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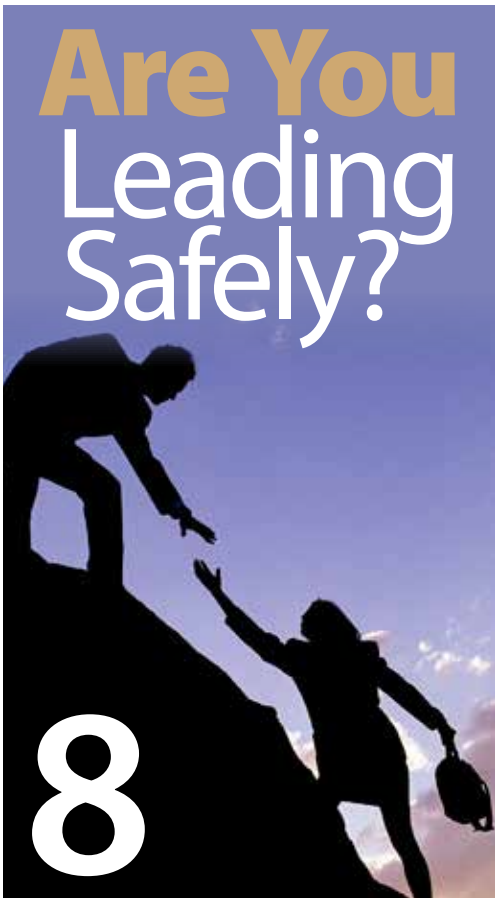

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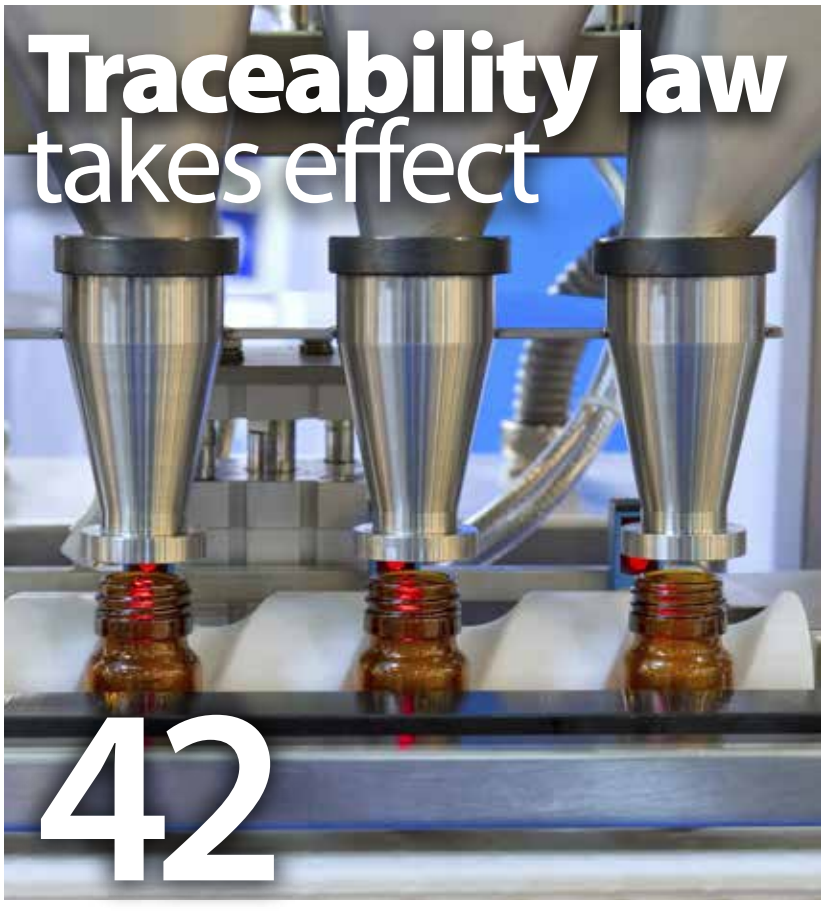
UDI: The Wait is Over

32



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1 US Bureau of Labor Statistics, May 2006 National and Occupational Employment and Wages estimates, Washington DC: United States Department of Labor, Bureau of Labor Statistics; 2007
2 www.invw.org/chemo-main

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Where the Market Has Taken Us

Scott Adams

In 2012, *Repertoire* conducted a survey with its sister publication, *The Journal of Healthcare Contracting*, to gain insight into the minds of those running America's health systems who were acquiring practices. One survey question related to how these systems would distribute med-surg products to acquired practices, whether through a prime vendor, self-distribution or segment a prime vendor for acute and a prime for alternate site.

Only 14 percent said they would use a dual system of acute care suppliers and alternate site suppliers. I remember sharing these results with Steve Inacker, President, Hospital Sales and Services at Cardinal Health, at Cardinal's national sales meeting that year. I made the statement to him that Cardinal was in a very good spot to capture a lot of market share if this held true. My concern, though, was whether these IDNs buying practices were like the dog chasing the car – what would they do once they caught it?

My gut reaction back then was that IDN executives didn't really understand the intricacies involved in servicing an alternate site account. They may have assumed their prime vendor for the hospitals would be able to service the alternate site accounts the same way.

Fast forward to 2015, and the amazing amount of consolidation and change that we have undergone: IDNs buying each other and acquiring practices, McKesson acquiring PSS, Medtronic acquiring Covidien, and now the deal between Cardinal and Henry Schein. You have to give credit to the Cardinal and Schein teams for following the customer and understanding their needs.

Alternate site facilities have different needs, issues and opportunities. Candidly, it's why we include an Acquired Practice column (sponsored by Schein) in *The Journal of Healthcare Contracting*, and why the distribution sales representative is more important today than ever before. Without a doubt this is what the executives at both Schein and Cardinal understood and why they forged this agreement.

Yes there is a lot of consolidation in the industry, but as you will see in Editor Mark Thill's cover story this month, it's more about an understanding of today's caregivers and servicing them efficiently so they can in turn serve their patients and deliver better outcomes.

Dedicated to Distribution
R. Scott Adams

PS: Last month you received a *Repertoire* calendar. Be sure to download the "LAYAR" app (it's free) on your smartphone or tablet and scan each month throughout the year. The manufacturers will be changing their messages regularly.

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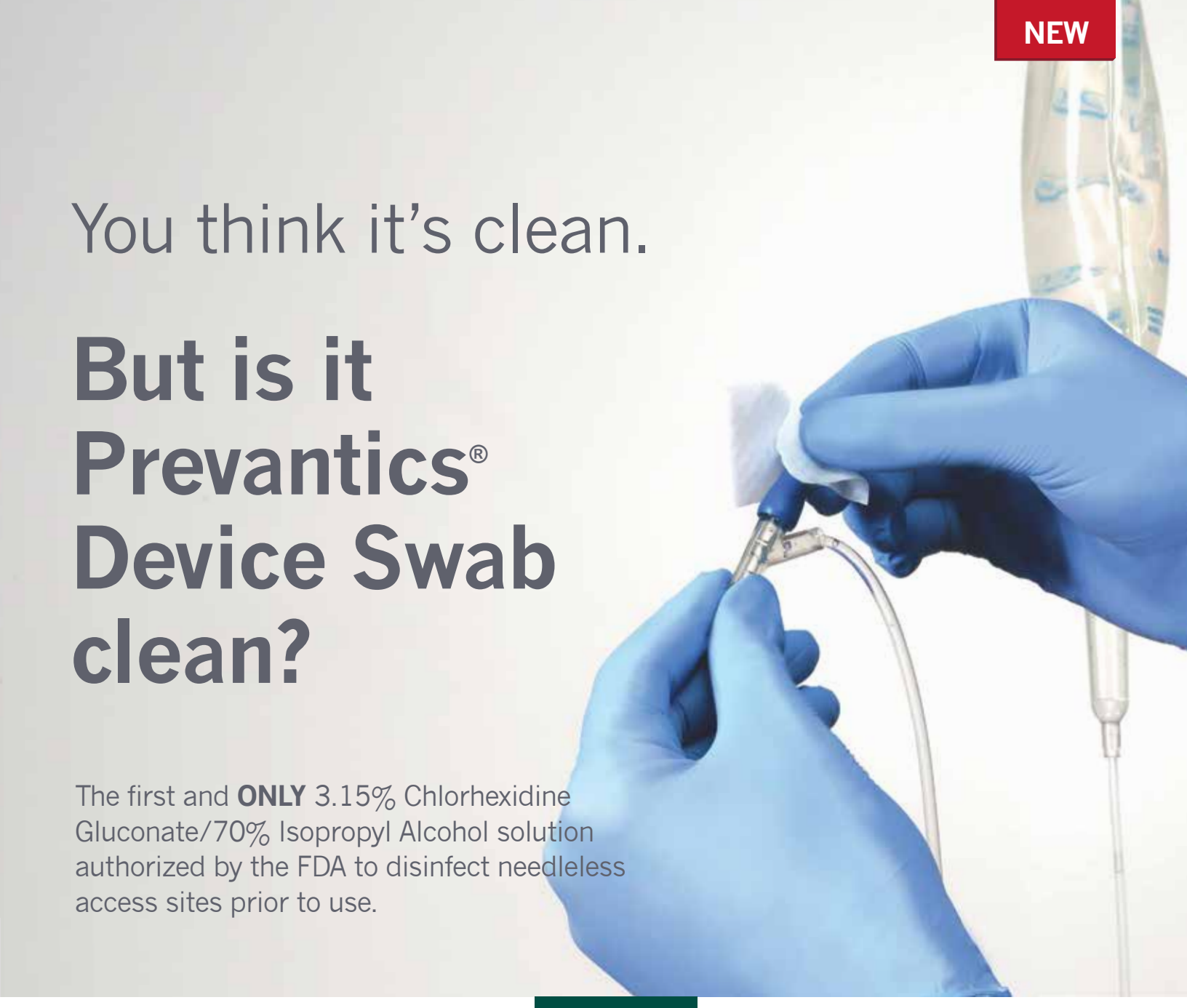

