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IMDA Annual Conference

IMCO 2014 National Convention

2014 NDC International Exhibition

HIDA

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long-term care trends

repcorner

On Call

Joe Lutz – pg 60

in every issue

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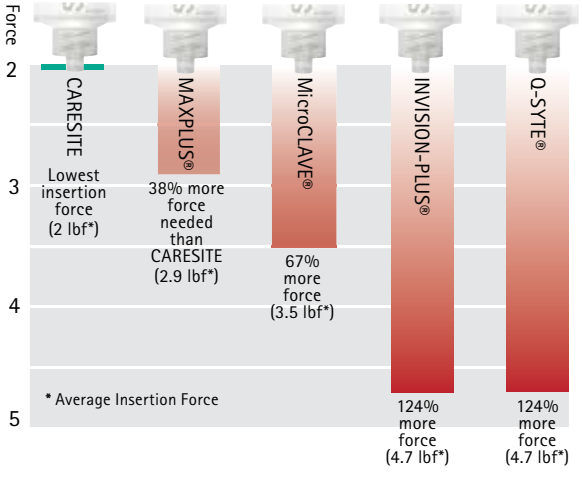

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The Ripple Effect


Brian Taylor

Medtronic recently announced it is acquiring Covidien for $43 billion. Its impact will be felt on many levels. Medtronic will relocate its executive headquarters to Ireland (where Covidien is based) and thus will be subject to the much lower (12.5 percent) Irish corporate tax rates. Medtronic will have easier access to profits it has kept offshore in lieu of paying U.S. taxes. Medtronic announced that access to this capital will enable the company to make a down payment on the acquisition and also fund a $10 billion investment in R&D and other investments in the United States. The net effect this will have on U.S. jobs is uncertain, but the message is clear – big companies feel the need to consolidate in order to play ball with larger providers and payers.

It is speculated that Massachusetts-based office for Covidien will relocate jobs to the Medtronic base in Minneapolis. This merger seems to be a good fit – a chance to consolidate expenses while combining complimentary product and market segments. Moreover, it positions the company to compete in a healthcare industry that is witnessing payers and providers consolidate quickly. As the ACA unfolds, supplier consolidation seems the logical response, and we will see more of it. This deal most surely will trigger others in an effort to grow and remain competitive.

At a recent MDSI meeting in Atlanta, there was much discussion about the landscape of IDNs and providers in the not-too-distant future. Some speculated that there might be as few as 20 mega-health systems left standing when the dust settles. Even those who disputed that number agreed that whatever the number is, it will be less than we have currently. McKesson's recent acquisition of PSS created the industry's largest distributor. Is more consolidation on the way?

Many questions remain unanswered:

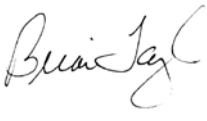
Will there be more consolidation on the distribution side?

Will independent dealers have to change their strategy to survive?

What will physicians do?

Will consolidation provide the savings and synergies needed to compete?

While I am not sure anyone has a crystal ball that will accurately foretell the answers, I do know that we won't have a shortage of topics to cover in these pages for a while!



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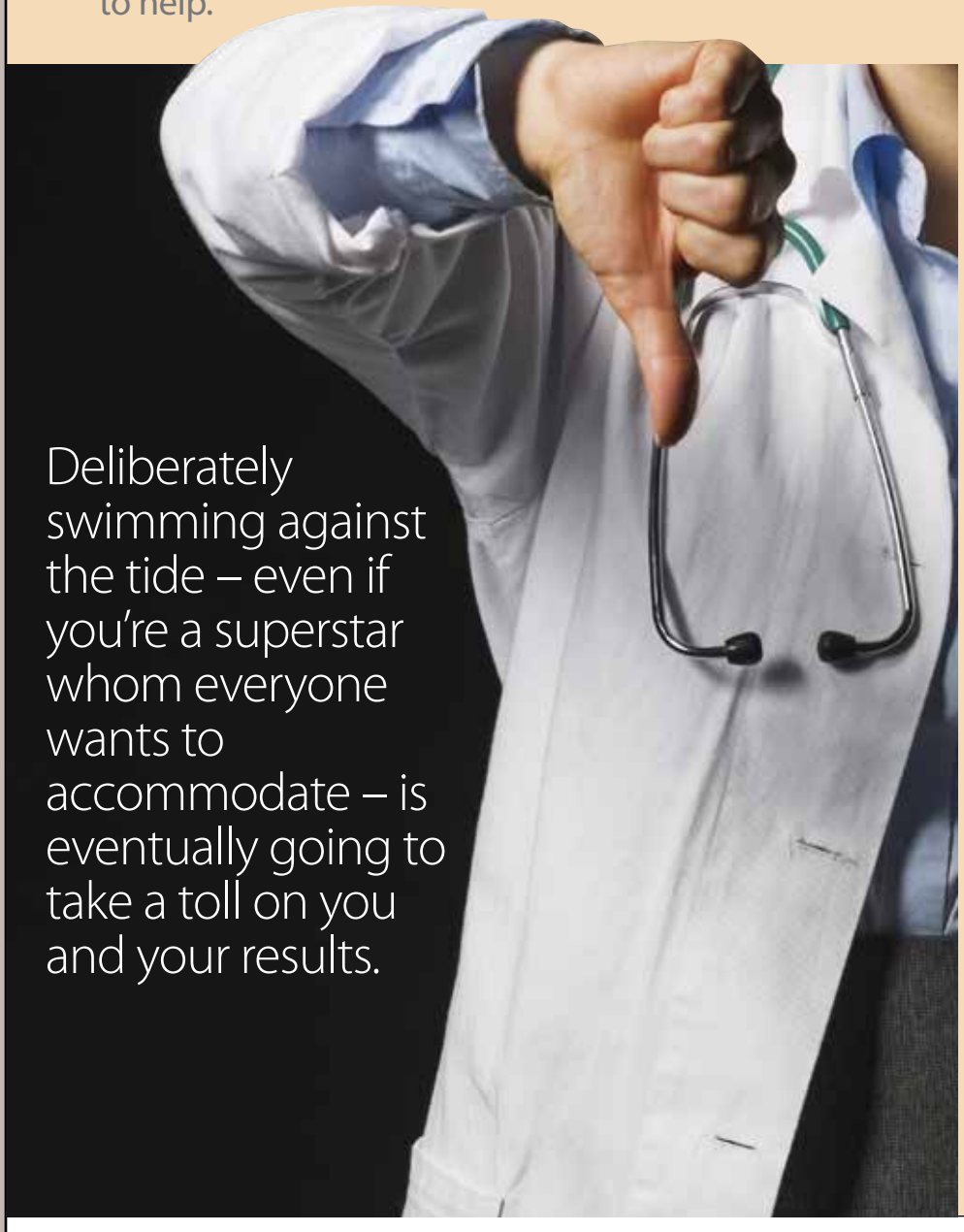
By Laurie Morgan, Capko & Morgan

When business as usual is not good business

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

Recently, we worked with a primary care practice of nine doctors that had been acquired by a regional healthcare player. The regional group had a corporate culture that was friendly, but still very businesslike and professional. A year into the acquisition, the parent organization could see their new practice was not adapting to the culture – and they brought us in to try to help.



Deliberately swimming against the tide – even if you're a superstar whom everyone wants to accommodate – is eventually going to take a toll on you and your results.

Acquired – on their terms

The free-wheeling doctors were not bothered by the culture mismatch. In fact, this new combination was partly driven by a previous failed merger with the state affiliate of a national health system. That earlier merger had failed because the practice's culture clashed severely with the formal, hierarchical one of the health system that acquired them. Instead of trying to adapt, the physician owners had stubbornly expected to maintain the autonomy they had when they were independent. Aggravated by the constant demands that they change, the doctors had sought out a rescue acquisition from their new parent – hoping the smaller, friendlier regional corporation would be a better match for their practice's casual vibe. However, having experienced one unpleasant experience already, the doctors hedged by negotiating acquisition terms they hoped would clearly permit them to maintain a separate culture.

Their requirements included maintaining their own separate phone system and EHR; refusing to match their staff job titles and descriptions to the corporate standard; setting their own rules for managing drug and device rep relationships; and maintaining different office hours from the rest of the system. The parent company had never allowed a division to maintain separate systems and policies before, but because adding a primary care practice in the area had been an important strategic goal, they reluctantly obliged.

The doctors were quite proud of this negotiating coup, but their

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new parent was losing patience fast. There were negative consequences for the practice, too – like dramatically increased stress for staff members, who were frequently forced to work on multiple systems and mollify upset patients who were confused by the inconsistent policies. Constant billing problems – mainly due to using two different EHRs – also taxed the team, and cost the parent corporation significantly. Even the reps who served them were tripped-up by the practice's irregular rules. Plus, everyone missed out on potential benefits like clearer career paths for the practice's employees and higher profit-driven bonuses for the doctors.

Swimming against the tide

As any rep well knows, whether you're working within them or selling to them, organizations of all cultures and sizes have their advantages and disadvantages.

Learning quickly how things get done inside your employer's framework is critical to success. Deliberately swimming against the tide – even if you're a superstar whom everyone wants to accommodate – is eventually going to take a toll on you and your results.

The decision to merge with a large system is a difficult one for any practice. Sacrificing the practice's culture for the corporate one may seem like too high a price.

Once that happens, people's frustration and annoyance start to outweigh the high hopes they had for your glorious potential.

The decision to merge with a large system is a difficult one for any practice. Sacrificing the practice's culture for the corporate one may seem like too high a price. But how the team adapts is a big determinant in the success of the merger – and everyone's job satisfaction. Doctors who are afraid of a possible bad outcome may try too hard to maintain their autonomy – and unintentionally make a tough situation much worse.

Reps see the good, bad and ugly of corporate life throughout their careers. You learn so much about adapting to changes – whether it's your firm being acquired by a multi-national conglomerate, the unexpected obsolescence of your product, your own choice to start fresh with a different company, a leap-of-faith with a start-up, or any of dozens of other career scenarios. When one of your practices is acquired by a large organization, it can be a threat to your business – but it's an opportunity, too. As an experienced corporate warrior, you can offer a gentle nudge in the right direction that can help your physician client navigate one of the trickiest transitions of his or her career. rep

IMCO connects with members, vendors

Group purchasing, home care are two key initiatives

IMCO unveiled several key initiatives and programs at its 2014 Convention, held this spring in Tampa, Fla. They included: SEL, or Sales Emphasis Lines; IMCO's group purchasing initiative; and changes to IMCO's home care and primary care programs.

"Ultimately, we must not and do not forget that we are in a service industry, and IMCO is here to serve you with alacrity, ingenuity and value," said Deb Bullock, IMCO president, at the general session.

Close to 600 people attended the convention, and 104 vendors exhibited at the trade show at Tampa Convention Center. IMCO's H2H sessions brought together members and vendors in private appointments during trade show hours. Meanwhile, IMCO announced that sales of IMCO brand products grew both in sales and SKUs in 2013, and is on track to do the same in 2014.

Education

Speakers and educational sessions included:

- Keynote speaker Mark Scharenbroich, author of *Nice Bike: Making Meaningful Connections on the Road of Life*, who spoke about the importance of relationships to achieving successful results, and about connecting people to people – management to front line, team member to team member, and company to customer.

- Jeffrey Dietrich, senior analyst for ITR Economics, an economic research and consulting firm, who spoke about "economics and medical distribution."

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- Stacey Hanke, co-author of *Yes You Can! Everything You Need from A To Z to Influence Others to Take Action,* who offered practical, immediate skills and techniques to help people be at their best in all face-to-face communication.

- Bob McCart, IMCO vice president of national accounts, and Suzanne Lord, vice president of sales and marketing at MSISI, who shared information on how IMCO members can maximize potential opportunities in group purchasing.

Initiatives

SEL, or Sales Emphasis Lines, is a new program of partnering with key IMCO vendors, says IMCO Vice President Bill McLaughlin Jr. "The SEL program helps identify the preferred vendors in the IMCO portfolio, and helps members focus on [them]. The shared goal is cooperative compliance to yield better pricing, enhanced support material and exclusive quarterly promotions, plus greater attention and support from the field sales force. The SEL vendors are committing to each member over and above their current position."






Group purchasing. IMCO has secured long-term authorized-distributor agreements with the four largest national GPOs. "It has gotten to a point where certain customers will not even meet with a distributor if that distributor is not listed as an AD with the GPO," says McCart. "So the first good thing is that IMCO's four GPO agreements give our distributors access to the GPO membership. The next hurdle for our distributors is access to manufacturer GPO-negotiated contracted costs. Again, if we are not an AD, access is denied."

Group purchasing in the non-hospital market is more important than ever, he adds. "It used to be that GPOs' focus was acute care and the O.L.M. (owned, leased or managed) alternate care accounts of the acute care system," he says. "That focus has evolved to the point of every GPO also offering their programs to affiliated members. Through customer mergers, acquisitions and affiliations, access to manufacturer better-cost tiers are now being offered in tandem with both hospital and non-hospital customers. For the last several years, national distributors have focused on offering better cost tiers to O.L.M. and affiliated customers. Now our IMCO distributor has the ability to neutralize that card and get down to the real issues of helping healthcare providers solve their biggest challenges."

IMCO Home Care. Introduced last year to offer independent home care providers competitive pricing, products and services, such as education, compliance, financing and marketing, IMCO Home Care continues to gain traction in large part due to the efforts of Vice President Pam Wedow and newly named Marketing Manager Suzanne Carlino.

"Home care is the fastest growing segment of our business," says Bullock. "With home care consolidation and competitive bidding, IMCO Home Care is providing solutions to many industry pain points. The five phases of our program will be rolled out over the next 24 months.

Primary care. Richard Bigham, who formerly held an executive role in sales/marketing for PSS, joined IMCO in April as director of primary care markets. "His fresh prospective is helping IMCO evolve, specifically with product development, sales rep training and marketing," says Bullock. Yates Farris continues in his role as vice president of primary care, and Steve Dennison has entered a new role as director of vendor relations. rep

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IMCO award winners

Winners Circle

- **Member Rep Rookie of the Year:** Oliver Lollis, Grove Medical, Greenville, S.C.
- **Vendor of the Year:** Attends Healthcare/Domtar
- **Vendor Rep of the Year:** Joel DeMarais, GOJO Industries.
- Sergio Bustamante, American Medical Supplies & Equipment, Miami, Fla.
- Marie Rabin, CARA Medical, Buffalo, N.Y.
- Greg Myers, Midland Medical Supply Co., Lincoln, Neb.
- Bill Muich, MMS – A Medical Supply Company, Earth City, Mo.
- Bob Vandergriff, MMS – A Medical Supply Company, Earth City, Mo.
- Melissa Barcewski, Premier Medical Distribution, Draper, Utah.
- David Marion, Seneca Medical, Tiffin, Ohio.
- Dana Frank, Seneca Medical, Tiffin, Ohio.
- Jeff Shuey, Seneca Medical, Tiffin, Ohio.
- Courtney Ward, Sun Surgical, Gainesville, Fla.

IMCO member reps earned $121,000 in SPIFs in 2013.

IMCO Brand 450 Promotion

Sun Surgical, Gainesville, Fla. won the promotion for the second year in a row. The Brand 450 Promotion is the annual sales contest for the IMCO brand of products, and includes quarterly promotions, member savings and, for the winning company, an all-expense-paid trip to the Daytona 300 and 500 races, complete with beachside accommodations and "backstage" garage passes.

