Metro PCS and Virgin Mobile to post-paid carriers like T-Mobile, Sprint, AT&T, and Verizon. The company has partnered with American Consumer Surveys, Twitter, Lyft, Pandora and others to provide even more ways by which to earn credits, such as by taking surveys, downloading apps, watching videos and redeeming coupons – credits that can be redeemed and directly applied to users’ smartphone bills. Users who earn enough credits receive free that month.

**Rugged efficiency on the go**

Janam Technologies LLC, a provider of rugged mobile computers that scan barcodes and communicate wirelessly, has launched its ultra-rugged, ultra-compact XT2 touch computer. Although it’s designed for use in challenging environments, the Android™-powered XT2 is said to provide maximum uptime, reliability and accuracy to enable mobile workers – including those in field service and delivery/sales – to do their jobs more effectively and efficiently.

Features include:
- Android 5 Lollipop operating system and is certified by Google to support all Google APIs, including Google Play.
- Weighs 10 ounces, with a 5-inch touch screen strengthened with Corning® Gorilla® Glass 3.
- Dual-band 802.11a/b/g/n, tooth 4.0 and 4G LTE connectivity for ready access to critical information.
- Slim-format SE4710 scan engine, designed to quickly and accurately capture barcode data from more than 2 feet away.
- Sealed to IP67 standards to provide protection from dust and survive immersion in up to 3 feet of water.

**Groovy**

The rapid evolution of the digital landscape can leave even savvy techies struggling to keep up with new trends and innovations. For those less comfortable around laptops and smartphones, Denver-based GroovyTek offers in-home, on-site and online training designed to help users grasp personal technology in relatable, understandable terms. The best part is, GroovyTek trainers will feel your pain; they are said to have an empathetic nature and seek to provide their customers with one-on-one, personalized consultative training sessions. Although GroovyTek’s service currently is limited to the Denver community, the company plans to expand to additional cities by the end of the year. It is also actively building additional platforms and resources dedicated to their core audience in the form of video curriculum and even new social media platforms.

**Summer safety**

BlueFox, a Swiss-based company that specializes in underwater technology and pool safety, is working to bring its BlueFox ST1 to market. The BlueFox ST1 is a bracelet designed to save lives by preventing accidental drownings. It is made for people of all ages, from toddlers to the elderly, and reportedly can be used in any body of water around the world. The fully automatic device reportedly can alert authorities, family members or other swimmers when a person is in danger of drowning. BlueFox ST1 includes an electronic base and an alarm module and is programmable to the age and swimming ability of the wearer. If the swimmer exceeds his or her depth and underwater time setting, the alarm module is disconnected from the bracelet and a balloon is forced to the water’s surface, alerting others in the area with a loud alarm signal. The alarm can also be sent to an external receiver, such as a walkie-talkie. BlueFox ST1 can be pre-ordered from a single bracelet to a family pack of 4, various retailer packages, or a distributor pack of 100 units. At press time, the device was expected to be available this August.
A Driving Force

Thanks to a supportive team at Seacoast Medical, Keri Willenborg has struck a happy balance between work and family.

By Laura Thill

Keri Willenborg addresses challenges every day. But for the Seacoast Medical national sales director, that’s nothing to bat an eye over. A single mother of five children ranging from 12 to 24 years, she spends much of her time taking care of others – be it family or her hospital customers. And, that suits her just fine.

A passion for sales

Hard work has been a driving force for Willenborg for as long as she can remember – a value she has passed on to her children. “I think all kids need to work,” she says. “Even my two youngest have jobs: My 14-year-old daughter umpires for softball games with me, and my 12-year-old mows lawns.” In addition, all of her children do volunteer work, she adds.

Willenborg realized her passion for sales in her 20s, when she took a job selling databases to public libraries. “I traveled to small towns across the country and grew to love Carnegie libraries,” she recalls. In years to follow, she further honed her entrepreneurial skills by helping start a meal prep business, which was franchised into 48 stores. From there, she eventually made her way into the healthcare industry, and to her current position with pharmaceutical distributor Seacoast Medical.

“After a friend of mine told me about the position at Seacoast, I interviewed with the CEO, Dave MacFarlane, and the president, Bob Harris,” she says. “To this day, I can honestly say, they have been the best people to work for. They run their business with integrity and treat their employees well. I feel very blessed, and I’ve learned a lot from both of them.”