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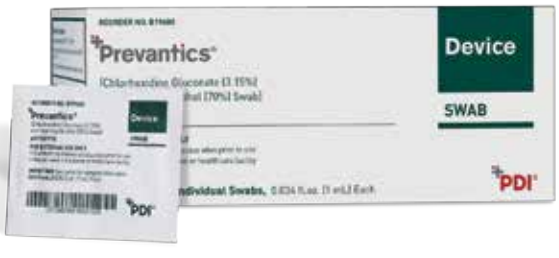

For more information on the breakthrough clinical study, visit pdihc.com/PrevanticsDeviceSwabClinical

[1]Hayden, M. K., et. al. . A Randomized Cross-Over Clinical Trial to Compare 3.15% Chlorhexidine/70% Isopropyl Alcohol (CHG) vs 70% Isopropyl Alcohol Alone (Alcohol) and 5s vs 15s Scrub for Routine Disinfection of Needleless Connectors (NCs) on Central Venous Catheters (CVCs) in an Adult Medical Intensive Care Unit (ICU), Oral Abstract Presented at 2014 ID Week Conference, October 11, 2014, Philadelphia, PA.

[2]2011 Guidelines for the Prevention of Intravascular Catheter-Related Infections, Healthcare Infection Control Practices Advisory Committee, US Centers for Disease Control and Prevention, 2011.

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Are You Leading Safely?

Why not taking risks is more dangerous than you think

By Randy Chittum, Ph.D.

"When I let go of what I am, I become what I might be."
– Lao Tzu

In 2015, this leadership column will focus on the theme of leading in a world, and industry, where uncertainty and complexity are paramount. From this "place" we might notice that what is most important is that which is emerging in the moment. What is emergent is more significant than what has been, or even our predictions for what might be. In this world, patterns may be discernible but not necessarily trusted.

The column focus this year is on how we lead given this level of uncertainty. As we often do, we start with how we get in our own way.

A reactive mindset

We spend a good part of our lives reacting to things around us not based on what makes sense but on what keeps us safe. Our needs for safety are unique, but always present. Did you know the brain has five times as many neural networks designated to identify danger versus pleasure? We are hardwired to feel at risk much of the time. The problem this presents to leaders is that we will find it hard to bring the most creative, powerful version of ourselves forward when the safety mechanism is operating in the background.

Personal courage shows up on many models of leadership competence. What does it actually mean to be personally courageous at work and in our leadership role? We might imagine it as speaking unpopular truth, especially to power. We might further imagine it as pursuing a bold vision of a future. It is certainly those things and many more.

Personal courage begins with not being defined by our need for safety. How can we speak truth to power when we protect ourselves from offending others? How can we pursue bold vision when we protect ourselves against failure?

This all serves to keep us playing a small game. We could survive with that mindset when things seemed to be more predictable and incremental improvement was sufficient to stay in the game. As stated earlier, these are not those times.

> We are hardwired to feel at risk much of the time. The problem this presents to leaders is that we will find it hard to bring the most creative, powerful version of ourselves forward when the safety mechanism is operating in the background.

Create your outcomes

Learning to operate from an outcome-creating mindset as opposed to a protection-reacting mindset is the deepest work of leadership. This shift is a true transformation, because once done it cannot be undone. This move starts with a deep understanding that safety is an illusion.

Ever hear of stories of the person who stood up to power and got fired for their boldness? Because they support a narrative that keeps us playing small, these stories get told over and over. In truth, these events are rare and always lack context in their telling. We are much more likely to fail a little bit at a time by unconsciously focusing on NOT taking risks – playing small.

There is much more coming this year on this topic. For now, ask yourself "What is one area of my leadership where I repeatedly feel an instinct to act that I then ignore?" ep

HIDA Health Reform Update

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

HIDA supported language included in Federal Spending Bill

You may have read back in December that the U.S. Congress passed a $1.1 trillion omnibus spending bill to fund nearly all of the federal government through September 30. Not reported as heavily, yet carrying significant implications for long-term care customers and patients, is a provision requiring the Centers for Medicare and Medicaid Services (CMS) to conduct a study within 90 days to measure Medicare's Competitive Bidding program's impact on enteral patients in skilled nursing facilities (SNFs), nursing homes, and intermediate care facilities.

Specifically, CMS will look at how the Competitive Bidding program has affected patient treatment, including impacts on patient health, whether product access has been reduced, and if costs have increased due to new suppliers unfamiliar with the clinical demands associated with enteral care. For years, HIDA has advocated these settings and enteral nutrition formulas and supplies are not well suited for competitive bidding, and it appears our message has been heard. The requested study reflects these concerns and is a noteworthy win for the extended care market.

Also worth mentioning: the bill includes $5.4 billion to help the government fight the recent Ebola crisis, while also allowing the U.S. to prepare for and respond to future infectious disease outbreaks. HIDA and our members worked directly with the Department of Health and Human Services (HHS) as well as other stakeholder organizations over the past several months to coordinate the supply chain response. HIDA continues to communicate regularly with HHS as the industry works on lessons learned and how to improve response and coordination efforts moving forward. HIDA also monitors and collects personal protective equipment guidance and news of interest for distributors via our Ebola Resource Center.

FDA bends on traceability enforcement

Pharmaceutical manufacturers, wholesalers, and repackagers must comply with national prescription drug traceability requirements effective January 1, outlined in Phase 1 of the Drug Quality and Security Act (DQSA). Since our last update on key DQSA topics and questions to discuss with

Overall, this is welcome news for pharmaceutical trading partners still refining TI/TH/TS systems or transitioning processes to online formats. Regardless, this underscores the short window of time organizations have to become compliant with the DQSA before facing possible penalties.

your customers, however, the Food and Drug Administration (FDA) announced its intention to exercise discretion when enforcing certain aspects of the track and trace law until May 1, 2015.

What this means is that the FDA has essentially given manufacturers, repackagers, and wholesale distributors a four-month grace period to comply with the DQSA's new Transaction Information, Transaction History, and Transaction Statement (TI/TH/TS) requirements. The FDA does not intend to take enforcement action against trading partners that fail to provide or capture product tracing information, but the agency still reserves the right to enforce the law for egregious offenders.

Overall, this is welcome news for pharmaceutical trading partners still refining TI/TH/TS systems or transitioning processes to online formats. Regardless, this underscores the short window of time organizations have to become compliant with the DQSA before facing possible penalties.

As always, if you or your customers have additional questions about the DQSA, Ebola, or Medicare's Competitive Bidding program, please contact us at HIDAGovAffairs@HIDA.org. rep

Sharing the Risk

If 25 years of supply chain experience has taught David Walsh one thing, it's the value of communication.

By Laura Thill

The rules of the game have changed. "Twenty-five years ago, partnerships and capitated costs meant something much different than they do today," says David Walsh, administrative director of supply chain, Saint Francis Hospital and Medical Center (Hartford, Conn.). Quality outcomes have become increasingly important, he says, and manufacturers understand they must "share the risk" by guaranteeing their products will help reduce hospital readmissions. "Honesty and openness; the willingness to share information; and the ability and desire to service hospitals" are essential qualities he looks for in his manufacturer partners.

David Walsh

But, manufacturers aren't the only ones who must lay their cards on the table. True, Walsh looks to partner with a vendor that is ready to make an investment. However, "if we are going to have a long-term relationship, we both must be honest. We must both be able to throw punches and walk away smiling. It's very important in our role that we, too, accept our responsibility in the agreement. If we don't do what we are supposed to do, we can't penalize the vendor.

"It's not just about our partners bringing value to the table, but us as well," he says. "When we sit down with our physicians and leaders, we discuss our strategies" – a new concept for many of them, he adds. "The role of supply chain is more important today than ever before," he says. "Our manufacturer partners must have confidence in our ability to strategize and bring value to the table.