Show floor winners

- **Grand Prize/Member:** Randy Bomberger, Manheim (Pa.) Medical.
- **Grand Prize/Vendor:** Bailey Cobbs, independent rep, attending with Innovative Healthcare Corp.
- **Best Booth:** Innovative Healthcare Corp.

Golf

The winning IMCO scramble team comprised Roy Arthur, Luffeys; Jason Greiner, Cincinnati Surgical; Brian Eve, Cincinnati Surgical; and Kurt Rosinski, Health o Meter. The golf scramble, sponsored by GOJO Industries, was held at Feather Sound Country Club.

The IMCO 2015 National Convention is scheduled for May 2-6, 2015, in Jacksonville, Fla.

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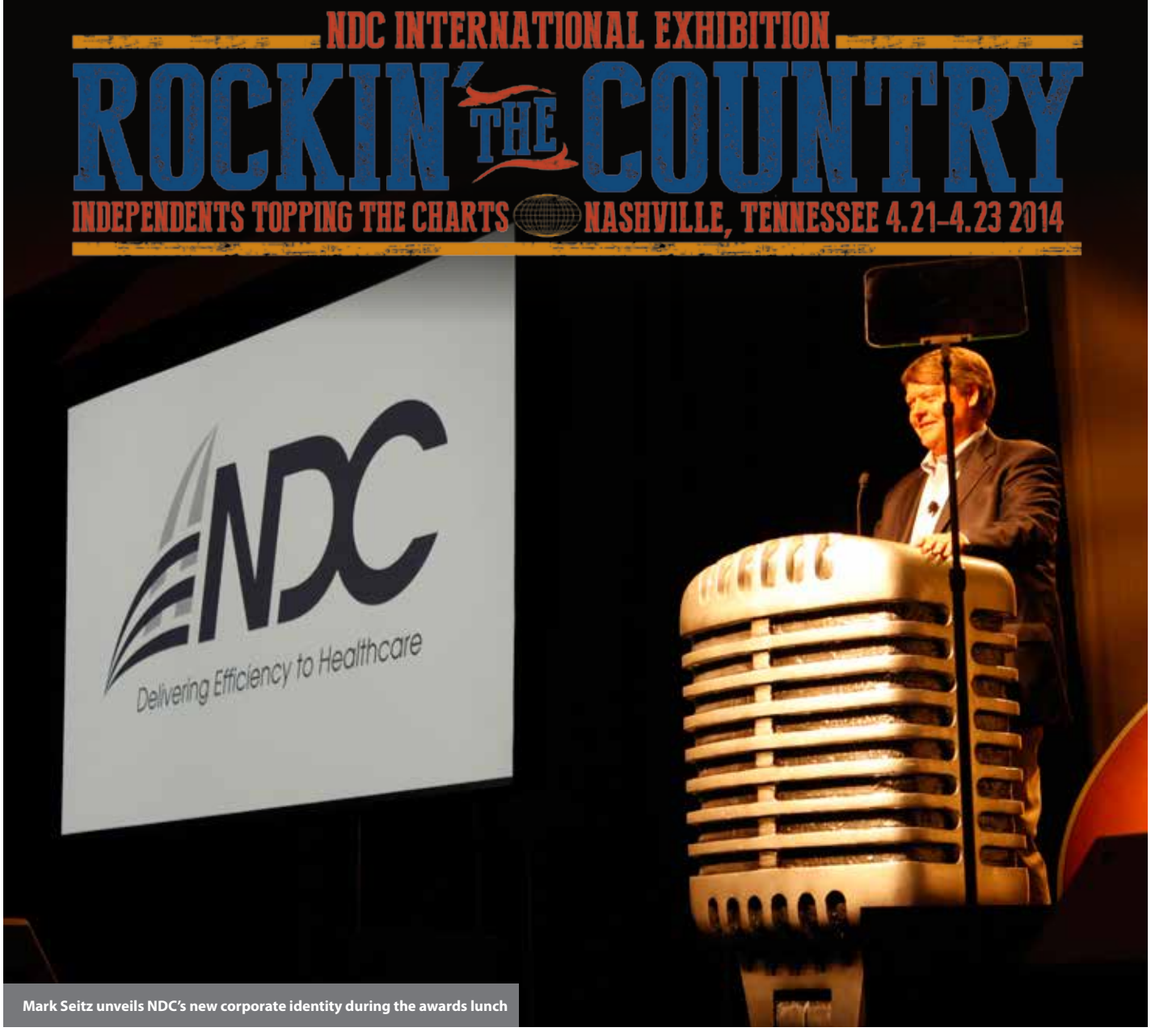
NDC strikes a new chord

President and CEO Mark Seitz unveils strategic rebranding initiative

With a new venue at Nashville's state-of-the-art Music City Center, the tempo of the 2014 NDC International Exhibition was upbeat, according to show organizers. For the first time, NDC University (NDCU) – a two-day sales training event – ran concurrently with the meeting, bringing together the largest graduating class of students and over 800 exhibition attendees for two full days of "Rockin' the Country – Independents Topping the Charts."



Mark Seitz unveils NDC's new corporate identity during the awards lunch

Sing a song

The opening session, sponsored by the Midmark Corporation and Smith & Nephew, featured the Grammy-nominated songwriters of KidBilly Music, which facilitates team-building through song. NDC distributors and manufacturers composed a song to illustrate the power of creative brainstorming, a critical skill for success in today's increasingly complex business environment. The session culminated with the audience taking the stage and performing the song:

(chorus)
Serving our customers, independents do it better
There's a lot of change and we have to work together
We sell the good stuff with the help of our vendors
Working hand-in-hand, independents do it better

We live our lives with the lives we save
We're there when you need us, every night and day
We're part of the community of the people we serve
We're right down the road, so we're ahead of the curve

KidBilly achieves maximum audience participation during the opening session

The GPO Strategy topic packed the house during the educational sessions

The power of partnership

This "working hand-in-hand" attitude set the tone for the rest of the exhibition, according to organizers. A variety of educational and networking activities ensued, providing attendees the time and format to connect with business partners and industry colleagues. The Premier Vendor Exchange allowed for semi-private meetings between NDC Premier Vendors and key distributor personnel.

Tuesday's educational sessions were well-attended and provided participants with relevant training and take-aways to innovate and improve their businesses. Distributors learned of opportunities to maximize the benefits of their NDC membership. Standing-room-only attendees at the GPO Strategy Session and Contracting Workshop received insight into working with NDC to gain a competitive advantage in an increasingly challenging market.

Rebranding initiative

NDC President & CEO Mark Seitz opened Tuesday's Awards Lunch by unveiling a new corporate logo, the first piece of a strategic rebranding initiative. Seitz also announced an NDC tagline: "Delivering efficiency to healthcare."

"This rebranding embodies NDC's renewed commitment to our business partners – distributors, manufacturers and GPOs alike," said Seitz. "It is more than just a logo. It is a reflection of how NDC will do business moving forward; how we will increase our already high standards, and provide an even better customer experience."

Through investments in people, technology and customers, NDC intends to move forward as a healthcare supply chain solution, continuing to provide customers a competitive advantage through creative solutions, Seitz said. This summer, NDC will launch a new corporate website, serving as the foundation for a future single portal for all customers. By expanding the NDC customer base to include enhanced services for manufacturers and GPOs, independents can build a stronger network, move more products through more channels and, ultimately, increase their relevance in the industry, he said.

Dukal took center stage to accept Vendor of the Year

AllMed was awarded Member of the Year for an outstanding performance in 2013

This year's theme had Graham Medical all shook up

NDC award winners

Member Sales Representative of the Year: Chris Lord, Claflin Company.

Member of the Year: AllMed Medical Supply.

Vendor Sales Representative of the Year: Wayne Shen, Dukal Corp.

Vendor of the Year: Dukal Corp.

Rockin' the industry

More than 150 vendors exhibited at the trade show. Aggressive show specials were designed to stimulate on-site purchase orders, resulting in millions of dollars in transactions on the show floor. After the trade show, exhibition attendees enjoyed a private concert at the Wildhorse Saloon by the country/rock group Parmalee, sponsored by Innovative Healthcare Corp. and Roche Diagnostics.

As NDC distributors and manufacturers forge ahead, they will continue to adapt and emerge as innovators within the industry, said Seitz. The partnerships of NDC with all its customers – distributors, manufacturers, and GPOs – have been the foundation for past success, and will be just as critical moving forward. Touch points such as this exhibition allow all of those within the NDC network to strengthen, expand, and work together to deliver efficiency to healthcare, he added

The NDC International Exhibition will return in 2015 to the Nashville Music City Center and the Omni Nashville. Dates are booked for March 29-31.

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HIDA's Health Reform Update

By Linda Rouse O'Neill, Vice President, Government Affairs, HIDA

The following update by the Health Industry Distributors Association (HIDA) is designed to keep healthcare distributors and other key stakeholders current on the latest government-affairs related topics.

Competitive bidding delay garners bipartisan support

The effort to delay Medicare's competitive bidding program for DMEPOS received a significant boost for the supply chain when 39 senators signed on to a bipartisan letter to Centers for Medicare and Medicaid Services (CMS) Administrator Marilyn Tavenner urging she delay further expansion of the program until the Office of Inspector General (OIG) finishes its examination of the program's second round. HIDA's grassroots efforts were instrumental in securing signatures from both sides of the political aisle, sending a strong message of congressional interest in this issue.

HIDA's recommendation to the FDA: recognize that multiple standards are necessary given the aggressive timeline proposed and various capabilities that exist among trading partners, including providers.

The letter urges CMS to allow the OIG to complete its investigation on competitive bidding licensure problems and verification of Round Two single payment amounts and give Congress time to review the results before implementing the program nationwide in 2016. This letter is a very positive sign for distributors, as it marks the first time the Senate has weighed in on the controversial issue of competitive bidding since Round Two commenced.

FDA nears final guidance for pedigree

If you're still trying to sift through the Food and Drug Administration's (FDA's) pedigree requirements for the Drug Quality and Security Act, you're not alone. HIDA recently participated in a public workshop conducted by the agency on the interoperable data exchange and compliance strategies for distributors, manufacturers, and providers affected by the law.

Manufacturers and distributors are awaiting final guidance on transaction history, transaction information, and transaction statements requirements for the supply chain. HIDA and other industry stakeholders have submitted recommendations to the FDA during the current comment period, which the agency will review prior to drafting its final guidance.

HIDA's recommendation to the FDA: recognize that multiple standards are necessary given the aggressive timeline proposed and various capabilities that exist among trading partners, including providers. HIDA also recommends that the eventual guidance provide flexibility so that both paper and electronic practices currently used by supply chain partners can continue to meet new requirements.

Gift disclosure comes under the microscope

The Physician Payments Sunshine Act has been in effect for several months now, and it is time for distributors and manufacturers to take note as the law enters its second phase. The Sunshine Act seeks to make public all "transfers of value" reported by vendors starting September 30, but a multi-step process must take place before that happens.

In June, applicable manufacturers began reporting payments and/or gifts to physicians and teaching hospitals for the August 2013 to December 2013 time period. Providers must first register under CMS's Enterprise Portal before any review of gift disclosure information submitted by manufacturers and group purchasing organizations takes place. The CMS Open Payments system officially opens in July for final provider review before any data goes public in September.

HIDA's Government Affairs team will continue to keep you informed of gift disclosure developments, as well as other regulatory issues affecting the supply chain.

For more information, visit us at www.HIDA.org or contact us at HIDAGovAffairs@hida.org.

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Generics Mean Business

As generic devices prove themselves to be as reliable as brand name products, more IDNs will be amenable to using them.

By Laura Thill

The future is in generics, says supply chain consultant Chris Baskel, former system director of supply chain management at Spectrum Health. Particularly as standard devices, such as shoulder anchors and hip replacements, come off patent, more manufacturers are expected to offer generic copies, he says. And, they'll work just as well as the originals. In fact, Baskel is so certain of this, he currently is educating healthcare systems on the value of adopting generic technology and substantially reducing costs – sometimes by as much as 50 to 75 percent. "If a generic shoulder anchor costs $100, compared to $350 for a brand name device – and assuming an average of four anchors are used per case – that would add up to $1,000 savings for the hospital," he says.

Chris Baskel

"The emerging generic market is creating exact replicas of the stable name brand products hospitals have used for years," Baskel says. "However, there will be little to no movement toward a generic market until physicians' behavior begins to change. There is a tight bond between many physicians and name brand companies based on relationships that have developed over time. Thirty years ago, the idea and introduction of a generic pharmaceutical market would have raised a lot of eyebrows. Today, it's a given."

> "The first opportunities will be in orthopedics – spine implants, shoulder anchors and eventually hip/knee replacements."

Still, convincing IDNs and their physicians to adopt generic technology could be a hard sell, he continues, and not without good reason. "First and foremost, where would healthcare be today without the life-saving new technology developed by innovative manufacturers over the course of time?" he says. Traditionally,

IDNs have worked hard to be early adopters of new products and devices, he says. But, taking a wait-and-watch approach just might be the best way to go. For one, it's prudent and safer to employ products that have a proven track record over time. A quick Internet search will explain why, he adds.

Intuitive Surgical's da Vinci robotic surgical system, for example, was designed to provide surgeons greater visibility and control when performing certain invasive procedures. "This robotic system performs as advertised when it is used correctly," says Baskel. "But, it is another example of a technology rushed into use by some hospitals before physicians were properly trained to use it."

Indeed, a number of patients who underwent surgery with the assistance of the da Vinci received tissue burns and electrocutions that resulted in organ damage, infection, severe bleeding and other complications. In at least one case, a piece of the da Vinci system broke off during surgery and lodged in a patient's pelvis.

Along the same lines, there were cases where bioabsorbable suture anchors broke with screw-in insertion, as well as reports of inconsistency in the quality of the bioabsorbable material. ("Bioabsorbable Anchors in Glenhumeral Shoulder Surgery," 2009, Shane J. Nho, M.D., M.S.; LCDR Matthew T. Provencher, M.D., MC, USN; Shane T. Seroyer, M.D.; and Anthony A. Romeo, M.D.) "In many cases, the smart move may be for hospital administrators and purchasing executives to take a wait-and-see approach as others use new technology, and see how successful it is and what the pitfalls might be," says Baskel. "Given what we know today, what would the best choice be? To switch to the new technology, or a stable generic technology that has worked admirably for years?"

"The first opportunities will be in orthopedics – spine implants, shoulder anchors and eventually hip/knee replacements," he says, adding that for-profit hospitals and clinics likely will be the early adopters. But, in time, he believes Medicare and Medicaid will encourage hospitals to follow suit. "Until this happens, there may not be [a lot of] incentive for hospitals to make the switch to generics," he says. "But, one way or another, these are savings they are missing out on.

"Currently, it is very difficult to convince physicians to change from working with brand hip and knee companies," he continues. "Yet, there is no medical-based evidence to support a clear leader in the marketplace. There are five major hip manufacturers selling three types of hips: low-demand hips for elderly patients; medium-demand hips; and high-demand hips for young and active adult patients." In theory, these products have always been sold based on medical research and outcomes, he says. "In reality, they are commodities sold based on physician preference and long-standing relationships. Can you imagine the difficulty [this will cause] changing to a generic products when they hit the market?"