From the start, Willenborg was surprised at – and enthralled by – the complexity of the industry. “I thought I would have to thoroughly understand the various pharmaceuticals I sell,” she explains. But, she soon learned that she did not require the same level of understanding as a pharmacist. “On the distribution side, it’s all connecting contracts, understanding the GPOs and recognizing decision makers in the hospitals.” She works with the supply chain – from materials managers to pharmacists – and presents contracts to a value analysis team (VAT). “I must learn about each hospital’s current buying patterns, evaluate where there might be holes, and then introduce them to the right Seacoast products that could provide a cost savings and increased efficiencies. My greatest challenge is when I’m confident we can offer a customer a cost savings, but the hospital is already locked into a contract for a specific term.”

Striking a balance

Raising five kids is not easy for two parents. It’s less so for working parents, and that much harder for a single, working parent. Joining Seacoast Medical, “a company that supports women and encourages people to strike a balance between work and family,” has made it possible, notes Willenborg. “Dave and Bob appreciate the importance of
a flexible schedule and the need to sometimes work from home. They understand that time on the road means time away from family, and it’s necessary for families to catch up following these trips.”

But, there are some things that even the most understanding employer can’t help with. “As a single mother, I must always stay on top of doctors appointments, sports practices, school meetings and band recitals,” says Willenborg. “Having a strong network of family has been my saving grace. Networking with other parents, carpooling and, of course, sharing some of the responsibility with my children’s father has made it possible to balance it all.

“I’ve given many talks to organizations on this very topic, and the one thing I stress is to never lose sight of what’s important,” she continues. “A career is replaceable. Children are not. They are young once, and I never lose sight of that.” Family dinners are a key opportunity for parents to spend time and communicate with their children, she adds. “Even if we just order pizza, it’s time we spend together.”

Interestingly, Willenborg has found that many skills she has acquired to connect with her hospital customers have carried over to her home life, and vice versa. “In this day and age, raising a family of five kids who are constantly on the go can be tough, but very similar to servicing hospital customers,” she says. As such, staying connected – whether to family or customers – requires a multimedia approach, including texts, e-mail, messaging on Facebook and good, old-fashioned face-to-face communication.

Indeed, she is a true representative, in every sense. As a Seacoast Medical sales rep, “I want my customers to know me as the salesperson who

“It takes a tremendous amount of focus and courage to step up to bat, especially when the bases are loaded and your team has two outs!” she says.
offers a quality product and service at a good price.” Along the same lines, she hopes her parenting skills have paid off, and that when others look at her family, they see five well-behaved children. “At times, both jobs can be deeply challenging,” she says. “But, they can also be very rewarding.” That said, at Seacoast Medical, the company CEO and president can confirm that she is doing a good job. “As a single parent, you are the CEO, and you must trust your gut without a strategic plan.” It’s a big help when one’s company recognizes such challenges, she points out.

“I’ve given many talks to organizations on this very topic, and the one thing I stress is to never lose sight of what’s important. A career is replaceable. Children are not. They are young once, and I never lose sight of that.”

Time for play
One of the biggest lessons learned for Willenborg has been the importance of taking time to do something for herself. No matter how busy it gets at work or home, she finds time to indulge in her two passions — softball (both playing and umpiring) and dance. She has been active in both sports since she was young and is confident that the balance she acquired from her dance experience helped her refine her hand/eye coordination that has made her a good softball player. But, the best part of both activities is the camaraderie, she notes. “I played softball with the girls from my private school for years growing up. To this day, my teammates are some of my dearest friends.”

In fact, it was one of her good childhood friends who convinced her to return to dance. “I danced for 18 years and eventually taught ballroom dancing for Arthur Murray in my early twenties,” she recalls. “My best friend, Karen, recently approached me about taking a tap dancing class. My initial reaction was ‘Are you crazy?’ But returning to tap dancing has been ‘thoroughly cathartic,’ she says. “Not only am I spending time with my best friend, after 20-some years, I am doing something I have always loved. The experience has been a real treat! Not an easy one, she admits, but ‘great exercise and fun!’

As it turns out, performing in front of an audience — both on stage as a dancer and at the plate as a batter — have made Willenborg a stronger sales rep. “It takes a tremendous amount of focus and courage to step up to bat, especially when the bases are loaded and your team has two outs!” she says. “In dance, performing in front of an audience is much the same.” Both experiences have prepared her for addressing C suite executives, she notes. “Often, the stakes are high. My presentation can either make or break a potential partnership.”

It’s no surprise, then, that she has encouraged her children to take up baseball or softball. I have one child trying out for one of the largest and most competitive school softball teams in the state,” she says. Group sports such as baseball/softball require a team effort, she points out. And team effort is exactly what it takes to be part of a healthy family or succeed in one’s career.
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*Respiratory Syncytial Virus.