"It can't be about the cath lab doing its own thing with the vendors," he continues. "There must be a strategy. Even when we know the direction we are looking to take, we must have a strategy to get there." To accomplish this, supply chain executives must have a clear understanding of how the market works, and bring that information to the rest of the team, he notes. "We have the benchmarking tools, clinical data on utilization and best practices data." And if the research supports that patients' cardiovascular function improves with

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certain procedures or devices, "the products have been well worth the investment."

Communication is key

No matter how spot-on the strategy is, there's only one way to make it work, notes Walsh: Communicate, and then communicate some more.

"In the past 2 ½ years, we have restructured the supply chain at Saint Francis Hospital and Medical Center to meet the needs of the future," he says, referring to his team's *Vision of Tomorrow* project. "We have realigned [our strategy] to meet our customers' needs." To do so, supply chain works directly with a team of physicians and nurses, as well as service line and senior administrative leaders, he explains. "We have a robust value analysis process that involves all areas of the hospital system and focuses on quality, costs and outcomes [to determine whether] the strategy has accomplished what it intended to.

"In the process, we have created a wonderful team atmosphere," he says. "People here want to be involved. They recognize the value they can bring to the table." Indeed, it has become more important than ever for team players to "clearly define what their abilities are – what they can and will do – and then communicate, communicate, communicate." There's no denying it works. In his first year at Saint Francis, he reduced the IDN's operating budget by $2.5 million, he says. "The following year, we had a $3.5 million reduction, and this year we will see a $7.4 million reduction – all through standardization and utilization.

"This is an ongoing project," says Walsh. "We will adjust to meet [everyone's] needs and constantly improve the process. My goal is to maximize technology, streamline certain processes, improve our reporting structure around cost per procedure, and to ensure that as we get into cost-sharing agreements, what we look at will be measureable."

At the same time, he is mindful that the current structure of the healthcare system can change at any time. "The reimbursement structure, ACOs and bundled payments – all of this can change tomorrow," he says. "We must move forward with the information we have on hand, and then be prepared to be flexible and change our course if necessary."

Different setting, same process

A brief stint in working in electronics in the military nearly a quarter of a century ago taught David Walsh, administrative director of supply chain, Saint Francis Hospital and Medical Center, that transistors and resistors "didn't do it for me." His earlier experience with planning and logistics for a private-sector manufacturer – together with his wife's encouragement – led him to a position at Massachusetts General in environmental services. "I discovered I enjoyed it, and it worked well with my background in planning and logistics," he recalls. It wasn't long before the hospital moved him into supply chain distribution. "I spent the next 16 years progressing through the ranks," he says. "At one point, I was responsible for the IDN's non-acute care network."

From there, he transitioned to South Shore Hospital as director of materials, facilities and nutritional services, and moved to his current position at Saint Francis Medical Center in 2012. "The greatest benefit I have been able to bring to supply chain is my private industry experience," he says. "The healthcare industry involves different products and widgets, but the process is the same. I have an understanding of logistics, planning and lead-time.

> Manufacturers understand they must "share the risk" by guaranteeing their products will help reduce hospital readmissions. But, if we are going to have a long-term relationship, we both must be honest. We must both be able to throw punches and walk away smiling."

"Twenty-five years ago, partnerships and capitated costs meant something much different than they do today."

I understand the challenges distributors face and I understand the healthcare industry."

In his current role as administrative director of supply chain at Saint Francis Medical Center, Walsh is responsible for all aspects of supply chain, including managing capital needs and long-range plans. In addition he has:

- Established a value analysis committee for product and opportunity review. The committee represents all service lines and includes physicians.
- Established centralized system for distribution reducing cost and increasing efficiencies and coverage.
- Reduced warehouse inventory by 60 percent.
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- Implemented contract database management.
- Restructured Supply Chain to better meet needs of the institutions, including OR representation and physician involvement internally.
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- Standardized product nomenclature.
- Decreased non-file spend from $33 million to $4.3 million (87 percent reduction).
- Completed an aggressive master data management initiative and presented it as educational sessions with three professional organizations in the past year.

Worth Watching

Headlines and trends in healthcare

The following are some of the leading stories the Major Accounts Exchange (MAX) monitored in recent months, and worth paying attention to in early 2015.

CMS releases proposed rule changes for MSSP ACOs

CMS (Baltimore, MD) issued a proposed rule designed to improve its Medicare Shared Savings Program. Among the changes are a proposed longer lead transition time for participating ACOs to transition from a no-risk to a shared-risk model and a Track 3 option that would incorporate aspects of the Pioneer ACO program, such as higher rates of shared savings and a defined list of beneficiaries for each performance year. Other proposals include changing the way beneficiaries are assigned to ACOs by paying more attention to primary care services and allowing some specialist providers to participate in multiple ACOs and redefining the methodology for ACO benchmarks to better reflect its local market rather than its past performance alone. The rule has a 60-day comment period.

Jefferson University System, Abington Health announce merger agreement

Jefferson University System (formerly Jefferson Health System) (Radnor, PA), Thomas Jefferson University, and Abington Health (Abington, PA) signed a letter of intent to merge. The deal would create the largest healthcare provider in the region, with five hospitals and more than 13,000 employees. Stephen Klasko MD, Jefferson's president and CEO, is expected to serve as president and CEO of the combined organization. Under the shared governance model, Jefferson and Abington will each appoint an equal numbers of members to a combined board, which will also have a few independent trustees. The health systems expect to execute a definitive agreement in 120 days, and the deal will close sometime in 2015.

FDA begins requirement for medical device manufacturers/health facilities to use electronic tracking

In September 2014, the US Food and Drug Administration (FDA) (Silver Spring, MD) began the long-awaited move requiring electronically readable unique medical-device labels for high-risk devices. Broader use will take up to seven more years. In the past, medical-device manufacturers said it didn't make sense to mark their products with unique identification numbers since hospitals and other healthcare providers are not required to use the system, but that's no longer the case. The FDA now

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requires reports on adverse events leading to a patient death, and high-risk medical devices (such as implants) must include a unique device identifier (UDI) if the safety failure occurs at specified facilities such as hospitals, ambulatory surgery centers, or nursing homes. Those medical facilities are required by law to report cases of patient deaths related to a device to the FDA and now are required to report the UDI as well. Manufacturers also must notify the FDA.

Sutter Health announces restructuring

Sutter Health (Sacramento, CA) will undergo a major restructuring in 2015, consolidating its five-region model into two divisions: Bay Area and Valley. A Sutter Health official said the change came, in part, due to the response Sutter received when it asked thousands of company managers for input on how to improve the health system and prepare it for the changing healthcare environment. Sutter also created several new positions, including SVP for patient experience and SVP for medical and market networks, a role that focuses on the system's health insurance products and health management services. Stephen Lockhart, currently CMO for Sutter Health's East Bay Region, will become system CMO. The restructuring will also create a new office of innovation to develop new care delivery models.

CMS launches new ACO initiative for rural, underserved areas

CMS (Baltimore, MD) announced a new ACO initiative that is designed to encourage new ACOs to form in rural and underserved areas, and for current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk. The initiative is called the ACO Investment Model, and will build on the experience with the Advance Payment Model. CMS will provide up to $114 million in upfront investments to up to 75 ACOs across the country. The model is in response to stakeholder concerns and some research which suggests some providers lack adequate access to the capital needed to invest in infrastructure necessary to successfully implement population care management. Participation in the ACO Innovation Model will be limited to the following groups:

- New Shared Savings Program ACOs joining in 2016: The ACO Investment Model seeks to encourage uptake of coordinated, accountable care in rural geographies and areas where there has been little ACO activity, by offering pre-payment of shared savings in both upfront and ongoing per beneficiary per month payments.
- ACOs that joined Shared Savings Program starting in 2012, 2013, and 2014: The ACO Investment Model will help ACOs succeed in the shared savings program and encourage progression to higher levels of financial risk, ultimately improving care for beneficiaries and generating Medicare savings.
- The application deadline for organizations that started in the Shared Savings Program in 2012 or 2013 was December 1, 2014. Applications will be available in summer 2015 for ACOs that started in the Shared Savings Program in 2014 or will start in 2016.