Nevertheless, as healthcare reform moves forward, more physicians will choose to join larger healthcare systems, he continues. So, several years from now, when these physicians are working for an IDN that is advocating generic implants and anchors, they will have to come on board, he says. At the same time, as more health systems are under pressure to publish the prices of their implant and device procedures, and physicians and patients become more aware of the savings to be had by using generics, interest will grow, he adds. "And, slowly but surely, the cost of implants will become more transparent to both the hospitals and consumers," he says. "There is no excuse. All hospitals and IDNs should publish their prices because it's the right thing to do." His former employer, Spectrum Health, has done so for some time, he adds.

> "If a generic shoulder anchor costs $100, compared to $350 for a brand name device – and assuming an average of four anchors are used per case – that would add up to $1,000 savings for the hospital."

"History is repeating itself," says Baskel, referring to the movement from brand name pharmaceuticals to generics in the 1980s. "Manufacturers are fighting this like crazy, and hospitals and physicians are scared of lawsuits and bad publicity." But, just as generics now drive the pharmaceutical market, as IDNs and physicians become better educated on the value and savings to be had, generic devices and implants will quickly catch on. rep

Editor's note: For more information, contact Chris Baskel at cmbaskel@comcast.net.

Think Twice

Choosing Wisely campaign encourages doctors to have frank discussions with patients about what tests and procedures they really need – and those they don't.

Daniel Wolfson talks about the "sweet spot" of healthcare. It's that point where safety, quality and affordability of healthcare intersect. In real-life terms, it's that point where patient and doctor meet, talk, and decide which diagnostic and therapeutic procedures make the most sense in a particular instance. It's a spot that distributor sales reps will probably become much more aware of in the coming months and years.

Wolfson is executive vice president and chief operating office of the ABIM Foundation, a nonprofit foundation whose mission is to advance professionalism in an effort to improve healthcare. It is also the driving force behind Choosing Wisely®, an initiative to help physicians and patients engage in conversations about the overuse of tests and procedures, and support physicians' efforts to help patients make smart and effective care choices.

The concept of Choosing Wisely was originally piloted by the National Physicians Alliance, who through an ABIM Foundation "Putting the Charter into Practice" grant, created a set of three lists of specific steps physicians in internal medicine, family practice and pediatrics could take in their practices to promote the more effective use of healthcare resources. Since then, 60 specialty societies have created lists of more than 300 "Things Physicians and Patients Should Question," which provide specific, evidence-based recommendations physicians and patients should discuss to help make decisions about the most appropriate care based on their individual situation. (To view a complete list of those recommendations go to http://www.choosingwisely.org/wp-content/uploads/2013/02/Choosing-Wisely-Master-List.pdf.)

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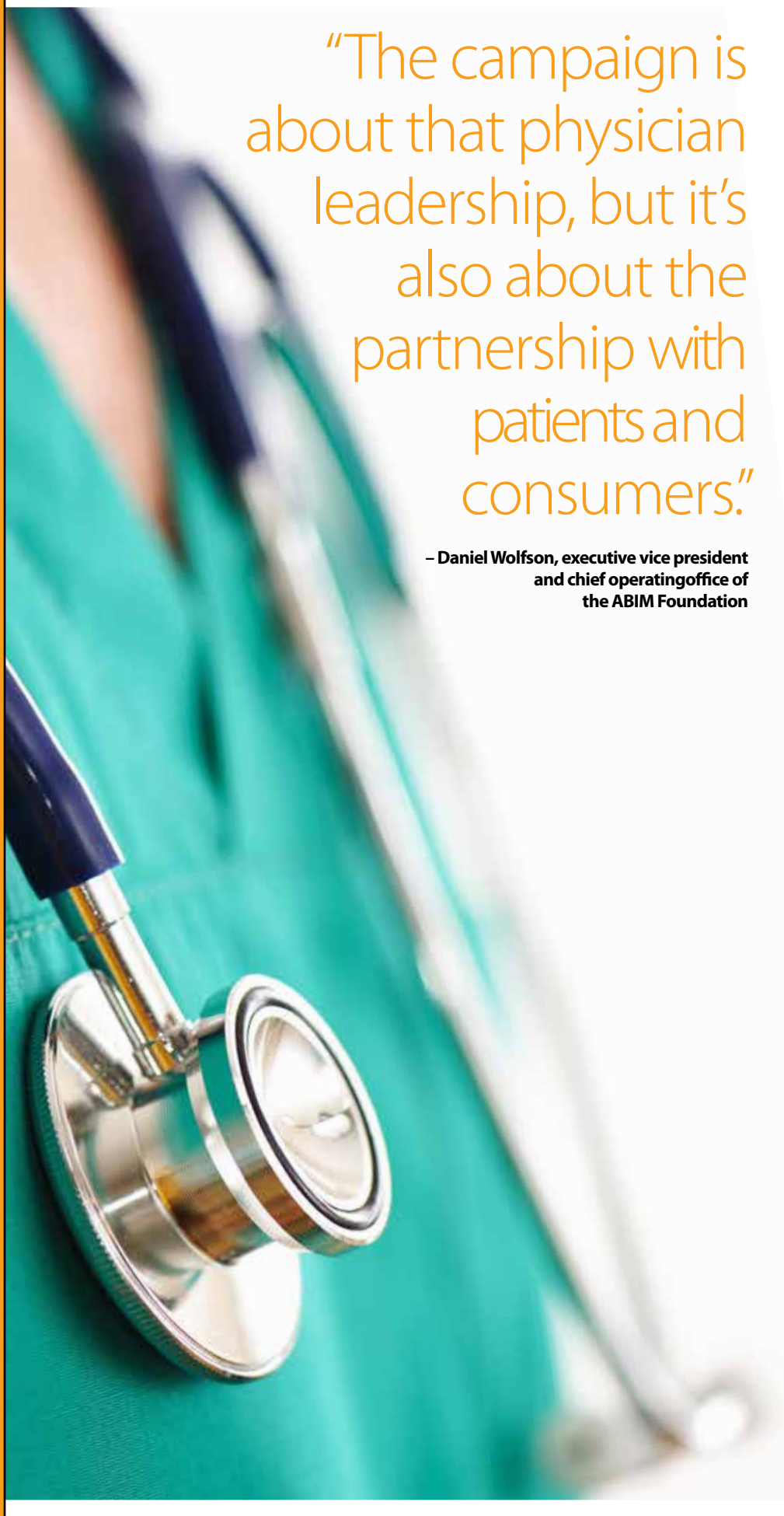

"The campaign is about that physician leadership, but it's also about the partnership with patients and consumers."

– Daniel Wolfson, executive vice president and chief operatingoffice of the ABIM Foundation

Physicians take lead

"The underlying basis of our work is professionalism, and we think Choosing Wisely is part of that," says Wolfson. "It is allowing physicians to lead, and take ownership of identifying and eliminating waste, that is, tests and procedures for which the risks outweigh the benefits. The campaign is about that physician leadership, but it's also about the partnership with patients and consumers. We are not only saying to physicians, but to patients as well, that less can be better."

In fact, *Consumer Reports* has already developed more than 100 patient-friendly brochures on specific conditions identified by societies participating in Choosing Wisely, and is working with consumer groups to disseminate them.

Choosing Wisely isn't intended to ration care or to encourage doctors to stop ordering tests or procedures that might be beneficial, Wolfson says. But it is intended to encourage doctors and patients to stop ordering tests and procedures without questioning how they might (or might not) affect the treatment plan, or how they might actually cause harm to the patient through such things as unnecessary biopsies or other procedures.

"The things that are appropriate will continue to be utilized," he says. "The things that aren't will be less utilized." Example: The American Society for Radiation Oncology – as one of its Choosing Wisely recommendations – suggested that providers refrain from routinely recommending proton beam therapy for prostate cancer outside of a prospective clinical trial or registry. Their rationale: Proton beam therapy might be an excellent tool for ocular disease or cancer in children, but as a front-line tool for prostate cancer, it's expensive and it doesn't produce better results than much less costly alternatives, says Wolfson.

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More isn't always better

"We want to change the attitude that more is always better," says Wolfson. "We want physicians to take responsibility for providing unnecessary care. And we want to bring about attitudinal changes on the part of patients and physicians."

Many tests and procedures are applied more frequently, and to too many people, than originally intended, he says. Colonoscopy is an example. One of the American Gastroenterological Association's Choosing Wisely recommendations calls for average-risk individuals to delay colorectal cancer screening for 10 years after a high-quality colonoscopy is negative. Colonoscopy shouldn't be ordered more frequently as a matter of course for non-symptomatic, average-risk patients.

"But none of these recommendations are absolutes," says Wolfson. "There needs to be a conversation between patient and physician about what's necessary for that particular patient and circumstance. So the recommendations aren't saying to eliminate [tests and procedures]. They're saying, 'Have a conversation' before [doing them]."

After just two years, Choosing Wisely has taken off, gaining popularity both in the United States and other countries, he says. A recent survey of 600 U.S. physicians, funded by the Robert Wood Johnson Foundation, showed that one in five are aware of the campaign. Among them, 62 percent say they are more likely to have reduced the number of times they recommended a test or procedure because they learned it was unnecessary. That compares to 45 percent among those who are unaware of Choosing Wisely. And 70 percent of physicians say that after they speak with a patient about why a test or procedure is unnecessary, the patient often avoids it.

But there's more work to be done, the survey shows:

- **73 percent** of physicians say the frequency of unnecessary tests and procedures is a very or somewhat serious problem.
- **66 percent** of physicians feel they have a great deal of responsibility to make sure their patients avoid unnecessary tests and procedures.
- **53 percent** of physicians say that even if they know a medical test is unnecessary, they order it if a patient insists.
- **58 percent** of physicians say they are in the best position to address the problem, with the government a distant second (15 percent).
- **72 percent** of physicians say the average medical doctor prescribes an unnecessary test or procedure at least once a week.
- **47 percent** of physicians say their patients ask for an unnecessary test or procedure at least once a week.

> "When physicians are engaged and feel they are part of the solution, there's a willingness to examine the evidence."

The next step

"We have tried to provide a platform for physicians through which their specialty societies can take leadership on this issue," says Wolfson. "And when physicians are engaged and feel they are part of the solution, there's a willingness to examine the evidence. Making changes in practice is much more likely to occur.

"This campaign is unleashing professionalism. It is empowering physicians and allowing them to do the right thing for their patients," he continues. "And it is allowing them to re-focus on the patient/physician relationship."

The Choosing Wisely campaign – and all it represents – will only keep growing, he predicts. Next up? Additional recommendations from the participating specialty societies, as well as involvement by some non-physician sectors, including the American Dental Association, American Physical Therapy Association and the American Academy of Nursing.

"The world is changing, reimbursement systems are changing. That makes Choosing Wisely an opportune mechanism to do something about waste in America – to hit that sweet spot of safety, quality and affordability of healthcare. It's a win/win for everybody. Patients get better care; doctors don't give unnecessary care (which they don't want to do anyway), and society is served by the by-product – savings." rep

Conversation Needed

"The most important goal of Choosing Wisely is to provide evidence-based suggestions that can help improve our patients' healthcare quality," says Reid Blackwelder, MD, FAAFP, professor and director of undergraduate medical education, Kingsport Center, East Tennessee State University, and president of the American Academy of Family Physicians. "Our recommendations aim to reduce unnecessary, or even harmful, treatments and tests by encouraging conversations between physicians and patients."

Family physicians want these kinds of conversations to occur, he says. "We want to work with our patients to address the triple aim of improving their health outcomes, improving their satisfaction, and reducing unnecessary expenses." Together, doctor and patient can carefully consider and openly discuss tests and treatments in the critical context of the particular patient, he adds.

> "We are really good at helping our patients change behaviors, and now we get to be part of changing ours."
>
> **– Reid Blackwelder, MD, president of the American Academy of Family Physicians**

AAFP's recommendations are just that – recommendations. "These are not hard and fast rules," says Blackwelder. "We do not treat diseases or conditions, we treat people."

AAFP has been particularly active in the Choosing Wisely campaign, listing 15 things that physicians and patients should question. "After making 15 recommendations, we believe it is time to do some review and assessment," says Blackwelder. "Right now we are looking at our members' acceptance, and that of their patients, of the Choosing Wisely recommendations. We want to explore what barriers might keep patients and physicians from embracing these recommendations, and how we may be able to assist with the shared decision-making process."

"We are really good at helping our patients change behaviors, and now we get to be part of changing ours."

AAFP: Fifteen Things Physicians and Patients Should Question

1. Don't do imaging for low back pain within the first six weeks, unless red flags are present.
2. Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.
3. Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.
4. Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.
5. Don't perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.
6. Don't schedule elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks, 0 days gestational age.
7. Avoid elective, non-medically indicated inductions of labor between 39 weeks, 0 days and 41 weeks, 0 days, unless the cervix is deemed favorable.
8. Don't screen for carotid artery stenosis (CAS) in asymptomatic adult patients.
9. Don't screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer.
10. Don't screen women younger than 30 years of age for cervical cancer with HPV testing, alone or in combination with cytology.
11. Don't prescribe antibiotics for otitis media in children aged 2–12 years with non-severe symptoms where the observation option is reasonable.
12. Don't perform voiding cystourethrogram (VCUG) routinely in first febrile urinary tract infection (UTI) in children aged 2–24 months.
13. Don't routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam.
14. Don't screen adolescents for scoliosis.
15. Don't require a pelvic exam or other physical exam to prescribe oral contraceptive medications.

Source: Choosing Wisely, an initiative of the ABIM Foundation, www.choosingwisely.org/wp-content/uploads/2013/02/Choosing-Wisely-Master-List.pdf

A Quest to Deliver High Value Care

"Choosing Wisely encourages physicians and patients to question the routine use of tests and treatments that are unlikely to help and may actually harm patients," says Daisy Smith, MD, FACP, senior physician educator, American College of Physicians. As such, it fits with ACP's mission, that is, "to enhance the quality and effectiveness of healthcare by fostering excellence and professionalism in the practice of medicine," she says. "ACP members are dedicated to improving patient outcomes, and this is the goal of Choosing Wisely and the ACP's High Value Care Campaign."

The barriers to change are formidable.

"We have surveyed a subset of our membership who spend over 50 percent of their time in practice on reasons why they ordered additional unnecessary tests, and were a bit surprised with what we found," says Smith. "The No. 1 reason physicians over-ordered tests was because of their discomfort with diagnostic uncertainty. The second most commonly cited reason was fear of malpractice. The third was concern for inadequate patient follow up/access (more prominent for hospitalists). The fourth was time pressure, and the fifth was patient requests.

"These data showed us that the major focus or concern driving physician behavior is a desire to do the best for their patients, and so we used the frame of avoiding the harms of unnecessary testing (this may include financial harm to the patient) in our education to providers around this issue. This resonates much more with providers than saving money."

The ACP has integrated its own Choosing Wisely recommendations and those of other specialty societies, as well as the tools of its High Value Care program, into its education programs, products and services, says Smith.

"This includes High Value Care learning objectives and programming at our live meetings; High Value Care recommendations in our popular medical knowledge self-assessment program (MKSAP); a High Value Care sub-score on our internal medicine

in-training examination; and High Value Care callouts in our new evidence-based point-of-care resource, SmartMedicine," she says. In addition, ACP has collaborated with the Alliance for Academic Internal Medicine and MedU to create free curricula on High Value Care for medical students, residents, and practicing clinicians. These curricula have been accessed over 30,000 times since they were developed and have expanded the reach of the initiative and the discussion beyond isolated lists.