Cardinal Health names Pamela Kimmet as chief human resources officer
Cardinal Health (Dublin, OH) appointed Pamela Kimmet as chief human resources officer, effective June 30, 2016. Pam joins the company from Coca-Cola Enterprises, where she was SVP, human resources. She will report to George Barrett, chairman and CEO of Cardinal Health. Kimmet succeeds Carole Watkins, who is retiring following 20 years with Cardinal Health.

ACO Med Supply names new president, VP of operations
ACO Med Supply (Charlotte, NC) made two executive appointments. The company named Greg Harmon as president and Harlan Mason as VP of operations. In his new role, Harmon will be responsible for providing strategic leadership for the company by working with the CEO and other management to establish long-range goals, strategies, plans and policies. Harmon has worked at ACO Med Supply since 2001, and served as chief sales officer since January 2010. In his role, Mason will be responsible for strengthening ACO Med Supply’s supply chain capabilities and efficiencies through technology, systems, and infrastructure as well as strengthening leverage of vendor partnerships.

Ryan Doherty promoted to Midwest Regional Sales Manager, Midmark Medical Division
Midmark Corporation announced the promotion of Ryan Doherty to Midwest regional sales manager for its medical division. Doherty will report directly to Matt Bourne, vice president of sales, medical division. Doherty began his career with Midmark in 2004 as a medical sales representative covering the Connecticut and New York territories. In 2013, he earned his master’s degree in business administration from State University of New York at Albany. Shortly thereafter, Doherty assumed the role of strategic account executive for the Northeast and Mid-Atlantic regions where his work was focused on growing Midmark’s business with strategic System III & IV IDN health systems. Doherty has won numerous awards during his tenure with Midmark, including “Strategic Account Executive of the Year” and the “Award of Excellence” for top sales performer.

McKesson acquires LABSCO
McKesson Corporation acquired LABSCO in a transaction that closed May 13, 2016. LABSCO will become an affiliate of McKesson’s Medical-Surgical Inc. This acquisition supports McKesson Medical-Surgical’s strategic priorities of expanding its service offerings for the community-hospital and regional-reference lab markets. Terms of the acquisition were not disclosed.
We use this conference as an opportunity to advance our strategic initiatives with current suppliers, and a chance to identify prospective business partners.

David Myers
Exec. VP & Chief Customer Officer, Acute Care
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LEADERSHIP

What are you practicing?

By Randy Chittum, Ph.D.

Much has been made lately about how many hours are needed to become an expert or highly skilled. Of course, the answers have been greatly simplified, especially for something as nuanced as leadership. My favorite quote about leadership is “learning to lead is like learning to play the violin in public.” It is the public nature of leadership that I believe makes it different than say learning to play golf, or the piano.

Contrary to the popular phrase, practice does not make perfect. Practice makes permanent. So then it becomes imperative to know what you are practicing.

Contrary to the popular phrase, practice does not make perfect. Practice makes permanent. So then it becomes imperative to know what you are practicing.

Every moment of your leadership lives you are practicing something, almost entirely unconsciously. So back to the title – what are you practicing? And how deliberate is that practice?

Deliberate practice
Anders Ericsson has studied practice and determined that a key characteristic of those who improve and develop expertise is that their practice is different. It is what he calls deliberate practice. Two important elements distinguish deliberate practice:

1. The practice is focused on a very specific area for improvement
2. The practice is repeated and has feedback loops that allow for self-correction

This is much easier to imagine in practicing golf, for example. We have all seen the person hitting balls on the driving range for hours on end. In many instances that person is simply further ingraining poor habits. Of much more value would be a focused practice. To meet the two elements from above, he might hit far fewer balls but with a very specific practice outcome. Maybe today he will work on hitting a slight fade with his nine-iron. He will have a very specific distance and target in mind. He will be very mindful of how different swing thoughts and patterns create different results. It is almost certain that he will try different things while dialed into the feedback that he gets (ball flight, proximity to target, etc.).

Deliberate leadership
My challenge to you is apply this to your leadership. You will first have to answer the question – do you have a leadership practice? One of the beautiful things about working in systems is that the system can double as a “practice field.” Virtually anything you need to learn can be practiced in an organization. The second question you will have to deal with is – what area of improvement do you care enough about to develop (and follow) a deliberate practice routine?

For example, let’s say that you desire to develop a greater capacity for strategic thinking. You might play with all sorts of new behaviors. You could develop a habit of asking different, and bigger, questions. You could practice bringing an appropriate emotional state to important strategic conversations. You could develop a practice of pausing to reflect before responding. You could practice by imagining your industry from the perspective of another industry. And it goes on. The key, as outlined above, is that you can repeat the practice, get feedback on the impact, and adjust. It is deliberate.  

By Randy Chittum, Ph.D.
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