Advocate Health Care, NorthShore University HS plan merger

In September, Advocate Health Care (Downers Grove, IL) and NorthShore University HealthSystem (Evanston, IL) announced plans to merge and form a new integrated system to be called Advocate NorthShore Health Partners. The new system will be the largest in Illinois and 11th largest in the country, serving over 3 million patients each year. Advocate Health Care CEO James Skogsbergh and NorthShore CEO Mark Neaman will jointly lead the organization. The new system should officially launch in early 2015 after regulatory approvals. rep

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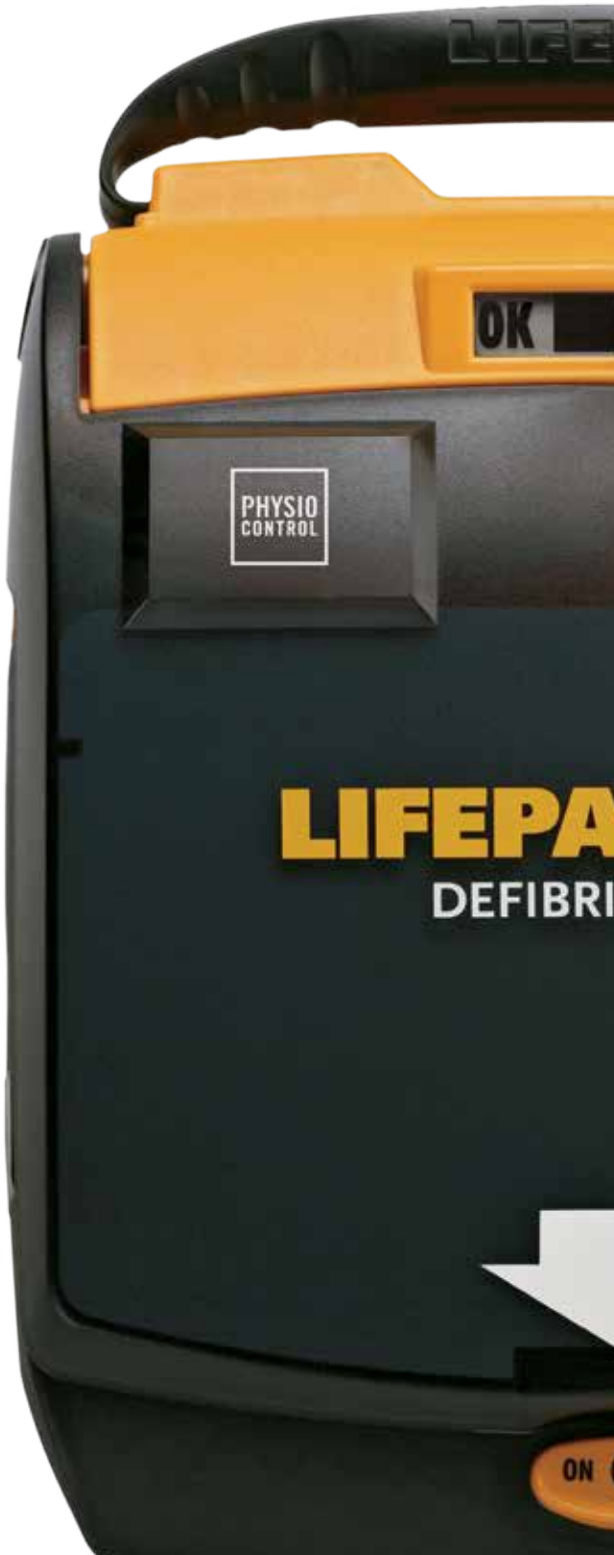

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*Andre A, Jorgenson B, Froman J, et al. Automated External Defibrillator Use By Untrained Bystanders. *Prehospital Emergency Care.* 2004;8:284-291.

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Agreement reflects unique supply chain needs of non-acute vs. acute-care providers

The recent acquisition by Henry Schein, Inc. of Cardinal Health's physician office business demonstrates that the needs of the physician office differ from those of the acute-care hospital, and that healthcare leaders recognize as much, according to those involved.

The two companies announced in late November that the physician-office-focused business of Cardinal Health's Medical segment would be consolidated into Henry Schein's Medical Group.

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As a result of the agreement, Henry Schein Medical gains service to more than 25,000 physician office customer locations, adds $300 million in annual sales, and brings on approximately 200 sales professionals.

"We have been servicing almost 25,000 physician offices and strengthening our presence for a long time," said Steve Inacker, president, Hospital Sales and Services, Cardinal Health. "But serving the physician office requires a unique platform and service capability, some of which we had and some of which we recognized we had to build.

"We had the ability to service the physician office space, but clearly, our strength was in what we would call large-pallet distribution and ValueLink®, our low-unit-of-measure offering," continued Inacker. "The physician office fell somewhere in between those. We had some capabilities, but we recognized that [to continue to fully serve] the office-based practitioner, we needed to build more. Our alliance with Henry Schein has allowed us to build those capabilities. We can grow them with the alliance much more quickly, and we can deploy capital more efficiently. We didn't have to invest in infrastructure to do that.


Steve Inacker

"The key to this is being able to offer a defined portfolio of products across the entire continuum of care. Nobody else has the breadth that Henry Schein and Cardinal Health have together."

– Steve Inacker

"Henry Schein's outstanding service capability offered a more comprehensive and efficient solution for our [IDN] customers than either company could offer individually," continued Inacker. "We will offer a wider breadth of product and world class service and value. In this case, one plus one equals three."

"Our whole focus has been the non-acute-care space," said Henry Schein Medical President Dave McKinley. The company's programs, sales tools, order entry systems, and infrastructure are designed specifically for the non-acute-care space, he added.

"It was a matter of looking in the mirror and asking, 'What are we good at, and how can we best support our customers going forward?' We know that the continuity across points of care is important. This is a good way to address it."

Focus on the IDN customer

"The whole intent is to better serve the customer," said McKinley. "Cardinal Health and Henry Schein will seamlessly collaborate to serve IDNs. And that's our intent – to provide a greater level of service across points of care."

Henry Schein and Cardinal Health will each fulfill their areas of expertise when it comes to working with IDNs, added Inacker. "Henry Schein will be responsible for servicing the physician office environment, and Cardinal Health will be responsible for the non-physician-office-based component. We see it as very symbiotic. The materials executives we have spoken to are very positive about it."

"We are following our customer," McKinley said. "Our customer is consolidated. With the Affordable Care Act, they are looking at how they can coordinate care. Based on their needs, we had to ask ourselves, 'How do we reflect the trends in the marketplace, and how do we change and achieve this collaboration?'"

Henry Schein and Cardinal Health will service IDNs seeking one contract for both acute-care and non-acute-care services, if they desire, he added. "It's whatever the customer wants; it's not what Henry Schein or Cardinal Health wants. We will offer seamless collaboration when it comes to supporting acute-care settings and non-acute-care offices, so supply chain executives can meet their objectives. By working together, we achieve a three-way partnership, if you will."

Adds Inacker, "We think we can create a lot more value between Henry Schein and Cardinal Health than they could achieve with any other relationship. The key to this is being able to offer a defined portfolio of products across the entire continuum of care. Nobody else has the breadth that Henry Schein and Cardinal Health have together."

Unique needs of the non-acute-care market

The agreement between Henry Schein and Cardinal Health reflects a changing market and changing attitudes on the part of IDN supply chain executives, according to both companies.

Not too many years ago, many IDNs were acute-care-focused organizations, said McKinley. They owned some clinics, but not as many physician offices as they do today. "When you mentioned Henry Schein to [materials managers] 10 or 15

Henry Schein will serve its new physician-office customers from its five major distribution centers around the country.

years ago, they probably didn't know us," he said. "Today, we have changed our focus; we have followed the customer; and our brand has increased substantially among supply chain leaders across the country. I think it's recognition of a changing market and environment."

The agreement also signals that the supply chain needs of the physician office and that of the acute-care hospital are clearly different. That includes sales representation.