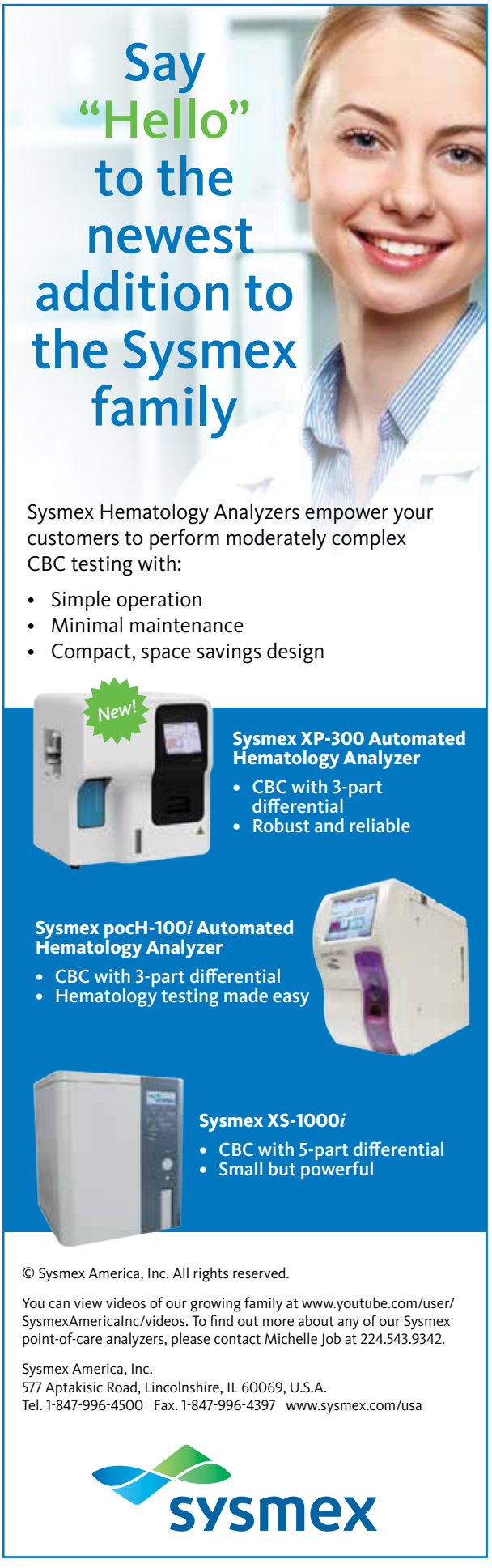
Payers are excited about Choosing Wisely as well as the ACP's High Value Care initiative and have expressed an interest in supporting this work, says Smith. That said, "the ACP has been very cautious about accepting any support from payers for this work, as this may be perceived as a conflict of interest and focus unnecessarily on saving money, when our real focus is on improving outcomes," she says. "In addition, we aim to promote and protect the healing relationship between a patient and their provider.

"A key step in our High Value Care framework involves customizing a care plan that incorporates the patient's values and addresses their concerns. We do not believe that one-size-fits-all care is high value care." rep

American College of Physicians: Five Things Physicians and Patients Should Question

1. Don't obtain screening exercise electrocardiogram testing in individuals who are asymptomatic and at low risk for coronary heart disease.
2. Don't obtain imaging studies in patients with nonspecific low back pain.
3. In the evaluation of simple syncope and a normal neurological examination, don't obtain brain imaging studies (CT or MRI).
4. In patients with low pretest probability of venous thromboembolism (VTE), obtain a high-sensitive D-dimer measurement as the initial diagnostic test; don't obtain imaging studies as the initial diagnostic test.
5. Don't obtain preoperative chest radiography in the absence of a clinical suspicion for intrathoracic pathology.

Source: Choosing Wisely, an initiative of the ABIM Foundation, http://www.choosingwisely.org/wp-content/uploads/2013/02/Choosing-Wisely-Master-List.pdf



Take a Step Back

Choosing Wisely is about practicing quality medicine, not merely pointing out tests and procedures that don't change outcomes or clinical management, says Theodore Freeman, MD, who sits on the executive committee of the American Academy of Allergy, Asthma and Immunology, and who helped compile the Academy's Choosing Wisely recommendations. What constitutes "quality medicine" varies from patient to patient, and may vary in the same patient over time, he adds.

"What we have to avoid is the feeling that just because a test or procedure can be beneficial in a certain diagnosis in some circumstances, that the test or procedure is beneficial in most or all circumstances. It is only human when a technique has proven successful in one case, to apply it again and again.

"Quality medicine does not require that exhaustive testing or procedures be done for each patient. It does require a thoughtful application of diagnostic and therapeutic procedures tailored to each patient. Choosing Wisely reminds each of us to step back and assess the value of each test and procedure we undertake for each patient we see."

> "What we have to avoid is the feeling that just because a test or procedure can be beneficial in a certain diagnosis in some circumstances, that the test or procedure is beneficial in most or all circumstances."
>
> **– Theodore Freeman, MD**

The Choosing Wisely campaign helps the medical community addresses two significant barriers to change – habit and patient resistance. "Since Choosing Wisely is available to patients, it addresses their resistance and encourages them to discuss tests and procedures with their physicians, which helps to address the physician's habits even if the physicians do not read Choosing Wisely criteria themselves," says Freeman.

And when he talks about "physicians," Freeman is referring to more than AAAAI members. "It has wider appeal, and each item should be considered a recommendation to all primary care practitioners, who deal with diagnosis. Practicing quality medicine should be important to every physician. The importance should be self-evident and innate in every physician, not just members of the AAAAI." rep

AAAAI: Five Things Physicians and Patients Should Question

1. Don't perform unproven diagnostic tests, such as immunoglobulin G (IgG) testing or an indiscriminate battery of immunoglobulin E (IgE) tests, in the evaluation of allergy.
2. Don't order sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis.
3. Don't routinely do diagnostic testing in patients with chronic urticaria.
4. Don't recommend replacement immunoglobulin therapy for recurrent infections unless impaired antibody responses to vaccines are demonstrated.
5. Don't diagnose or manage asthma without spirometry.

Source: Choosing Wisely, an initiative of the ABIM Foundation, www.choosingwisely.org/wp-content/uploads/2013/02/Choosing-Wisely-Master-List.pdf

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2 CoaguChek XS PT Test package insert, 2013.

3 Roche CoaguChek XS System and the Alere INRatio 2 System Method Comparison Study, 2011. Study conducted independently by NB Consulting, Indianapolis, IN. Protocol written by Roche Diagnostics employees M. Leuther and M. Payette. Data on file.

4 GHX Market Intelligence. Data on file at Roche Diagnostics.

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Just the Facts

Choosing Wisely is an effort to educate physicians and patients about commonly used tests and procedures that are often overused or misused, that make little or no difference in treatment or outcomes, and that can – in some cases – cause harm to patients, says Douglas Wood, MD, chief of the Division of Cardiothoracic Surgery, UW Medicine, Seattle, Wash., and immediate past president of the Society of Thoracic Surgeons.

"For example, in many practices, it became commonplace for patients undergoing major surgery to routinely get cardiac stress testing," he says. Some surgeons also saw it as a way to protect themselves against potential medical liability.

Now, surgeons have a legitimate desire to identify patients who might have cardiac disease, and for whom pre-op stress testing is beneficial, says Wood. "But in the absence of signs, symptoms or findings of cardiac disease, it isn't useful. It doesn't change outcomes; it does not reliably help the surgeon identify disease that calls for intervention. In fact, it may have the counter effect of identifying things that result in further testing or invasive procedures that may result in harm."

Choosing Wisely can help shape physicians' behavior, he says. One way is through peer pressure. "Instead of feeling like everyone around you is doing this test in this clinical scenario, it empowers the physician to question it. They can think about being better stewards of resource management, and being more thoughtful about what they're putting patients through."

> "We shouldn't be doing tests simply because we can't think of a reason why not to."
>
> **– Douglas Wood, MD**

But education is a two-way street, he says. Physicians' activities are often driven by the expectations of their patients, who might expect or demand certain tests or procedures as a matter of course.

"Part of Choosing Wisely is to elevate the dialogue between patients and doctors," he says. "It's a means of empowering and educating patients, and creating opportunities for discussion, so patients can make more informed decisions. It allows patients and physicians to say, 'We have

Society of Thoracic Surgeons: Five Things Physicians and Patients Should Question

1. Patients who have no cardiac history and good functional status do not require preoperative stress testing prior to non-cardiac thoracic surgery.
2. Don't initiate routine evaluation of carotid artery disease prior to cardiac surgery in the absence of symptoms or other high-risk criteria.
3. Don't perform a routine pre-discharge echocardiogram after cardiac valve replacement surgery.
4. Patients with suspected or biopsy proven Stage I non-small cell lung cancer (NSCLC) do not require brain imaging prior to definitive care in the absence of neurologic symptoms.
5. Prior to cardiac surgery, there is no need for pulmonary function testing in the absence of respiratory symptoms.

Source: Choosing Wisely, an initiative of the ABIM Foundation, http://www.choosing-wisely.org/wp-content/uploads/2013/02/Choosing-Wisely-Master-List.pdf

some evidence that, in this situation, this extra procedure or test may not help, and may cause harm.'

"We shouldn't be doing tests simply because we can't think of a reason why not to," says Wood. "Our country can't afford to do that – which may be part of the reason our healthcare system is more expensive that that of any other country.

"But it also hurts patients. Doing tests is not benign. That's one thing patients and physicians don't understand. They may think, 'There's no consequence of doing this CT scan or pulmonary function test.' The problem is, tests that aren't indicated can often uncover unimportant things that lead to further testing, some of which may be invasive and result in harm.

"We always ought to ask, 'Is there a good reason to do this test?' I always ask our residents and fellows that question. I ask them what they intend to do with the result. If we think things through, we will be more thoughtful about the tests we order. We will help expose patients to fewer unnecessary procedures, and we will use our healthcare resources better."

Changing long-standing practices doesn't happen overnight, says Wood. "I don't think our work is ever done trying to figure out how we can use evidence-based medicine to correctly inform patients and to make thoughtful choices about what is useful in a medical evaluation and what is not. I think this is just the beginning. It's a great start to a conversation among physicians, and between physicians and their patients." rep

"I don't think our work is ever done trying to figure out how we can use evidence-based medicine to correctly inform patients and to make thoughtful choices."

Change of Habits

Choosing Wisely isn't just an effort to reduce tests and procedures that are likely to have little or no impact on outcomes, says Eric Bass, MD, MPH, professor of medicine at the Johns Hopkins University School of Medicine and Bloomberg School of Public Health, and president of the Society of General Internal Medicine. It is also an effort to consider the impact of tests and procedures that have the potential to cause more harm than good. SGIM is comprised primarily of academic general internists.

One SGIM recommendation – to weigh the benefit of cancer screening in adults with a life expectancy of less than 10 years – demonstrates the point. Consider screening colonoscopy, says Bass. "At some point, you wonder how much you're helping an older person with a short life expectancy by putting him or her through the prep and procedure of a colonoscopy."

Increasingly, physicians are factoring in life expectancy when making recommendations to their patients, he says. "But it's still a tricky recommendation, because it's difficult to predict what an individual's life expectancy is. It can be a challenging conversation to have with a patient, though some are receptive, and are reluctant to be put through invasive testing when they realize they may not live long enough to derive the full benefit."

"Some evidence suggests that routine health checks reduce patient worrying and may facilitate the administration of preventive measures. But apart from that, they don't add much value in terms of hard clinical outcomes."

– Eric Bass, MD

Another SGIM recommendation – that physicians forego routine pre-operative testing before low-risk surgical procedures – is focused on procedures that tend to have little impact on outcomes. Bass's colleagues at Johns Hopkins conducted a large study of the benefits

of pre-op tests – such as a CBC, chemistry panel, EKG, chest X-ray, etc. – before cataract surgery. "That study showed there was really no benefit in that setting," he says. "There are some patients for whom preoperative testing is a good idea, but it's not something that needs to be done routinely, without considering the individual's health status and risk."

Society of General Internal Medicine: Five Things Physicians and Patients Should Question

1. Don't recommend daily home finger glucose testing in patients with Type 2 diabetes mellitus not using insulin.
2. Don't perform routine general health checks for asymptomatic adults.
3. Don't perform routine pre-operative testing before low-risk surgical procedures.
4. Don't recommend cancer screening in adults with life expectancy of less than 10 years.
5. Don't place, or leave in place, peripherally inserted central catheters for patient or provider convenience.

Source: Choosing Wisely, an initiative of the ABIM Foundation, http://www.choosingwisely.org/wp-content/uploads/2013/02/Choosing-Wisely-Master-List.pdf

A third SGIM recommendation – to refrain from performing routine general health checks for asymptomatic adults – demonstrates the challenges associated with changing longstanding habits on the part of physicians and patients. "It addresses something we've done as part of our traditional approach to care," says Bass. "Some evidence suggests that routine health checks reduce patient worrying and may facilitate the administration of preventive measures. But apart from that, they don't add much value in terms of hard clinical outcomes."

But the recommendation about routine checkups comes with some big caveats – caveats that apply to many Choosing Wisely recommendations. "It assumes the patient has an established relationship with a primary care provider he or she trusts," and that the two can discuss the overall value of a routine checkup, says Bass. That discussion would consider the potential benefits of such a checkup, such as discovering or keeping tabs on potentially significant lifestyle issues or mental health concerns that otherwise might go unnoticed or uncared for.

"The best way to think about this recommendation is this: You should have an honest conversation about the best time to come back for a visit," he says. "If you're healthy and asymptomatic, and you have a doctor you can easily reach [if needed], you may not need to come back for a checkup every year. But for other people, based on risk factors and lifestyle, it may be important to come back, even more frequently than every 12 months."

Change can be difficult. "A lot of it comes back to our habitual approach to care, and not paying enough attention to thinking about the value of the care we're providing," says Bass. SGIM's new tagline – "Creating value for patients" – as well as Choosing Wisely, are vehicles to advise physicians and train the next generation to think carefully about the value of the care they provide, he adds. rep

A Learning Process

The Endocrine Society's leadership wanted to participate in the Choosing Wisely program in order to help endocrinologists engage patients in important discussions about their health and the benefits of various treatment options, says Robert Lash, MD, University of Michigan Health System, who served as chairman of the Joint Task Force of the Endocrine Society and American Association of Clinical Endocrinologists members who developed the Choosing Wisely list.

"These are observations of experts, not guidelines or standards of care," says Lash, referring to the list. "Given that each patient and situation is unique, there are many

"Given that each patient and situation is unique, there are many exceptions, and the recommendations are likely to evolve with advances in research."

– Robert Lash, MD

exceptions, and the recommendations are likely to evolve with advances in research. Endocrinologists are free to use this resource as they see fit.

"Thanks to ongoing research, we are always learning more about the best approaches for treating people with hormone and metabolic conditions. Although the Society does not have any current plans to create a new list, as clinical practice evolves, the Society would consider developing a new Choosing Wisely list in the future." TEP

Endocrine Society and American Association of Clinical Endocrinologists: Five Things Physicians and Patients Should Question

1. Avoid routine multiple daily self-glucose monitoring in adults with stable type 2 diabetes on agents that do not cause hypoglycemia.
2. Don't routinely measure 1,25-dihydroxyvitamin D unless the patient has hypercalcemia or decreased kidney function.
3. Don't routinely order a thyroid ultrasound in patients with abnormal thyroid function tests if there is no palpable abnormality of the thyroid gland.
4. Don't order a total or free T3 level when assessing levothyroxine (T4) dose in hypothyroid patients.
5. Don't prescribe testosterone therapy unless there is biochemical evidence of testosterone deficiency.

Source: Choosing Wisely, an initiative of the ABIM Foundation, www.choosingwisely.org/wp-content/uploads/2013/02/Choosing-Wisely-Master-List.pdf

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Colon cancer incidence rates dropping among older Americans

Growing use of colonoscopy credited

Colon cancer incidence rates have dropped 30 percent in the United States in the last 10 years among adults 50 and older, primarily due to the widespread uptake of colonoscopy, with the largest decrease in people over age 65, the American Cancer Society recently reported. Colonoscopy use has almost tripled among adults ages 50 to 75, from 19 percent in 2000 to 55 percent in 2010.

The findings come from Colorectal Cancer Statistics, 2014, published in the March/April issue of *CA: A Cancer Journal for Clinicians*. The article and a companion report, Colorectal Cancer Facts & Figures, were released by American Cancer Society researchers as part of an initiative by the National Colorectal Cancer Roundtable to increase screening rates to 80 percent by 2018.

Colorectal cancer, commonly called colon cancer, is the third most common cancer and the third leading cause of cancer death in men and women in the United States, according to the Society. Its slow growth from precancerous polyp to invasive cancer provides a rare opportunity to prevent cancer through the detection and removal of precancerous growths. Screening also allows early detection of cancer, when treatment is more successful. As a result, screening reduces colorectal cancer mortality both by decreasing the incidence of disease and by increasing the likelihood of survival.

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Using incidence data from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program and the Centers for Disease Control and Prevention's National Program of Cancer Registries, as provided by the North American Association of Central Cancer Registries (NAACCR), researchers found that during the most recent decade of data (2001 to 2010), overall incidence rates decreased by an average of 3.4 percent per year. However, trends vary substantially by age. Rates declined by 3.9 percent per year among adults aged 50 years and older, but increased by 1.1 percent per year among men and women younger than 50. That increase was confined to tumors in the distal colon and rectum, patterns for which a rise in obesity and emergence of unfavorable dietary patterns has been implicated.

Most strikingly, the rate of decline has surged among those 65 and older, with the decline accelerating from 3.6 percent per year during 2001-2008 to 7.2 percent per year during 2008-2010. The larger declines among Medicare-eligible seniors likely reflect higher rates of screening because of universal insurance coverage, the authors write. In 2010, 55 percent of adults aged 50 to 64 years reported having undergone a recent colorectal cancer screening test, compared with 64 percent of those aged 65 years and older.

Like incidence, mortality rates have also declined most rapidly within the past decade. From 2001 to 2010, rates decreased by approximately 3 percent per year in both men and women, compared with declines of approximately 2 percent per year during the 1990s.

To view the report Colorectal Cancer Facts & Figures,
go to www.cancer.org/acs/groups/content/documents/document/acspc-042280.pdf

Price-shopping?

Price transparency tools help patients understand the cost of medical treatment

How much should a consumer expect to pay for a facelift? Somewhere between $6,000 and $15,000, including an anesthesia fee of $1,000 to $1,300, and a hospital fee of $500 to $2,000, plus surgeon. That's according to CostHelper.com, one of a number of comparative-pricing guidelines that consumers can consult prior to receiving treatment.

Transparency in medical pricing is here. Leading the charge is the Centers for Medicare & Medicaid Services. The agency releases data that summarize the utilization and payments for procedures and services provided to Medicare fee-for service beneficiaries by specific inpatient and outpatient hospitals, physicians, and other suppliers. The Medicare Provider Utilization and Payment Data set includes information for the 100 most common inpatient services, 30 common outpatient services, and all physician and other supplier procedures and services performed on 11 or more Medicare beneficiaries.

To access the data set, go to www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html

But CMS isn't the only one trying to shed some light on healthcare prices. A number of private, Internet-based companies are doing the same.

Price transparency products on the market today show significant evolution, according to a 2013 report by Catalyst for Payment Reform. Still, health plans and vendors have much work to do to help consumers understand cost and quality differences, and which choices bring the best overall value according to their preferences.

Here's a look at three price transparency products on the market today.

CostHelper.com

Launched in 2006, CostHelper.com strives to give consumers prices on everything from robotic vacuum cleaners, to car battery chargers, to cat-teeth-cleaning, to wedding DJs. Its data comes from research conducted by CostHelper staff, as well as input from CostHelper users. Healthcare consumers can investigate prices on cancer treatment, skin care, general surgery, reproductive health and more.

Contemplating an STD test at the doctor's office? Expect to pay somewhere between $50 and $200, says CostHelper, depending on the test.

Price transparency products on the market today show significant evolution, according to a 2013 report by Catalyst for Payment Reform.

Healthcare BlueBook

"What we do is simple – we help consumers save on healthcare expenses while helping Fair Price providers attract cost-conscious consumers," says Healthcare BlueBook (www.healthcarebluebook.com). The website allows the user to search for prices for a variety of medical tests and procedures by zip code. And Healthcare BlueBook says it goes further, by promoting providers' value propositions to local employers and consumers.

Live in Downtown Chicago? The fair price for a cardiac exercise stress test is $160, for both physician (interpretation) and technical (the test) fee, according to Healthcare BlueBook. Denver? $151.

Pricing Healthcare Inc.

Founded in 2012, Pricing Healthcare (www.pricinghealthcare.com) says that it gathers pricing information for healthcare providers and services, then allows consumers – for a subscription fee – to compare procedure-level prices across the healthcare facilities in their area. Unlimited price searches are said to be available to anyone willing to submit at least one medical bill item from the last two years.

Editor's Note: To view the 2013 report, "The State of the Art of Price Transparency Tools and Solutions" from Catalyst for Payment Reform," go to www.catalyzepaymentreform.org/images/documents/stateoftheart.pdf.

The Window to a Patient's Health

The leap between oral and systemic health may not be as great as some physicians once believed.

Is the mouth a window to patients' health? For years, many dentists and their staff have recognized the link between their patients' oral health and other diseases, including cardiovascular disease, diabetes, and arthritis. Today, more and more physicians are making the connection as well. In fact, one Pennsylvania-based physician, Dr. Charles Whitney, recently added dental hygienist Lisa Wadsworth to his team of medical caregivers at his practice, Revolutionary Health Services. Through education and community outreach, Whitney and Wadsworth hope to bridge the gap between medicine and dentistry and encourage collaborative care.

Dr. Whitney, who is an advocate of *Third Era Medicine*, which focuses on preventing illness through diagnostic testing, nutrition, exercise and collaborating with other healthcare practitioners to treat the whole patient, says Wadsworth's clinical dental experience will help him educate patients on the threat of untreated periodontal disease to their health. Recently, *Repertoire* spoke with Whitney about his approach to patient care.


Dr. Charles Whitne

Repertoire: We understand you practice *Third Era Medicine*. Has oral healthcare been a part of your practice up to this point?

Dr. Charles Whitney: I didn't realize the value prior to my Bale/Doneen training on heart attack and stroke prevention (an approach to cardiovascular disease prevention that includes patient education, identifying root causes of the disease and setting goals for modifying risk factors). That's where I learned about what happens when oral bacteria enter the bloodstream, spray everywhere and influence many disease processes. Before that, all I knew was that dentists should do oral cancer screenings, and that a small handful of my patients needed antibiotics before dentists' appointments because of diseased valves.

Repertoire: How can untreated periodontal disease impact your patients – particularly those with cardiovascular disease, diabetes and arthritis?

Dr. Whitney: I strongly believe that high-risk oral bacteria – both endodontic and periodontal – will directly cause inflammation and produce endotoxins locally at sites far distant from the mouth. The endotoxins and inflammation produced will drive many disease processes, including incurable ones like Alzheimer's disease and pancreatic cancer. Regarding cardiovascular disease, I believe there are many risk factors building up, comparable to filling the arterial walls with gasoline. However, there will also be a small number of factors that act like a match to light the flame and cause a plaque rupture that causes a heart attack or stroke. An oral bacteremia event is clearly one of the matches!

Repertoire: In your experience, are medical schools currently addressing the oral-systemic gap?

Dr. Whitney: I think there is greater awareness among younger physicians, but I'm not sure if that's through direct education or common sense and the press. I still see very minimal discussion about the oral-systemic connection, even among forward-thinking organizations that focus on proactive wellness.

Repertoire: What role will Lisa Wadsworth, RHD, BS, director of operations, play in your practice with regard to educating patients on the dangers of untreated periodontal disease? How will her presence change the diagnostic protocol at your practice?

Dr. Whitney: Lisa Wadsworth certainly will be [responsible for] educating my patients and our local community. I also hope to have her lead a national effort to bridge the gap between medicine and dentistry and encourage collaborative care. One problem that I frequently encounter is a patient whose medical profile suggests pathology from the oral cavity, but who is being told by their dental team that no problems exist. Blood in the sink is being tolerated at home and in the dental office, while blood inflammatory markers and saliva testing suggest the presence of high-risk oral bacteria. I believe Lisa will be very effective in leading a community and national effort to educate the consumers and health professionals alike that NO blood in the sink can be tolerated.

Repertoire: Do you expect to begin performing oral examinations in the office?

Dr. Whitney: We will not be able to diagnose oral pathology without a dentist in the office. Unfortunately for me, but fortunately for dentists, periodontal disease is a medical condition that physicians cannot treat. All I can do is suspect the diagnosis, educate [patients] and offer basic home oral care recommendations. However, we are considering having Lisa Wadsworth perform hygiene assessments, especially on patients like those described above, whose clinical profile and dental office assessments mismatch.

"We will not be able to diagnose oral pathology without a dentist in the office. Unfortunately for me, but fortunately for dentists, periodontal disease is a medical condition that physicians cannot treat."

Repertoire: Can you tell me about your referral relationships with local-area dentists?

Dr. Whitney: It's building gradually through a grass roots effort, as the need for collaboration arises. Although the local dental professionals are at first surprised that a physician is contacting them, they are very happy once they understand why. I'm trying to identify dental professionals who truly understand that periodontal disease is an infectious disease that needs both mechanical debridement as well as protocols to eliminate the infection. rep

A revolutionary approach

Bridging the oral-systemic gap calls for new ways of thinking, both on the part of dentists and physicians. Which is why Charles Whitney, M.D., owner of Revolutionary Health Services, has adopted a *Third Era Medicine* approach to medical practice. Rather than treating patients with a Second Era mindset, which focuses on treating symptoms of disease, he believes in empowering patients to create a personal health plan – including oral healthcare.

Through Projection Diagnostics ™, Whitney works to project his patients' health trajectory. Third Era screening includes tests such as:

- Carotid-IMT ultrasound
- Visceral fat measurement
- Oxidative stress estimate
- Blood inflammatory markers
- NT-Pro BNP

Whitney works to determine root causes of abnormal test measurements and provide each patient with a personalized health plan. Projection diagnostics not only helps determine when intervention is necessary, it informs clinicians when certain prescription medications can be avoided, according to Revolutionary Health Services. For more information, visit www.revolutionaryhealthservices.com.

A Clean Break from Infection, part 2

When limited resources make it challenging for long-term-care facilities to manage infection prevention, sales reps can help.

No matter how diligent long-term care facilities are when it comes to addressing infection control issues, there is always room for improvement, according to Sherrie Dornberger, RN, executive director, National Association of Directors of Nursing Administration/Long-Term Care. Overall, they do a "terrific job," she says. Nevertheless, "infection prevention and control programs vary by facility, particularly since many long-term-care facilities don't have a dedicated infection preventionist on staff," she says. In addition, limited staffing and insufficient supplies can make it very difficult for administrators and staff to effectively perform necessary infection prevention activities.

Meeting the challenge

"I believe the biggest infection control challenges long-term-care administrators face stem from the reality that long-term care facilities and their residents are at inherently increased risk of infection," says Dornberger. "Regular person-to-person contact, and contact with objects and surfaces in the facility, is an integral part of residential care, but it is also a primary risk factor for acquiring and spreading pathogens. Along the same lines, [while] decreased immune function is a normal part of the aging process, in long-term-care facilities, various medical conditions, increased incontinence, memory loss and dementia, and decreased skin integrity can make elderly populations especially vulnerable to infection.

"Another challenge is that clinical staff in long-term care facilities cannot rely on isolation precautions to the same extent as acute-care settings because of the negative effect isolation can have on residents' well-being," she continues. "This makes other infection prevention efforts and overall facility cleanliness especially important."

In spite of these challenges, long-term-care administrators and staff are aware of the issues at hand and do their best to address them, starting with appearance and overall cleanliness. "For both consumers and facility administrators, concerns about appearance, general cleanliness and the

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"By all accounts, cleanliness is a key consideration in the selection of a long-term care or assisted living facility."

risk of infection are frequently intertwined," says Dornberger. "By all accounts, cleanliness is a key consideration in the selection of a long-term care or assisted living facility. A recent Clorox Professional Products Company survey of U.S. adults with a friend or family member in a long-term care facility found that 71 percent cite overall cleanliness as a top factor influencing their decision to select a long-term-care facility.

"Common problems such as urine odors and stains can have a huge impact on families' and potential residents' perceptions of cleanliness, quality of life and sense of wellbeing," she continues. "Therefore, eliminating odors and maintaining a clean environment is crucial. The U.S. Centers for Medicare & Medicaid Services (CMS) even suggests that consumers evaluate facilities for odor as part of their decision-making process."

While consumer perceptions are important in that they can impact a facility's bottom line, facility administrators usually are aware that cleanliness has a direct impact on infection prevention, says Dornberger. "Unpleasant odors and visibly stained or soiled surfaces can signal the presence of harmful microorganisms, such as Shigella, Salmonella, Hepatitis A, E. coli and Norovirus, all of which are associated with outbreaks of illness," she points out. "Lapses in infection prevention protocols – including cleaning and disinfection – are often correlated with citations by the CMS Survey and Certification, which can also impact business."

Distributor sales reps can help their customers stay on track by providing them with appropriate educational resources and ready-to-use products, says Dornberger. "The best way for sales teams to help support infection prevention and control in long-term-care facilities is to make sure that customers have the right products and appropriate training and education they need for the job," she says. "All long-term care facility staff members need to understand existing and emerging pathogens of concern and the recommended cleaning and disinfecting products and procedures to best address them. For instance, when dealing with *C. difficile*, using bleach or EPA-registered bleach-based products are the best options, because alcohol and quaternary-ammonium compound based products will not kill *C. difficile* spores. Manufacturers often have educational resources and training tools available to aid in correct product usage, she adds.