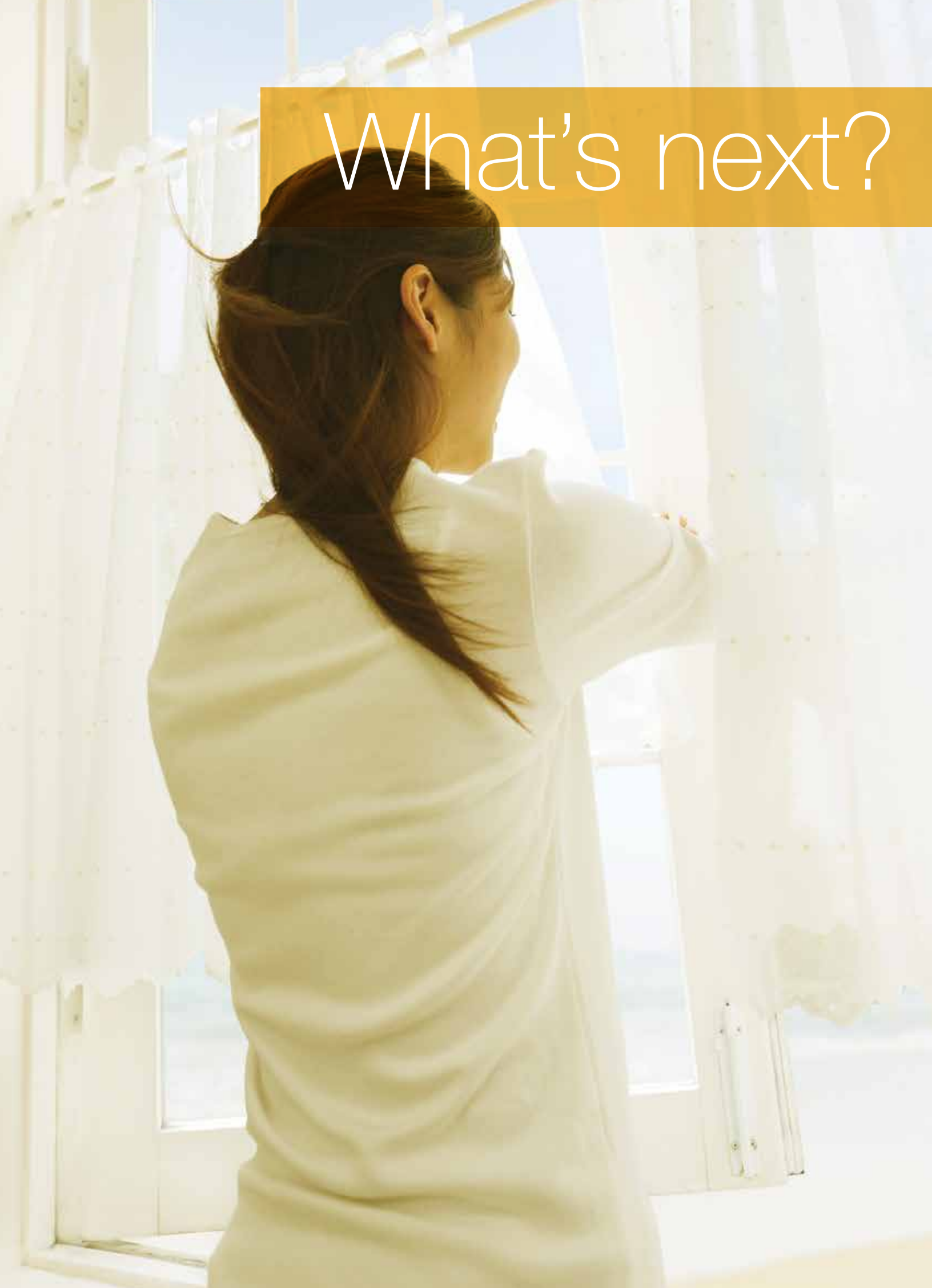
"The physician office space requires unique tools and a service platform to best serve their needs, whether they are IDN-owned or independent," said Inacker. "Our customers are looking for partners who can bring a more efficient and cost-effective supply chain across the entire continuum of care. A key part of this solution are the physician office reps. They are critical in working with the customer to service the unique needs of that marketplace, whether it's basic account management, driving cost-savings opportunities, data analysis, training and education, or product formulary development. Reps are truly the partners who can help physician office customers run their businesses better. They are the glue in this strategic alliance."

> "We have followed the customer; and our brand has increased substantially among supply chain leaders across the country."
>
> **– Dave McKinley**

As the Henry Schein team traveled throughout the country in December to speak with Cardinal Health physician office sales reps and acquaint them with Henry Schein's capabilities, "they were pleased and excited to be joining us," said McKinley. "We have about 900 sales reps and managers – a specialized sales force – out there. And we will support them with about 300 [inside] people."

Cardinal Health's physician reps should be fully integrated into the Henry Schein organization by the end of the first quarter of 2015, he said.

What's next?



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Similar cultures

"The cultures of our two organizations are very similar," said Inacker. "We have similar values and morals, and the way we approach the marketplace is similar." This creates fertile ground for a successful integration of teams and ultimately, an optimal customer experience, he said.

Cardinal Health's physician-office customers will note changes in some of the systems they use to access their distributor's product catalog, order products, receive invoices and submit payment. Henry Schein will serve its new physician-office customers from its five major distribution centers around the country. According to McKinley, customers will benefit from best-in-class service as a result of Henry Schein's non-acute-centric distribution centers: Orders are shipped complete and fulfilled the same day from their primary distribution center.

> "Healthcare today is all about collaboration and Cardinal Health and Henry Schein have taken a huge leap forward in coordinating the non-acute and acute settings of healthcare."
>
> **– Dave McKinley**

Sean Postol, who has been leading Cardinal Health's physician-office business, will remain with Cardinal Health after the transition. Postol is national vice president, sales and segment sales support.

"Our focus remains to drive the most efficient and cost-effective supply chain for our customers," said Postol. "We believe this alliance will only strengthen our ability to do that. We have worked closely with the Henry Schein team to bring this to fruition."

"We are excited about the level of talent that the agreement brings together," added Postol. "The sales reps are ready to capitalize on this. They are excited about the opportunities they can bring to their customers. And as they move to Henry Schein, they join a class organization that does an incredibly good job of servicing office-based practitioners. The unique tools sets will be at their fingertips."

Added Inacker, "They feel they will get the support and the programs they have always needed to really show what they can do in the marketplace."

Manufacturers will continue to be "an important part of the value we deliver to the marketplace," said Inacker. "Cardinal Health and Henry Schein have committed to a seamless and smooth transition for suppliers. The Cardinal Health team will continue to collaborate with our manufacturer partners, and an integration team from both companies will continue to work on a transition plan."

Said McKinley, "Henry Schein is getting larger. This should be good news to manufacturers, as we have more capabilities."

As part of the agreement, Henry Schein has committed to purchase Cardinal Health™ Brand products and use Cardinal Health as a primary source for various medical products. Henry Schein was selling Cardinal Health brand products prior to the new agreement, but "certainly this adds to a preferred brand of products now for us," said McKinley. "We have more access to a greater number of SKUs than before."

Said Inacker, "It's not a different model for us in that we already sell our products through other distributors. We believe a lot more value will be created, and [the result] will be a less cumbersome environment for our customers."

"This agreement is the first of its kind in the space," said McKinley. "Healthcare today is all about collaboration, and Cardinal Health and Henry Schein have taken a huge leap forward in putting the customer first to deliver optimal service across the continuum."

"I think the overarching message is the opportunity for [Henry Schein and Cardinal Health] to accelerate our offerings on a combined basis and bring about a more efficient supply chain that will meet the needs of our customers," said Postol.

Said Inacker, "The short answer to why we're doing this is, we're better able to serve our customers, drive efficiencies, and drive value." rep

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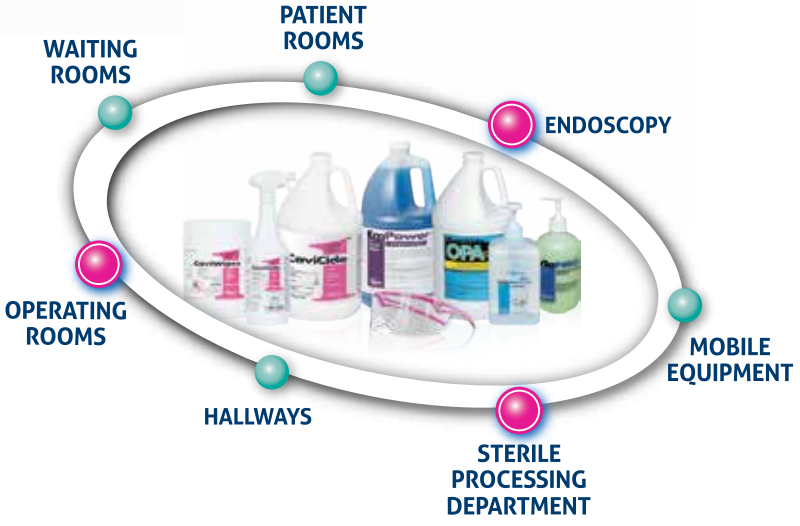

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AN-2014-11-0003

Henry Schein and Cardinal Health: The customer's view

Greater volume on the non-acute-care side of the business may be the key factor in changing healthcare providers' and distributors' approach to this part of the market.

Repertoire recently asked several healthcare supply chain executives to offer their perspectives on Henry Schein's acquisition of Cardinal Health's physician-office business. Chris Holt, senior vice president and executive officer, VHA Upper Midwest; Bob Taylor, assistant vice president of supply chain, UAB Health System, Birmingham, Ala.; and David Hargraves, David A. Hargraves, MBA, CPM, CMRP, vice president clinical supply chain, vice president operations, BioTronics, Pittsburgh, Pa., offered their comments.

Repertoire: At one point in time, perhaps 15 years ago, it seemed that IDN materials managers would have preferred to have one distributor service both their acute-care and non-acute-care facilities. Would you agree or not? Would you say that sentiment has changed since then? If so, why?

Chris Holt: Fifteen years ago, most of the product flow was to the hospitals themselves, and the non-acute volume was small enough that it was sensible to have one distributor for acute and non-acute. Interestingly, this trend led to the large acute distributors aggressively expanding their non-acute capabilities in order to provide "one stop shopping." But since that time, non-acute volumes have grown dramatically, and they now represent a much higher percentage of total volume. It's harder to pigeonhole acute distribution capabilities, processes and systems into non-acute channels, creating the opportunity for niche distributors in the non-acute space. There are still potential advantages and synergies in receiving both types of distribution from one company, but it is harder and harder to be great at both.