Many long-term-care facilities are under tight budget constraints and often look for ways to do "more with less," says Dornberger. To service them, there are many product solutions on the market that have multiple applications and are designed to meet the diverse needs of a long-term care setting, she points out. "For example, facilities may be interested in products that can clean and disinfect in one step or that are effective on both hard and soft surfaces," she says. "Likewise, sales reps can offer ready-to-use products, which do not need to be diluted before use, thereby reducing the risk of staff error." Products such as this can make life easier for administrators and staff, as well as enhance the quality of life for residents, she adds. rep

A recent Clorox Professional Products Company survey of U.S. adults with a friend or family member in a long-term care facility found that 71 percent cite overall cleanliness as a top factor influencing their decision to select a long-term-care facility.

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Passports, Please

Vendor passports would be simpler, cheaper and fairer for all

By Bruce Stanley

Over the last five years, the industry has placed significant emphasis on vendor access and credentialing. We may have reached the point where expectations are beginning to be understood and accepted. But that's only the beginning. The real test will be simplifying the process, both financially and technically.

Here's the problem: Sales representatives interact with many facilities using multiple credentialing organizations, with differing styles. They spend valuable time re-documenting previously submitted credentials. When they transfer or move to another company, they often must repeat the credentialing process due to concerns about the state of old data and its ownership. The current process gives control of the data to third-party organizations, not to the representatives themselves.

What's more, each facility, IDN, or group establishes its own standard using its own choice of third-party credentialing organization. Despite significant debate over the value of such organizations, I believe that they can and will provide the platform for next phase.

A passport process would prove that our healthcare system has the ability to better manage the personal data of reps while providing the necessary compliance required by healthcare facilities.

How passports would work

The idea of a credentialing passport has been floated since the early days of the vendor credentialing "outbreak." In the early 2000s, no uniform standards were applied to credentialing, and this posed the largest barrier to passport implementation. But after many years of hard work developing industry standards by the Coalition for Best Practices in HCIR Requirements, the possibility of creating a passport is closer to reality. Now only economic and parochial interests appear to be barriers.

A vendor passport is simply one document, with industry-accepted standards, that would gives reps access to any facility in the United States. Reps would annually submit their data to one organization and would be required to update any new information. They would retain data ownership. They would be issued a validated data card, similar to a driver's license, indicating they have been "credentialed."

A passport would be "issued" by the primary institution through its preferred credentialing organization. Just as with country-issued passports, reps would be considered "citizens" of each facility. Each facility could still retain its own unique requirements (just as some countries may require, say, eye scans, in addition to passports).

Every credentialing organization would be audited annually to ensure adherence to protocols of privacy and data security, and its employees would be trained in documentation and data management. Just as major banking institutions send customers annual privacy notices, third-party credentialing organizations could do the same. The third-party organizations would be "certified" by the Coalition or other organization (such as the Joint Commission) and provided with a seal of approval to issue the universally accepted passport.

An issue of trust

Some believe that it's fruitless to devote more energy to a process that has already been initiated. I disagree. While the current process works, it does not work efficiently or optimally for anyone. For example, there is still confusion over data security and its maintenance.

Sounds simple. So why isn't the concept of a vendor passport accepted? The barriers seem to be either too much vested interest in perpetuating a very cumbersome process, or lack of vision.

The passport system requires trust. It would allow reps to do what they do best – sell and counsel customers on new techniques, new product, and better processes. It would also prove that our healthcare system has the ability to better manage the personal data of reps while providing the necessary compliance required by healthcare facilities.

The passport process would also demonstrate that our industry is not promoting cost-shifting from one party or another, but that the focus of credentialing is foremost to protect patients and caregivers. First steps would be for a forum of leaders led by the Coalition to meet and discuss the ramifications and possibilities for a streamlined process that utilizes the thorough work done by the HCIR initiative.

The passport system would allow reps to do what they do best – sell and counsel customers on new techniques, new product, and better processes.

It only makes sense to complete the journey and show how our industry can self-manage, meet an operating challenge, and build the best process using technology to support best practice worldwide. rep

Bruce Stanley is a supply chain and contracting operations consultant with more than 30 years in the healthcare industry, and an adjunct professor at Endicott College's MBA program, teaching global supply chain, contracting and healthcare informatics and regulations. He served as senior director, contracting operations, for Becton Dickinson. He is a former chairman of the AdvaMed working group focused on vendor access-credentialing, and has collaborated with MassMedic and AdvaMed on legislative initiatives related to this topic. In 2011, he co-founded The Stanley East Consulting Group, in Ipswich, Mass., a global consulting practice specializing in supply chain, contracting, order fulfillment and project management for small and medium-sized companies, startups, and companies in transition or divestiture.

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Rapid strep test

Physicians and their patients benefit from rapid confirmation of streptococcal infection.

The more information your physician customers have up front, the more accurately they can diagnose and treat their patients' symptoms. This is especially true in the case of streptococcal infections. Strep throat is an infection in the throat and tonsils caused by group A *Streptococcus* bacteria. The bacteria can be passed from one person to the next through contact with droplets from an infected person's cough or sneeze. One can become ill three days after being exposed to the germ, and once infected, be contagious for up to three weeks, even if there are no symptoms.

Group A *Streptococci* can lead to an array of diseases, including pharyngitis, scarlet fever, impetigo, rheumatic fever, pneumonia, meningitis, otitis media, sinusitis, endometritis and septicemia. *Streptococcal* pharyngitis – or strep throat – is especially common in children. Common symptoms of strep throat include the following, according to the Centers for Disease Control and Prevention:

- Sore throat
- Severe pain when swallowing
- Fever
- Red, swollen tonsils, sometimes with white patches of pus
- Tiny red spots (petechiae) at the back of the roof of the mouth
- Headache
- Nausea
- Swollen lymph nodes in the neck
- Body aches
- Rash.

While many patients can benefit from antibiotic treatment, that's not the case for everyone. Pharyngitis is often caused by viruses, which do not require antibiotics. When antibiotics are prescribed unnecessarily based on empirical evidence, it can lead to antibiotic resistance of bacteria. For this reason, it's especially important that physicians quickly and accurately

Most rapid tests have a sensitivity of 95 percent and a specificity of 98 percent.

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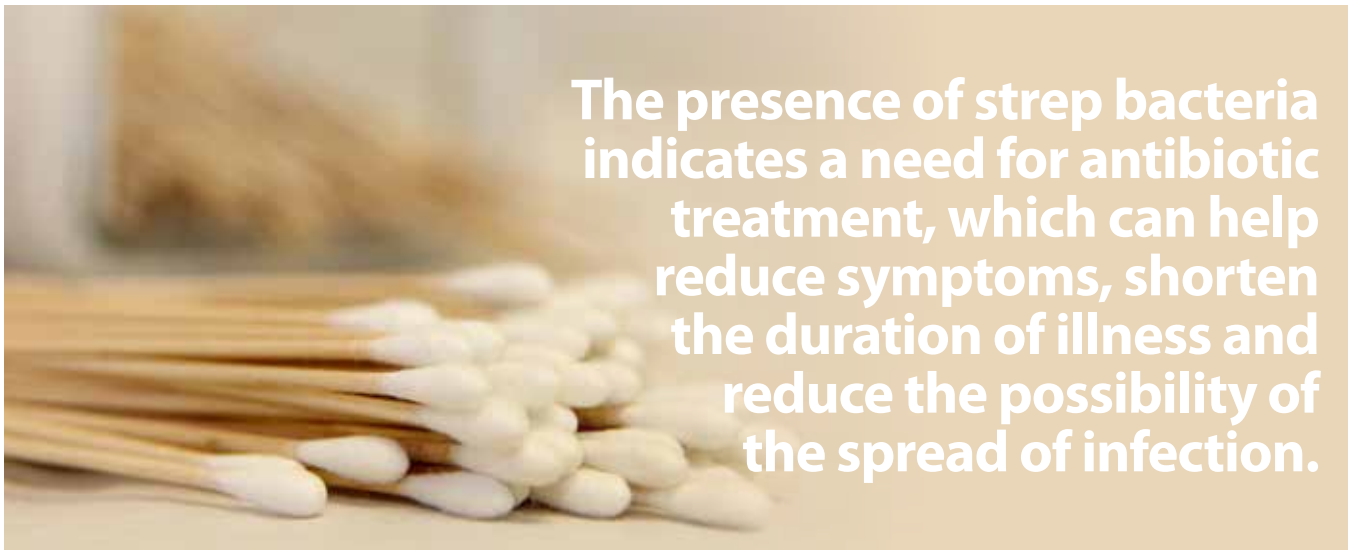

identify streptococcal infection. Rapid strep tests enable them to do so.

What's a rapid strep test?

A rapid strep test is a quick, accurate tool used to determine whether or not strep bacteria are present in the patient's throat. The presence of strep bacteria indicates a need for antibiotic treatment, which can help reduce symptoms, shorten the duration of illness and reduce the possibility of the spread of infection.

The test begins with a cotton swab rubbed over the patient's tonsils and the back wall of his mouth. Rapid strep tests are designed to respond to the presence of the particular Group A streptococcal bacteria responsible for strep throat, and will not detect viral causes of pharyngitis. A reaction between a protein on the surface of strep bacteria and chemicals in the test materials leads to a positive test, and a positive culture requires antibiotic treatment. Most rapid tests have a sensitivity of 95 percent and a specificity of 98 percent.

Test results generally are available in about 5-10 minutes, enabling the physician to consult with the patient and initiate the appropriate treatment protocol before the patient leaves the office. The test is ready to use and may be stored at room temperature.

Working with customers

Because rapid strep testing is very common, physicians generally raise few, if any, objections to ordering new tests. Sometimes, they may have concerns about being reimbursed. When this happens, sales reps should advise them to contact their insurance carriers and provide the CPT code – 87880QW. Although they may not be reimbursed for HMO patients, reimbursement through private carriers should not be an issue.

At other times, sales reps might encounter a physician who claims not to need a test to diagnose strep A. Physicians such as this believe they can see the white film caused by strep A on a patient's throat and make a diagnosis based on that. Sales reps should remind their customers that a diagnostic result can help eliminate the subjectivity of results, as well as provide a tool for generating revenue for the practice.

Target customers include:

- Pediatricians
- Family Practices
- Urgent Care/ Walk In Clinics
- Multi-Specialty Clinics
- Community Health Centers
- Reference Labs

Distributor sales reps should approach their customers with the following probing questions to gauge their interest in – and determine their need for – rapid strep tests:

- "Doctor, do you currently use a rapid strep A kit? If not, why?"
- "Would having a result while the patient is in the office help you make a quicker diagnosis and provide a faster patient treatment?"
- "Do you ever see parents with sick children who would like an immediate diagnosis?"

When physicians have fast, accurate information about their patients' health, they can diagnose illnesses and prescribe accurate treatment, all in one patient visit. rep

Editor's note: *Repertoire* would like to thank Sekisui Diagnostics for its assistance with this piece.

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MADE IN THE USA

Understanding – and detecting – influenza

Rapid tests help ensure quick diagnoses to prevent the spread of flu.

There's no time like the present to prepare your customers for flu season. Although, physicians generally see an uptick of sick patients with flulike symptoms from November through March, the seriousness of the disease calls for year-round discussion.

Seasonal influenza, or flu, is a respiratory infection caused by a variety of viruses. Influenza infection compromises the mucociliary lining of the respiratory tract and makes individuals susceptible to such bacterial agents as Staphylococcus aureus, Streptococcus pneumonia and Hemophilus influenza. Many people do not realize how serious and contagious flu is. But, several facts and statistics provided by The Centers for Disease Control and Prevention (CDC) suggest otherwise:

- As many as 5 to 20 percent of Americans contract the flu each flu season.
- Over 200,000 people are hospitalized with seasonal flu-related complications.
- Older people, young children, pregnant women and people with certain health conditions are at high risk for complications.

Many experts believe the best way to prevent the spread of flu is by getting vaccinated and adhering to proper hand hygiene and infection control protocols. Isolating ill individuals can help contain the disease as well.

The more information providers have upfront about their patients' symptoms, the faster they can diagnose and treat the illness (reducing unnecessary or wrong antibiotic prescriptions), and isolate patients or release them to an urgent care center if necessary. Diagnostic tools, such as rapid flu tests, make it easier for physicians to diagnose whether patients' symptoms are flu or signs of another respiratory illness. Today, rapid tests are available that can detect the presence of influenza A and B virus in a patient sample within 10 minutes.

About the test

CLIA-waived (and some non-waived), rapid influenza tests require only a few basic steps to complete with a nasal swab, nasopharyngeal swab or nasal wash. When using certain test brands, a single specimen collection (nasopharyngeal swab or nasal wash) can be used to test for both flu and respiratory syncytial virus (RSV). A nasal swab and/or nasal wash is said to be more comfortable for patients than a nasopharyngeal swab. However, the CDC-preferred specimen type also includes nasopharyngeal swabs, which reportedly provide higher quantities of detectable virus. Certain rapid influenza tests may be stored at room temperature for up to 24 months from the date of manufacture. The tests are considered relatively accurate compared with viral cell culture, but not as sensitive as the lab-based PCR. Some tests reference themselves against PCR. Cell culture is no longer considered the highest sensitivity.

How to sell rapid flu tests

Doctors generally order more flu tests from early October through March. Distributor sales reps will find the greatest selling opportunities among pediatricians, internists, general practitioners and family practitioners. Physicians working at emergency and urgent care centers also are likely customers, as well as hospital physicians and long-term care practitioners. Distributor reps should rely on several qualifying leads to introduce their customers to rapid flu tests, including the following:

- "What CLIA-waived test do you currently use at the office, and how accurate is it?"
- "How would having greater confidence in an influenza test impact your treatment decisions?"
- "How do you ensure reliability among test users at your practice?"
- "When you see a patient with flu-like symptoms, how do you make your diagnosis?"

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Reference: 1. Data on File.

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CLIA WAIVED

Influenza: a highly contagious disease

Even the most resilient people can be hard-hit by influenza. A highly contagious respiratory illness caused by influenza viruses that infect the nose, throat and lungs, influenza can sometimes lead to death. Over a period of 30 years, between 1976 and 2006, estimates of flu-associated deaths in the United States range from a low of about 3,000 to a high of about 49,000 people, according to the CDC. Generally, however, people experience such symptoms as:

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

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

People at increased risk of developing flu include:

- Young children and adults over 65.
- Pregnant women.
- American Indians and Alaskan natives.

People who have:

- Asthma.
- Neurological conditions.
- Chronic lung disease.
- Heart disease.
- Blood disorders.
- Endocrine, kidney or liver disorders.
- Metabolic disorders.
- Morbid obesity.
- Long-term aspirin therapy.

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

- "How do you know when influenza breaks out in your area?" (Surveillance data can sometimes be delayed in getting published.)
- "How do you determine when to prescribe antiviral therapies, such as Tamiflu® or Relenza®?" (Both therapies are believed to be more effective when used within the first 48 hours of symptoms. By accurately diagnosing influenza, the doctor can avoid using expensive antiviral treatments for non-viral infections.)
- "Are you concerned about reducing the inappropriate use of antibiotics?"

Working with your customers

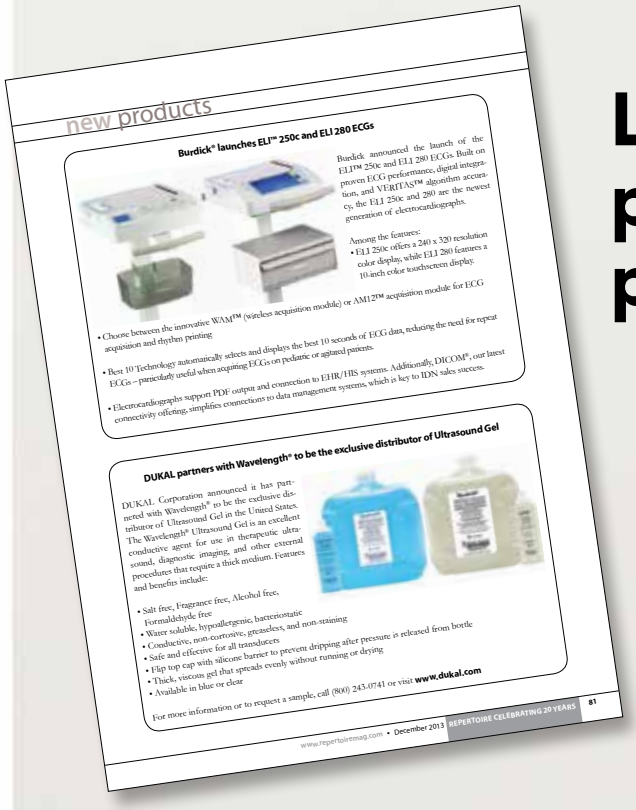
Physicians who object to rapid influenza tests often lack enough information to evaluate them. Distributor reps can expect to hear a few objections to the tests, including the following:

- "Why is it necessary to test for flu?" (Your response: "Clinical diagnosis alone is unreliable. In a peer-reviewed study of symptomatic pediatric patients, clinical diagnosis by pediatricians was 38 percent sensitive and 91 percent specific. Point of care (POC) testing has been known to significantly increase the appropriate use of antivirals and antimicrobials by more than two times compared with cases where POC tests have not been used.")
- "If we perform tests at a central location, we are concerned the test samples will not remain stable." (Your response: "Samples can be stored at room temperature or refrigerated. Depending on the manufacturer, certain samples can be stored for eight hours or longer.")
- "What if rapid influenza tests aren't sensitive enough?" (Your response: "Digital immunoassays (DIA) are a new category of diagnostic tests where the assay and instrument work together to combine advances in detection particles, optical image recognition, and interpretation algorithms to improve accuracy. These systems reportedly detect over 24 percent more Flu A+B positives than traditional rapid tests that are visually read.")

By taking time to educate customers on the importance of testing patients with flu-like symptoms, distributor reps can provide a value-added service by helping to prevent the spread of the disease. rep

Editor's note: *Repertoire* would like to thank BD for it's assistance with this piece.

New Product Showcase


new products

Burdick® launches ELI™ 250c and ELI 280 ECGs

Burdick announced the launch of the ELI™ 250c and ELI 280 ECGs. Built on proven ECG performance, digital integration, and VERITAS™ algorithm accuracy, the ELI 250c and 280 are the newest generation of electrocardiographs.

Among the features:
• ELI 250c offers a 240 x 320 resolution color display, while ELI 280 features a 10-inch color touchscreen display.

• Choose between the innovative WAM™ (wireless acquisition module) or AM12™ acquisition module for ECG acquisition and rhythm printing

• Best 10 Technology automatically selects and displays the best 10 seconds of ECG data, reducing the need for repeat ECGs – particularly useful when acquiring ECGs on pediatric or agitated patients.

• Electrocardiographs support PDF output and connection to EHR/HIS systems. Additionally, DICOM®, our latest connectivity offering, simplifies connections to data management systems, which is key to IDN sales success.

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DUKAL Corporation announced it has partnered with Wavelength® to be the exclusive distributor of Ultrasound Gel in the United States. The Wavelength® Ultrasound Gel is an excellent conductive agent for use in therapeutic ultrasound, diagnostic imaging, and other external procedures that require a thick medium. Features and benefits include:

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Flu Vaccination: Planning Ahead

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

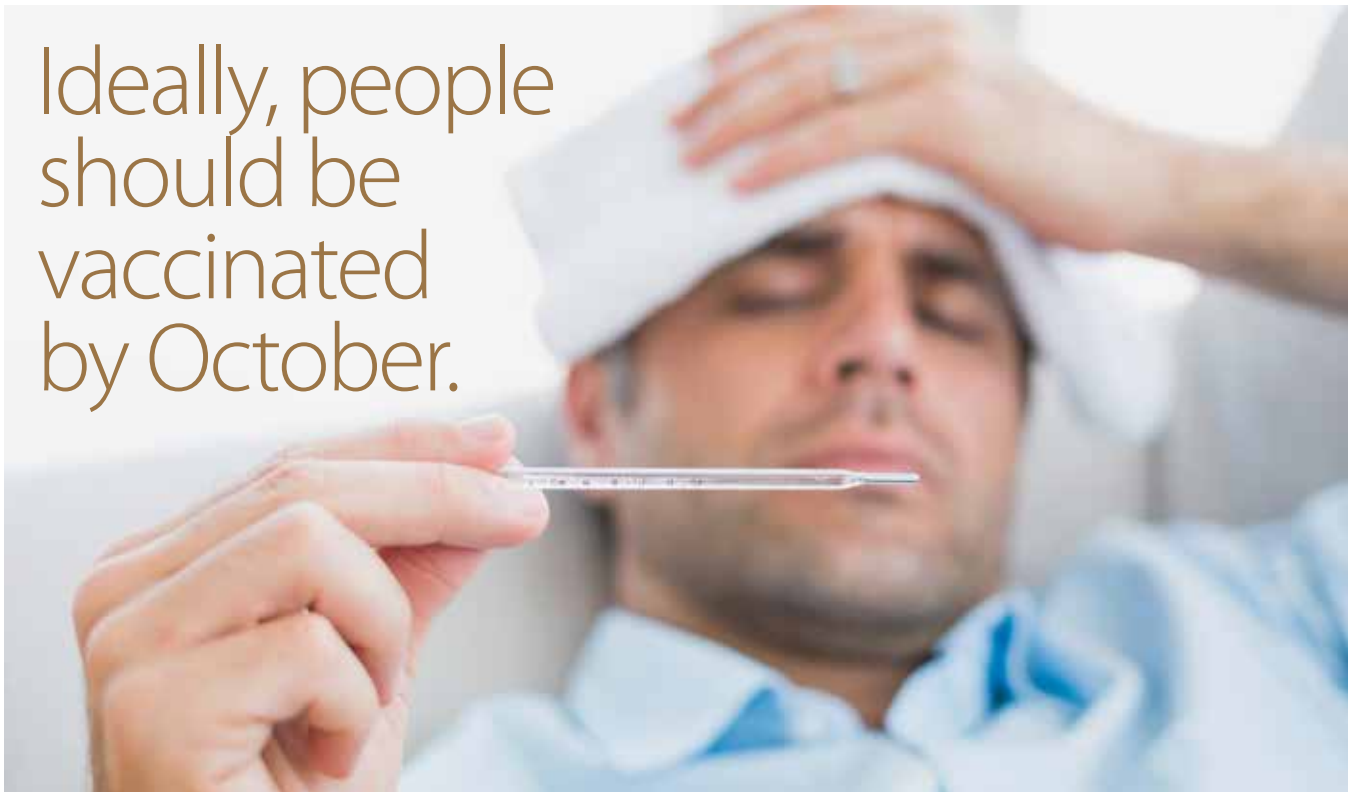
Although flu season technically doesn't begin until October, it is time to start planning. From gloves, masks and table paper to hand hygiene solutions and surface disinfectants, sales reps can help their customers take steps toward protecting their patients from the flu this fall. Reps should also take steps to protect their own health.

Annual vaccination against influenza is key in protecting oneself from the disease, says the Centers for Disease Control and Prevention (CDC). Although experts can never predict how a particular flu season will play out, they do know this: When more people are vaccinated per CDC recommendations, fewer people are likely to contract the disease and there is less opportunity for it to spread.

Influenza is a serious disease that can lead to hospitalization and sometimes even death, says the CDC. "An annual seasonal flu vaccine (either the flu shot or the nasal-spray flu vaccine) is the best way to reduce the chances that you will get seasonal flu and spread it to others," according to the CDC's website. "When more people get vaccinated against the flu, less flu can spread through that community."

How vaccines work

Flu vaccines cause antibodies to develop in the body about two weeks after vaccination. These antibodies protect against infection from the viruses that are in the vaccine. Each year, manufacturers develop a flu vaccine designed to protect against the influenza viruses determined to be most common during the upcoming flu season. Trivalent vaccines – or traditional flu vaccines – are engineered to protect against three flu viruses:



influenza A (H1N1) virus, influenza A (H3N2) virus and influenza B virus. Sometimes a quadrivalent vaccine is developed to protect against a fourth flu virus as well.

Trivalent flu vaccines include:

- Standard-dose trivalent shots manufactured using virus grown in eggs. These are approved for people six months and older.
- Standard-dose trivalent shots containing virus grown in cell culture, which is approved for people 18 years and older.
- Standard-dose trivalent shots that are egg-free, approved for people between the ages of 18 and 49 years.
- High-dose trivalent shots approved for adults 65 years and older.
- Standard-dose intradermal trivalent shots, which are injected into the skin instead of the muscle and require a smaller needle than traditional flu shots. This is approved for adults between the ages of 18 and 64.

Quadrivalent flu vaccine, which protect against two influenza A viruses and two influenza B viruses, include:

- Standard-dose quadrivalent shots.
- Standard-dose quadrivalent flu vaccines that are given as a nasal spray, approved for healthy people between the ages of two and 49 years. (Healthy indicates people who don't have an underlying medical condition that predisposes them to influenza complications.)

When is it right to vaccinate?

Vaccine shipments generally began in late July and August, and continue through September and October, until all vaccine is distributed. Ideally, people should be vaccinated by October. However, as long as flu viruses are circulating, vaccination should continue to be offered throughout the flu season – sometimes as late as January or February, when flu activity typically peaks. Because it takes about two weeks after vaccination for antibodies to develop in the body that protect against influenza virus infection, the CDC recommends early vaccination to protect people before influenza begins spreading in their community.

For more information about vaccines available for the 2014-15 flu season, visit http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6207a1.htm?s_cid=rr6207a1_w#Tab1. rep

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*References [1] Kaufman HE. Adenovirus advances: new diagnostic and therapeutic options. Curr Opin Ophthalmol. 2011;22:1-4 [2] FDA Section 510k number (K110722) for RPS Adeno Detector Plus™; March 15, 2011. *CPT stands for Current Procedure Terminology (CPT®) is copyrighted by the American Medical Association. QW modifier is added to cpt code to identify that the test is CLIA-waived.*

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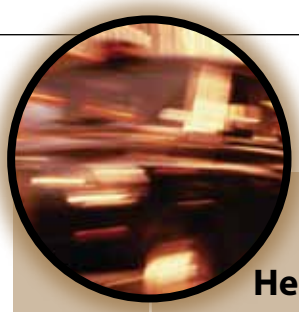

Windshieldtime

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

An end to distracted driving

Curved LED televisions embedded in the windshield of vehicles? This and more will be featured during Allstate Insurance Company's "Reality RidesSM" 2014 national campaign tour scheduled to begin in Philadelphia and travel to more than 40 American cities. Reality Rides consists of a driving simulator that utilizes a real – but stationary – vehicle equipped with virtual reality technology, including a new curved LED television embedded in the car windshield. The television displays an animated environment and reacts to the driver's motions. Using the car's steering wheel, gas and brake pedals, the driver is tasked with driving while also attempting to text, talk on the phone and enter navigation system directions. These simulations are designed to demonstrate the potential consequences distracted drivers could face while on the road. In addition, participants are given traffic tickets that reveal potential infractions a driver could receive if the situation happened in real life. Participants will also have the opportunity to take the Allstate X TXT® pledge that promises to not text and drive. Last year, the first tour surveyed more than 1,700 people who experienced the Reality Rides simulator, of which 73 percent said they learned more about distracted driving after experiencing the simulation. Key findings from the 2013 Allstate Reality Rides tour survey indicate drivers are aware of the dangers of distracted driving, but that there is still opportunity to influence their safer driving actions:

- More than one-third of drivers say they text and drive at least occasionally, and 71 percent believe their driving ability while texting is worse than if they were driving without distractions.
- Half of drivers say that they talk on the phone while driving.
- Nearly eight-in-ten drivers think texting while driving is the same or worse than drunk driving.
- After the simulation, 68 percent of participants said they will never text and drive again, and 62 percent said they wouldn't let others drive distracted.
- Seventy-seven percent of participants said they are less likely to ride with others who are texting and driving after participating in Reality Rides.

Role models?

Parents are just as likely to engage in driving distractions, such as cell phone use, as drivers from the general population, according to a recent University of Michigan study published in Academics Pediatrics. The study finds that 90 percent of parent drivers said they have engaged in at least one of the 10 distractions examined in the study while their child was a passenger and the vehicle was moving, according to lead author Michelle L. Macy, M.D., M.S., an emergency medicine physician at the University of Michigan's C.S. Mott Children's Hospital. The study, conducted in two Michigan emergency departments, shows that about two-thirds of respondents (570 parents of 1-to-12-year-old children who arrived in the emergency departments of the two hospitals) say they have talked on cellular phones while driving their child, and one-third say they have texted while driving their child. Each year, more than 130,000 children younger than 13 are treated in U.S. emergency departments after motor-vehicle collision-related injuries, according to Macy, who says she is also concerned about whether parents are modeling the right behaviors in front of children who will eventually learn to drive. rep

More than one-third of drivers say they text and drive at least occasionally, and 71 percent believe their driving ability while texting is worse than if they were driving without distractions.

Quick Bytes

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.

Neuro imaging

Personal Neuro Devices Inc., a developer of world-first mobile neuro applications, is working to turn Google Glass into a neuro-imaging device with Introspect, the PND Wearable. Google Glass is a voice-interactive computer with an optical head-mounted display that can determine an individual's location and what time it is, and provide Internet connectivity. For now, however, it is not a biometric device capable of bio-monitoring or neuro-feedback. Once PND wearable is available, the head-worn device – compatible with Glass, Glassware apps, mobile apps and cloud storage and analysis – will reportedly be able to provide:

- Monitored brain activity throughout the day, which could be shared with a physician to assist with diagnosis and treatment of conditions such as depression.
- Hyper-targeted content delivery in the blink of an eye, screened to match one's specific tastes and interests with mood-sensing algorithms.
- Immediate response to elevated stress levels, with visual prompts to take a break.
- Monitored brain health of mission-critical, emergency response, transportation and front-line personnel in the field.
- Feedback on the re-emergence of subtle neuro-psychological symptoms, which can help facilitate adherence to long-term medication therapy.
- Monitored changes in the neuropsychological symptoms of participants in phase ll and lll drug trials.
- Mobile neuro-feedback exercises for faster return-to-play and return-to-school after brain injuries, as well as maintenance of healthy brain function for older adults.

On the big screen

Xform Computing, which provides open-source-based cloud-streaming apps for mobile devices, has added its Dual-Screen technology to the latest update of the AlwaysOnPC App in the iTunes App Store. The AlwaysOnPC app delivers a cloud-based desktop computer to mobile devices and reportedly helps mobile users extend their AlwaysOnPC usage from their device to a nearby HDTV screen. When Dual-Screen mode is activated, the AlwaysOnPC desktop apps are displayed on the HDTV screen. Users can use the entire screen of their iPad or iPhone as a touch-pad and keyboard to control and use the AlwaysOnPC features. So, for example, iPad users with Apple TV at home can open and share videos or photos from sources such as Facebook, Dropbox, Vimeo, Adobe Flash-based video or others, using Firefox Browser with Flash support, by projecting it onto the HDTV. In addition, with Apple TV and an iPhone, a user can open and edit office documents, such as Microsoft Word, Excel or Powerpoint files, or display a meeting presentation, on a large HDTV screen.