> "It's harder to pigeonhole acute distribution capabilities, processes and systems into non-acute channels, creating the opportunity for niche distributors in the non-acute space."
>
> – Chris Holt

Bob Taylor: I think that was a very common preference for an IDN materials manager, as it greatly simplified the contracting process and reduced the number of distribution contracts. The volume from the acute business could be used as leverage for improved pricing and terms on the non-acute business. The consolidation of physician practices and other non-acute settings means that they are now a bigger part of the IDN's overall structure. Accordingly, what may have once been a somewhat incidental portion of the business is now quite significant and warrants a solution that is built around the different needs of this segment.

David Hargraves: When making supplier selections, the decision to go with a best-of-breed or consolidate to a single vendor has been debated frequently and fervently. Single-vendor solutions at their best offer a single point of accountability across a broad range of products and services. The benefits of working with a single vendor have been summarized in the past by seasoned supply chain professionals as having "one throat to choke," conceivably, for resolving service issues. Additionally, awarding ever more business to a single supplier increases your spend profile with that company and should result in lower costs. Contemporary supply chain professionals understand that there are tradeoffs with awarding to a single vendor, including decreased competition, decreased service levels and increased dependency. This knowledge has slowly changed the historical sentiment that it always makes good business sense to spend more with a single vendor, and some supply chain professionals are now balancing this practice with awards to best-of-breed suppliers. With best-of-breed vendors, you are typically getting

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the star player in this field, that is, someone who specializes in your particular market, which allows them to know your business better than a broad-based single supplier. This increased market knowledge allows the best-of-breed supplier to offer their customers the highest level of service. The downside is that you typically pay for this service, as best-of-breed suppliers may not possess the same leverage and scale as their broad-line competitors, and their higher level of service may bring higher costs. Specific to healthcare supply distribution, the fees paid for non-acute distribution have historically been significantly higher (2x-5x) than that paid for acute-care's bulk distribution services.

Repertoire: Cardinal Health's sale of its physician office business (and reps) to Henry Schein would seem to lend weight to the belief that the acute-care and physician-office markets are very different, requiring different skills, different services, different sales reps. To what extent would you agree or disagree with that? Why?

Holt: The Cardinal-Schein transaction is an example of companies choosing to focus on core strengths. The reality is that these two channels are very different. Much like a Wal-mart and a neighborhood corner store need different service and delivery models, a large urban hospital is very different from a doctor's office. The large hospital might have an onsite, dedicated sales rep, a daily truckload delivery, and a multitude of value-added services around data, inventory and process efficiency. The doctor's office needs a van delivery of a few boxes of product, a simple order interface to a smaller portfolio of products, and an occasional visit from a sales rep. Being an acute and non-acute distributor simultaneously can hurt the efficiency of both, so the specialization makes sense.

Taylor: I think there is a difference in the logistics related to servicing the physician office market vs. the acute care market. Although the products may, for the most part, be the same as what is used in the hospital med/surg setting, there is less infrastructure to manage the processes and movement of supplies. The model that may be efficient in an acute-care setting may become very inefficient in the non-acute, as the concentration and volume is insufficient to warrant dedicated materials staff. Having a model that is designed specifically for the unique needs and requirements of the physician office setting may result in logistics costs that, as a percent of supply cost, is higher than the acute care setting, but less than if the acute care model is overlaid in the non-acute setting. The 'high touch' model that is often seen in the non-acute setting can also result in higher service and satisfaction levels.

Hargraves: The acute-care and physician-office markets are very different and do require different skills and services. This is not to say that a broad line acute-care distributor could never adequately service a physician office, but the differences in the two market segments are real. The most tangible differences…are storage quantities and common purchase units of measure. While full cases, full pallets and even full trailer-loads of a given product are commonplace for large acute-care IDNs, a single case of product for a physician office could represent months of inventory, which ties up the practice's cash. Acute-care facilities typically order in bulk full-case quantities, while physician offices prefer low-unit-of-measure (LUM) for easier storage and lower inventory values. This then manifests into a significantly lower average order size for physician office and more frequent ordering patterns compared to acute-care facilities. Outside of this, you must also look at the existence and sophistication of the buyer of the products. The need for sales support in the physician market is much greater than at an acute-care facility due to lack of dedicated purchasing resources. While a large IDN may have a team of procurement professionals divided into specialty teams placing dozens of orders per day, the responsibility for inventory management and purchasing at a physician office typically falls on the office manager, a nurse or perhaps even the physician themselves. This difference significantly increases the need for a sales representative who knows their products, their services and their customers to assist with the ordering process.

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UDI: The Wait is Over

The Unique Device Identifier is here; supply chain needs to adapt rapidly, say experts

CHICAGO–UDI isn't just for freaks and geeks or your company's regulatory guys. Sales and marketing executives, supply chain professionals and front-line sales reps need to get up to speed…and fast…not just because the feds are requiring it, but because UDI represents opportunities for all sectors of the supply chain to improve their internal processes and sales and, above all, help clinicians provide better patient care. That was the message from speakers at the recent Fall Conference of the Healthcare Manufacturers Management Council, or HMMC, whom moderator Kevin Neuman, vice president of marketing and operations for Innovative Healthcare Corp., asked to discuss the strategic implication of UDI.

UDI stands for "Unique Device Identifier." After years of deliberation, in September 2013 the U.S. Food and Drug Administration issued a final rule on UDI as well as a database for medical devices. The clock has already begun ticking. Effective September 2014, for example, all newly manufactured Class III devices – considered the riskiest of all – were required to carry a UDI on their packaging. Other important dates are:

- Sept. 24, 2015: Newly manufactured life-sustaining equipment must be labeled. (For a list of devices that FDA classifies as "implantable, life-saving, and life-sustaining," go to www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/UniqueDeviceIdentification/UCM382463.pdf)
- Sept. 24, 2016: All Class II devices must be labeled.
- Sept. 24, 2018: Class I devices must be labeled.

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But manufacturers – and distributors that private-label – shouldn't wait for the regulatory deadlines, cautioned Dennis Black, director of e-business for BD. That's because a growing number of customers – including IDNs and group purchasing organizations – are demanding UDI now.

The UDI system consists of two core items:

- A unique number assigned by the device manufacturer to identify the version or model of a device. The number must be represented on the label in plain text as well as in a manner that can be read by automatic identification and data capture (AIDC) technology, such as a bar code. The identifier contains two elements: 1) the device identifier, or DI, which describes the manufacturer, product, brand name, number of items (in case, box or each); and 2) the production identifier, or PI (identifying the lot or batch number, date of manufacture, expiration date).
- A publicly searchable database administered by the FDA, called the Global Unique Device Identification Database (GUDID), which will serve as a reference catalogue for every device with an identifier. GUDID will house only so-called "static" information about manufacturers' products. No identifying patient information will be stored in this device information center, nor will companies' sales information – such as volume of goods shipped, customers or pricing, etc. – be represented. For a list of all device information to be submitted to the GUDID, see www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/UniqueDeviceIdentification/GlobalUDIDatabaseGUDID/default.htm.

The FDA's rule allows manufacturers to use one of two standards for the UDI:

- GS1 US, whose UDI system is called the GTIN, or Global Trade Item Number.
- The Health Industry Business Communications Council (HIBCC), whose UDI is the Labeler Identification Code, or LIC.

The FDA requires the use of ICCBBA (the international standards organization, that is related to the World Health Organization) for human cells, tissues, or cellular and tissue-based products (HCT/Ps) that are regulated as devices.

In most cases, the manufacturer – as the "labeler" of a medical product – bears responsibility for ensuring that all of its devices are properly labeled and accounted for in the GUDID. That said, distributors are accountable for their private-label products.

Implications

One of the federal government's primary reasons for pursuing a UDI is to facilitate product recalls, explained Black. The UDI will provide a way to more easily track which patients received a certain implantable device, for example.

> "If you take advantage of these standards, you will improve your business processes; you can better meet your customers' demands; you will be perceived as a leader by adopting standards; and you can position yourself as being easy to do business with, while realizing lower operating costs."
>
> **– Denise Odenkirk**

But the UDI has additional implications for the supply chain, offering benefits for providers and suppliers alike.

What customers want is simple, said Black. They want to be able to scan products at the point of receipt, at the bedside or in the lab – just as companies like Wal-mart and Whole Foods do in their industries. That identifying information can help providers control their inventory better and ensure they are paying accurate prices for contracted items. Once the UDI is integrated into electronic health records, providers can use it to compare one physician's usage of a particular product to those of his or her peers, and perhaps even to compare the patient outcomes associated with that usage.

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Traditionally, health systems have been hard-pressed to accurately identify their cost to serve. But with a UDI system in place, they can more accurately identify the materials portion of that care – and bill accordingly.

For providers, it comes down to "cost, quality and outcomes," said Ellenmary Martin, chief strategy officer, DUKAL Corp. Traditionally, health systems have been hard-pressed to accurately identify their cost to serve. But with a UDI system in place, they can more accurately identify the materials portion of that care – and bill accordingly. What's more, by giving them visibility into which products are being used, the IDN can monitor standardization efforts, and can compare product usage from clinician to clinician.

Contracting

UDI represents operational efficiencies for all players in the supply chain. Contracting is one of the most salient examples, according to Denise Odenkirk, senior director, industry solutions, GHX, who participated on a Health Industry Distributors Association-sponsored work group on contract administration. (The group issued a white paper on UDI and the contracting process in September 2014.)

"Today, contract administration is very complex," said Odenkirk. Most suppliers have "heroes" in the office making Herculean efforts to keep contracts up to date. "Even so, how many of you have gotten a call from an irate customer because the contract terms are wrong?" she asked. Common issues include:

- Price mismatches.
- Credits/rebills. ("They're miserable," said Odenkirk. "Usually, when you invoice incorrectly for an order, it's not just one time; you've probably invoiced incorrectly for the last three months.")
- Rebate denials (stemming from confusion about the accuracy of the price when the product was shipped).

Fixing issues such as these eats up non-value-added time, she said. "Your sales reps are taking care of pricing issues rather than selling."

The HIDA committee examined how other industries handle contract management, and recommended the healthcare supply chain do three things:

- Automate all contracting transactions, and redesign those processes that cannot be automated.
- Adopt industry standards and processes, including UDI.
- Share updated contract information with trading partners on a timely basis, and use EDI transaction sets where possible (e.g., 845 for contract information, 832 for price/sales catalog, 867 for sales tracings, 849 for chargeback reconciliation, etc.)

Implementing UDI and electronic data interchange may be challenging, but participants in the med/surg supply chain need only look at their counterparts in the pharmaceutical supply chain to see the potential benefits, said Odenkirk. The National Drug Code (NDC) has helped pharmaceutical manufacturers and wholesalers clean up their processes, she said.

"If you take advantage of these standards, you will improve your business processes, you can better meet your customers' demands, you will be perceived as a leader by adopting standards, and you can position yourself as being easy to do business with, while realizing lower operating costs," she said.

Marketing and sales executives tend to focus their efforts on this quarter's performance. "But [it will be in your best interest] to figure out how you will use these standards as a driver to improve operating efficiencies and sales."

Editor's note: To read the FDA's Final Rule on the Unique Device Identification System, issued Sept. 24, 2013, go to www.federalregister.gov/articles/2013/09/24/2013-23059/unique-device-identification-system.

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Timetable for UDI implementation

Compliance date	Requirement
One year after publication of final rule (Sept. 24, 2014)	• The labels and packages of Class III medical devices and devices licensed under the Public Health Service Act must bear a UDI. (A one-year extension may be requested no later than June 23, 2014.) • Class III stand-alone software must provide its UDI.
Two years after publication of final rule (Sept. 24, 2015)	• The labels and packages of implantable, life-supporting, and life-sustaining devices must bear a UDI. • A device that is a life-supporting or life-sustaining device that is required to be labeled with a UDI must bear a UDI as a permanent marking on the device itself if the device is intended to be used more than once and intended to be reprocessed before each use. • Data for implantable, life-supporting, and life-sustaining devices that are required to be labeled with a UDI must be submitted to the GUDID database.
Three years after publication of final rule (Sept. 24, 2016)	• Class III devices required to be labeled with a UDI must bear a UDI as a permanent marking on the device itself if the device is a device intended to be used more than once and intended to be reprocessed before each use. • The labels and packages of Class II medical devices must bear a UDI. • Data for Class II devices that are required to be labeled with a UDI must be submitted to the GUDID database.
Five years after publication of final rule (Sept. 24, 2018)	• A Class II device that is required to be labeled with a UDI must bear a UDI as a permanent marking on the device itself if the device is intended to be used more than once and intended to be reprocessed before each use. • The labels and packages of Class I medical devices and devices that have not been classified into Class I, Class II, or Class III must bear a UDI. • Data for Class I devices and devices that have not been classified into Class I, Class II, or Class III that are required to be labeled with a UDI must be submitted to the GUDID database. • Class I stand-alone software must provide its UDI.
Seven years after publication of final rule (Sept. 24, 2020)	• Class I devices, and devices that have not been classified into Class I, Class II, or Class III that are required to be labeled with a UDI, must bear a UDI as a permanent marking on the device itself if the device is intended to be used more than once and intended to be reprocessed before each use.

Source: U.S. Food and Drug Administration, "Unique Device Identification," www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/UniqueDeviceIdentification/default.htm

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Providers insist on UDI

Editor's note: Group purchasing organizations and IDNs are urging – and in some cases, demanding – that their suppliers include unique device identifiers on their packaging. We asked several provider organizations about their policy. Following are their responses.

Premier

Premier, Inc. has for years advocated in support of UDI supply chain standards that further enhance patient safety and reduce costs in the healthcare industry. In fact, it recently announced its support of the Healthcare Supply Chain Association's (HSCA) Committee for Healthcare eStandards (CHeS) Total Visibility Project, to improve the accuracy and accessibility of product information available to the healthcare supply chain. Premier was the first GPO to announce its endorsement of GS1 supply chain standards, and was the first organization to expect its contracted suppliers to comply with this important initiative. Use of the standards allows supply chain stakeholders to definitively identify all items purchased by healthcare providers, and efficiently exchange and update this information.

In its policy for sellers/suppliers, Premier requests that suppliers use the GLN (Global Location Number) to identify participating alliance members and use the GTIN (Global Trade Item Number) to identify their products within all reporting and data exchanged with Premier. Premier also requests that the supplier agrees that standardized product identifiers such as NDC (National Drug Code) and UDI increase efficiency and accuracy within the supply chain and improve patient safety. Premier sellers/suppliers must remain compliant with all applicable UDI requirements and compliance dates, and agree to support Premier's use of GTIN as the UDI. In addition, any barcodes that are placed on the supplier's packaging must be Grade "C" or better (i.e., able to be reliably scanned on the first pass of a barcode reader).

Healthcare Transformation Group

(**Editor's note:** The Healthcare Transformation Group was formed in 2010 by five healthcare systems to share best practices in supply chain. They are: Geisinger Health System, Intermountain Healthcare, Kaiser Permanente, Mayo Clinic and Mercy.)

HTG expects our supplier partners to label all Class 1, 2 and 3 products with a human readable GS1 128 linear concatenated barcode whenever possible; and in those cases where packaging size is limited, we will consider 2D acceptable. We expect these barcodes to be applied to all products by the defined FDA sunrise date provided for Class III devices. HTG does not recognize any exceptions to UDI labeling and will be pushing to ensure that GS1/UDI compliance is a central factor in partner identification and contracting through our GPOs and product negotiations. For more details around this guideline please reference the detailed guideline at: http://healthcare-transformationgroup.com/backend/wp-content/uploads/2012/08/HTG-Suppliers.8.15.12.pdf

Amerinet

Amerinet communicates our requirements on data standards to our suppliers through our corporate website and supplier portal. We have a specific web page that details the requirements for UDI, and a similar one for GS1 standards. Our primary request to our suppliers is that they comply with both the UDI requirements and GS1 standards, and that they publish this information to the GUDID (Global UDI Database) and GDSN (Global Data Synchronisation Network), respectively. We have incorporated language in our standard contracts respective to our suppliers' compliance with these standards.

Amerinet is a strong supporter of the UDI and the GS1 standards. It is important to note that the major GPOs worked together on a coordinated response to the proposed UDI rules through participation on the Healthcare Supply Chain Association Committee for Healthcare eStandards. HSCA issued a press release in support of the UDI rule (with suggested changed during the comment period), and Amerinet issued a similar press release. Several other GPOs also issued press releases in response.

For more information, go to www.amerinet-gpo.com/suppliers/unique-device-identification.aspx or http://www.amerinet-gpo.com/suppliers/gs1-standards.aspx

MedAssets

MedAssets is a GS1 standards advocate. We believe these standards will help organizations share data, promote accuracy, and work more efficiently – to improve patient safety and lower healthcare costs. In addition to GS1 delivering standardization and efficiencies, MedAssets supports the FDA's Unique Device Identification (UDI) ruling and sees the GS1 labeling system as being the best system in fulfilling expectations on product identification and patient safety.

Novation

Novation believes a robust UDI system will significantly enhance product identification, improve the device recall process, ensure the integrity of the product throughout the transportation process, and most important, advance and improve patient safety. A UDI system also has the potential to generate significant savings for the healthcare industry through improved efficiencies and automated processes.