New Android device

BLU Products, a mobile phone manufacturer, has announced BLU Studio 5.0 LTE, its addition to its STUDIO series of Android smartphone devices. In addition to its Qualcomm Snapdragon™ 400 Quad Core 1.4 GHz processor, the Studio 5.0 LTE features an IPS display of 220ppi, 1GB RAM, expandable microSD slot up to 64GB, 8.0 autofocus camera with LED flash, HD recording at 1080p@30fps, and front facing 1.6MP camera, running on Android v4.2. The device is available unlocked for $249.

High-quality touchscreen

iControl Networks and NETGEAR® have announced the launch of the NETGEAR Security Touch Screen (STS7000), a new Android™ touchscreen for iControl Connect™ solutions. The 7-inch screen reportedly allows users to manage and interact with their homes while staying connected to relevant Internet content, such as weather, traffic, news, sports and more. The NETGEAR STS7000 utilizes the Android operating system, and provides both home security and management functions in conjunction with interactive applications including:

- Music application allowing users to stream iTunes anywhere in the home via Apple Airplay® technology.
- Energy monitoring, management and thermostat control.
- Lighting control, enabling users to automate their lights and remotely turn on/off lights in and out of the home.
- Google Maps™, with real-time traffic alerts.
- INTELLicast™, for weather tracking and forecasting
- News and sports alerts. rep

On Call

For one Henry Schein sales consultant, volunteering with his local fire department has enabled him to put to use the products he sells each day.

By Laura Thill

Not everyone needs eight hours of sleep every night to stay sharp. But those who feel refreshed after a paltry four hours still need to find ways to fill the time. For some, that means catching up on old movies or filling out their reading list. For Joe Lutz, it began as an opportunity to put his photography skills to good use, and grew into a passion for helping others.

The Henry Schein field sales consultant has doubled as a photographer for his local fire department. More recently, he has served the department as a lieutenant and certified EMT. By day, he provides his physician customers with medical products solutions. In his spare time – be it the middle of the night or on weekends – he uses these products to save people's lives. "Needing only three or four hours of sleep each night can be a curse," he says. At the same time, if he is awakened at 3:00 a.m. to respond to a fire, well, that's okay.

Sparked by photography

It was Lutz's passion for photography that eventually led to the fire department. During his 30-year career as a sales consultant, when he was on the road, "I would have a camera in the car with me at all times," he says.

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"A neighbor, who was a fireman at the time, knew I enjoyed taking photos and connected me to the fire department," he continues. One thing led to another, and in 2000, he joined the department as a volunteer photographer. "The department provided me with a pager, and I would run out at night and on weekends, when they needed volunteers," he says. But, his volunteer work went beyond simply snapping shots, he points out. "I worked with the fire marshals, who educated me on doing investigative photography, which is an important side of this. They would want me to arrive at the scene as quickly as possible and look for signs of how the fire might have started," he says. They would also use his photos to evaluate how the fire fighters responded on site, so that moving forward, they could proceed more safely, he says.

The next several years were an eye opener, says Lutz. "As a photographer, it always amazed me to see the circumstances that came together to create this tragedy," he says. "And, most of these circumstances were preventable." If more people followed common sense safety protocols, such as not plugging in too many appliances and overloading circuits, or simply doing a better job of cleaning up after themselves, many fires could be avoided, he says.

Even keel

The more he saw of how efficiently the fire department responded to these calls – particularly how they used the medical products with which he was so familiar to treat victims – he began to question whether he could be doing more to help. "Watching the EMTs and having a lot of the product knowledge from my sales position, I realized I, too, could work as an EMT," he says. In 2007, he embarked on the necessary coursework to become certified. "This was a commitment, but I had the support of the fire department," he says. "It took me about six months to complete the program." Today, it's a bit more intense – about 240 hours – and can take about eight to 10 months of evenings and weekends to complete.

Lutz also volunteers as a lieutenant, which involves scheduling all of the other volunteer EMTs for nights and weekends. If his job as a photographer was intense, performing his EMT duties can be even more so, he notes. "It's a busy job," he says. "Our department responds to roughly 5,200 calls each year. When I work duty crew, I stay overnight at the fire station." When he's not on duty crew, he's on call, he adds.

"As EMTs, we warn everyone, 'Try to stay on an even keel. We are going to a person's worst day of his life.'" Indeed, he and his team see it all, from fires, car accidents and worse. "We jump in the ambulance and, while we are provided with information up front, we see what we are dealing with when we get there. It could be falls, lacerations, overdoses, cardiac arrest – pretty much anything. We stabilize the patients if we can and prime them for transport to the hospital.

Joe Lutz with his children, Joseph III, Ariana and Matthew.

"Sometimes patients aren't thinking clearly, and we try to act as their guardian angel," he says. "Recently, I was on a call for a gentleman who was homebound, with a lot of health issues. He wasn't doing well, but didn't want to go to the hospital. His wife was concerned that if he didn't go, he wouldn't make it through the night." But, if there was reason enough for his wife to call 911, then it was important to have the patient examined, Lutz adds. "I was able to connect with him and convince him to go to the hospital, and his wife was very grateful."

"It's a busy job. Our department responds to roughly 5,200 calls each year."

The work is often challenging, however. HIPAA privacy laws make it difficult for EMTs to follow up with patients to see how they have fared. "Still, every so often, we do get a note from a patient, thanking us," he says. "And, we sometimes learn when a patient has passed on."

As intense as it is, Lutz takes away a great deal of comfort from his volunteer work. It's fulfilling, yes. But, beyond that, "the brotherhood is amazing," he says. "It's a family, and everyone looks out for one another." The camaraderie has been a saving grace in the years following the death of his wife, Robin, three years ago, he adds, particularly as his children, Joseph III, Matthew and Ariana, have grown up and become more independent.

Hand in hand

Lutz is no novice to medical products sales. "Thirty years ago, I [joined] a mom-and-pop company (Tri-County Surgical) in New Jersey," he explains. "I made medical products deliveries while I was in college, helped out with office set-ups and [eventually] had an opportunity to move into sales." The company was later acquired by Caligor, which in turn was purchased by Henry Schein.

Today, his career as a medical products sales rep fits "hand in hand" with his volunteer work, Lutz says. Both call for excellent people and communication skills. In addition, "I am more in tune with some of the procedures going on in the physician practices, such as laceration [repairs] – how they'll be treated and what type of sutures will be used," he says.

If he has taken away one piece of insight from his work as an EMT, it's this: "I am a firm believer that all offices (physician and non-medical) should have an AED on hand." Particularly when an ambulance is coming from another call, "it may not be there when you need it," he says. "Having an AED on hand is for the safety of the physicians, their staff and their patients." rep

Fee-for-value

New payment methodologies will force specialty distributors to change their approach to sales

As specialty distributors approach hospital and IDN customers with new-technology opportunities, they need to keep in mind the things with which their potential customers are preoccupied – continuing pressure to provide safe, high-quality care in the midst of a transition away from fee-for-service reimbursement. Doors will open if those distributors can prove their technologies can help hospital and IDN executives get "from here to there."

Unsustainable cost increases

The traditional fee-for-service approach to reimbursement has led to unsustainable cost increases, said Bill Bopp, president, Gulf South Quality Network LLC, New Orleans, a clinically integrated network comprising eight hospital members and more than 1,600 participating physicians. Bopp made his comments at the 2014 IMDA Annual Convention and Manufacturers Forum. IMDA is the association for specialty sales and marketing companies.

Physicians and hospitals have traditionally gotten paid more for doing more. But Medicare is moving toward reimbursing providers on the basis of outcomes, he explained. Hospitals and IDNs that fail to perform stand to lose as much as 7.5 percent of their revenues. "The days of fee-for-service in the next 18 to 24 months will be gone in most of the country," he predicted.

With that in mind, Bopp laid out the chief dynamics playing out in healthcare today – dynamics that IMDA members should remember as they try to share technology solutions with their customers.

"The days of fee-for-service in the next 18 to 24 months will be gone in most of the country."

– Bill Bopp, president, Gulf South Quality Network LLC

1. **Limited funding.** Medicare is ratcheting down on reimbursement, and private payers are facing pressures of their own. With today's healthcare exchanges, insurers have to take all comers, said Bopp. No longer can they exclude people with pre-existing conditions. They're taking a risk, and it is in their best interest to make sure network providers deliver care efficiently.

2. **Data is key.** The highest infrastructure-related investment for most hospitals these days is information technology. For example, Gulf South's IT budget is $6 million, said Bopp. With data, providers can get a better view of how they're performing from a clinical and financial perspective, identify opportunities for improvement, and track (and duplicate) success. "When you bring in products or ideas, they need to be data-driven," he told IMDA members.

3. **Medicine is shifting from specialty care to primary care.** In the near future, health plans will insist their members pick a primary care physician or practice, whose responsibility will be to monitor people's health over the long term.

4. **Reimbursement is shifting from fee-for-service to pay-for-performance.** As a result,

healthcare providers will be held much more accountable for the way they care for people, and the amount of resources they consume while doing so.

5. **Consolidation will continue.** Hospitals are looking for ways to cut infrastructure costs, and the only way many can do so is to merge with others.

6. **Medicaid programs are expanding, which will bring downward pressure on reimbursement.**

7. **Baby Boomers will continue to transition from private-pay insurance to Medicare.** That means more revenue lost for hospitals and doctors.

8. **Value-based purchasing will expand.** Medicare is penalizing hospitals for readmissions and for providing care that leaves patients unhappy or unsatisfied. Private payers are climbing aboard the value-based train as well.

Penalties for readmissions

Another speaker – Marc Lato, M.D., FAAFP – gave IMDA members a glimpse of the challenges facing hospitals and IDNs as they work to reduce hospital readmissions. Lato is vice president of medical management for St. Joseph's Hospital and Medical Center, Phoenix, Ariz., part of Dignity Health.

The government has targeted readmissions for a good reason, he said. Every year, 2 million Medicare patients are readmitted within 30 days of discharge. The FY2014 formula for penalties was based on readmissions for acute myocardial infarction, HF and pneumonia. In FY2015, the government will raise the maximum penalty, and will add three conditions: acute exacerbation of chronic obstructive pulmonary disease, elective total hip arthroplasty, and total knee arthroplasty.

Medicare has penalized 2,217 hospitals for excess readmissions since October 2012, the first year of the hospital readmission reduction program, he said. The average penalty in FY2014 was 0.38 percent, down from 0.42 percent the year before. These 2,225 hospitals will forfeit $280 million in Medicare funds over the next year.

In their attempt to reduce readmissions, Dignity and other providers are focusing on the process by which patients are "handed off" from the inpatient setting to outpatient care, such as the home or long-term-care facility. Such transitions can be associated with adverse clinical events, unmet needs and poor satisfaction with care.

Traditionally, many pre-discharge activities have been performed for the convenience of the provider, not the patient, said Lato. For example, instructions for medications and follow-up care are given when it's convenient for the physician, but with little regard for whether the patient can understand the instructions or whether he or she has an advocate – a family member or friend – to listen, ask questions and get clarification. Some hospitals may compound the problem by having too many coordinators, too many assessments, too many care plans and too many follow-up phone calls, he said. Patients who fail to follow instructions are called "non-compliant," a term that attaches a certain blame to them. In fact, they simply might have failed to understand the doctor's instructions.

Critical-thinking care managers with decision support technology tools, who can engage the patient in his or her care, can help reduce mistakes and improve the patient's satisfaction level. Meanwhile, hospital staff can assess patients who may be at high risk for readmission, and train patients to communicate proactively. These patients need to understand the "red flags" of their condition, which necessitate a call or follow-up visit to their doctor. Other elements of successful transitions include physician engagement and accountability, family/caregiver engagement, and cross-continuum collaborative teams.

Next year's IMDA convention will be held in May in St. Louis, Mo. rep

IMDA award winners

IMDA past president Tony Marmo of Martab Medical, Allendale, N.J., received the association's Ernie Douglass Award. Named after IMDA co-founder Ernie Douglass, the award recognizes members who have gone above and beyond the call of duty serving IMDA, promoting specialty sales and marketing as well as excellence in their own companies.

Meanwhile, Northampton, Pa.-based Precision Medical, a manufacturer of specialty respiratory devices, received the Manufacturers Partnership Award at the 2014 Annual Conference and Manufacturers Forum.

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news

Cardinal Health CFO to retire at end of FY 2015

Cardinal Health's CFO, Jeff Henderson, will retire at the end of FY 2015 after a decade in the role. Cardinal will evaluate both internal and external candidates to fill the position and expects to name a successor by the end of 2014. Henderson will continue on as an employee until his retirement to help with the transition.

Claflin Medical Equipment names two new sales managers

Claflin Medical Equipment recently added two new account managers. Rob Cedillo will be located outside of Chicago, Illinois, and Matt Wall will be located in Austin, Texas. "Rob and Matt have extensive healthcare experience and will help fulfill our strategic initiatives in these markets," said K.C. Meleski, national sales manager.

Henry Schein elects Dr. Dianne Rekow to board of directors

Henry Schein Inc elected Professor E. Dianne Rekow, DDS, PhD, to its board of directors. Rekow currently serves as dean of King's College London Dental Institute and professor of orthodontics. According to a release, she has extensive experience in innovative dental products, practices, and education, as well as keen insights into global trends influencing the evolution of the dental profession.

McKesson Specialty Health, US Oncology Network announce executive leadership appointments

McKesson Specialty Health, a division of McKesson Corp (San Francisco, Calif.), appointed Nick Loporcaro as president, McKesson Specialty Health, effective July 16. Loporcaro recently served as president, McKesson Canada. He will be succeeded by Alain Champagne, SVP, pharmaceutical distribution and operations, McKesson Canada. In addition, US Oncology Network (The Woodlands, Texas) named Kirk Kaminsky as president of US Oncology Network and Provider Services, effective immediately. Kirk previously served as SVP, McKesson Specialty Health Operations.

Medline to relocate distribution center in Allentown to Brockport

Medline Industries Inc will relocate its Allentown, Pennsylvania area distribution center to Brockport. It plans to open the facility in September 2014 and phase out the Pennsylvania distribution center by October. The new center will initially employ 40.

NDC announces date for 2015 annual meeting

NDC will hold its annual meeting on March 29-31, 2015 at the Music City Center in Nashville, Tennessee. NDC's 2015 meeting will bring NDC distributors, manufacturers, and GPO partners together for a three-day event featuring a large trade show and education, entertainment, and networking opportunities.

Welch Allyn acquires assets of PediaVision Holdings

Welch Allyn acquired certain assets of PediaVision Holdings LLC. PediaVision is the developer of Spot, a portable binocular vision screener with wireless communication capabilities designed to screen for refractive error, which can be associated with several ophthalmological issues. According to Welch Allyn officials, the acquisition complements the company's existing screening technology, specifically the Welch Allyn SureSight Vision Screener and Autorefractor. Welch Allyn plans a launch of a branded version of the product later this year.

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