Novation has encouraged suppliers to embrace early adoption, and we have implemented a process to communicate with medical device suppliers regarding compliance dates for all device classes. Finally, we have changed our NOVAPLUS® Graphics Standard Guide to require UDI compliance.

Traceability law takes effect

Federal Drug Quality and Security Act of 2013 creates a national standard for tracing drug products from the unit level back to the factory

Providers and suppliers have embarked on a 10-year journey implementing the provisions of the Federal Drug Quality and Security Act of 2013. Signed by President Obama in November 2013, the law creates a uniform national system for tracing all human drug products from the unit level (i.e., the bottle, tube, etc.) back to the manufacturer's factory.

Concerns about counterfeiting, compounding and gray-market selling have dogged the pharmaceutical industry for years. Traceability – often called "pedigree" – has been addressed on a state-by-state basis, resulting in what some call a patchwork quilt of regulations, which has created difficulty for manufacturers and wholesalers servicing multiple states. The U.S. Food and Drug Administration has tried to address the issue for years – some would say clumsily. But it took the 2012 fungal meningitis outbreak, blamed on the New England Compounding Center in Framingham, Mass., to spur Congress to action.

Ten years after enactment, the system will facilitate the exchange of information at the individual package level about where a drug has been in the supply chain, according to the FDA. The new system is intended to:

- Enable verification of the legitimacy of the drug product identifier down to the package level.
- Enhance detection and notification of illegitimate products in the drug supply chain.
- Facilitate more efficient recalls of drug products.

The Three Ts

Manufacturers, distributors and providers will notice that the word "pedigree" is becoming obsolete, replaced by new terminology, which some are calling the "Three T's":

- **Transaction Information (TI):** Includes the name of the product, strength and dosage form, NDC, container size, number of containers, lot number, transaction date, the shipment date and the name and address of the sellers and buyers.
- **Transaction History (TH):** Paper or electronic statement that includes the transaction information for each prior transaction back to the manufacturer.
- **Transaction Statement (TS):** Paper or electronic attestation by the entity transferring ownership of the product that it: 1) is authorized under the Act, 2) received the product from an authorized party, 3) received TI and TS from the previous seller, 4) did not knowingly ship suspect or illegitimate

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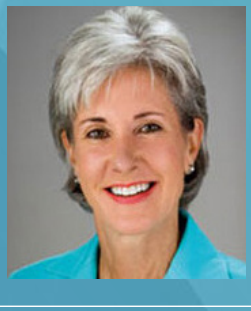

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product, 5) had systems and processes in place to perform verification, and 6) did not knowingly provide false transaction information and did not alter the transaction history.

Manufacturers were to begin sending distributors TI, TH and TS information beginning on Jan. 1, 2015. Manufacturers will be required to pass this information in electronic format by November 2017.

Next steps

An adjunct of traceability is the adoption of a universally recognized, universally applied numbering system for products in the supply chain.

The DQSA calls for manufacturers to affix a product identifier to each individual package and case of product by 2017, noted Liz Gallenagh, Esq., vice president, government affairs and general counsel, Healthcare Distribution Management Association, speaking at an HDMA seminar on traceability this fall. Repackagers must affix product identifiers by 2018. A product identifier is a standardized graphic (a two-dimensional data matrix) that carries the product's standardized numerical identifier (SNI), lot number, and expiration date in both human- and machine-readable format, she said. By 2023, supply chain members must electronically trace product at the individual package (unit) level.

Resources

The Drug Quality and Security Act contains provisions for a number of things in addition to traceability, including:

- Licensure of wholesalers and third-party-logistics providers
- Identification, reporting and disposition of suspect products
- Returns
- Repackaging
- Third-party-logistics providers
- Recordkeeping

The Healthcare Distribution Management Association has a variety of informational materials on pharmaceutical traceability and the Drug Quality and Security Act of 2013 at www.healthcaredistribution.org/ir_issues/pedigree.asp.

The U.S. Food and Drug Administration offers explanations of the law at www.fda.gov/drugs/drugsafety/drugintegrityandsupplychainsecurity/drugsupplychainsecurityact/default.htm rep

Key provisions of the Drug Quality and Security Act of 2013

Drug manufacturers, wholesale drug distributors, repackagers, and many dispensers – primarily pharmacies – will be called on to work in cooperation with the U.S. Food and Drug Administration to develop a new traceability system over the next 10 years, says the FDA. Among key provisions to be implemented are requirements for:

- **Product identification.** A unique product identifier on certain prescription drug packages, for example, using a bar code that can be easily read electronically.
- **Product tracing.** Information about a drug and who handled it each time it is sold in the U.S. market.
- **Product verification.** Systems and processes in place to verify the product identifier on certain prescription drug packages.
- **Detection and response.** A system to quarantine and promptly investigate a drug that has been identified as suspect, meaning that it may be counterfeit, unapproved, or potentially dangerous.
- **Notification.** Systems and processes to notify FDA and other stakeholders if an illegitimate drug is found.
- **Wholesaler licensing.** Wholesale drug distributors to report their licensing status and contact information to FDA. This information will then be made available in a public database.
- **Third-party-logistics provider licensing.** Third-party-logistics providers, those who provide storage and logistical operations related to drug distribution, to obtain a state or federal license.

Source: U.S. Food and Drug Administration, www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/DrugSupplyChainSecurityAct/default.htm

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Addressing MRSA in long-term care settings

Hospitals aren't the only facilities at risk for the spread of MRSA. Long-term care facilities – home to immuno-compromised and post-surgical patients – must also take measures to avoid outbreaks.

Associated with decades of often unnecessary antibiotic use, healthcare-associated Methicillin-resistant Staphylococcus aureus (HA-MRSA) continues to plague a number of healthcare settings, according to the Mayo Foundation for Medical Education and Research and the Mayo Clinic. Since antibiotics don't destroy every germ they target, germs that survive one treatment with antibiotics soon learn to resist others. Because MRSA is a type of bacterium that can resist the effects of many common antibiotics, infections can be extremely difficult to cure.

Originally seen in hospitals, where it often caused serious bloodstream infections in people who were sick with other diseases and conditions, today MRSA occurs in a variety of nonhospital settings as well, sometimes affecting the skin of otherwise healthy individuals. Older individuals and those with weakened immune systems are particularly vulnerable to infection, as are those who receive intravenous tubing or urinary catheters, which can provide a pathway for MRSA to enter one's body. Because MRSA is difficult to treat, the infection can spread through the body, infecting one's joints, bones, heart, lungs and blood stream.

Originally seen in hospitals, where it often caused serious bloodstream infections in people who were sick with other diseases and conditions, today MRSA occurs in a variety of nonhospital settings as well, sometimes affecting the skin of otherwise healthy individuals.

Once an outbreak of MRSA occurs in a long-term care setting, patients who are infected or colonized with MRSA often are placed in isolation. Healthcare workers and visitors may be required to wear protective apparel and follow strict hand hygiene practices. And, surfaces and laundry items must be disinfected.

Enforcing healthcare personnel handwashing procedures when they move from one patient to the next is crucial in helping to reduce the spread of any infection, including MRSA. When MRSA is suspected, traditionally, doctors have diagnosed it by checking a tissue sample or nasal secretions for signs of drug-resistant bacteria. The sample is sent to a lab where it's placed in a dish of nutrients that encourage bacterial growth, according to the Mayo Clinic. Because it takes about 48 hours for the bacteria to grow, however, newer tests that can detect staph DNA in a matter of hours are becoming more widely available.

Rapid tests offer a fast and efficient means of screening patients with a suspicion of MRSA. Test results are available in a matter of hours, reducing the turnaround time for detection of MRSA colonization. Infected or colonized patients can be isolated more quickly, leading to lower rates of MRSA transmission.

Prepare your accounts

Distributor sales reps can provide a service to their long-term care customers by supplying them with the necessary products to address the spread of infection, including:

- Hand hygiene products
- Surface disinfectants

- Gowns, gloves, masks and table paper when appropriate
- Rapid MRSA screening tests

Sales reps should encourage their accounts to be proactive. Careful handwashing remains the best defense against germs, notes the Mayo Clinic. Ideally, healthcare workers and visitors to long-term care facilities should wash their hands briskly for at least 15 seconds, then dry them with a disposable towel and use another towel to turn off the faucet. In areas where there is limited access to soap and water, Mayo recommends providing hand sanitizers containing at least 62 percent alcohol.

In addition, healthcare workers and visitors should be reminded to keep patients' (and their own) cuts and abrasions clean and covered with sterile, dry bandages until they heal. The pus from infected sores may contain MRSA, and keeping wounds covered will help keep the bacteria from spreading. When patients do have cuts or sores, healthcare workers should wash towels and bed linens in a washing machine set to the hottest water setting (with added bleach, if possible) and dry them in a hot dryer. And, personal items, such as razors, clothing or towels, should not be shared among patients and residents. rep

What is MRSA?

MRSA infections can resist the effects of many common antibiotics, so they are more difficult to treat. This can allow the infections to spread and sometimes become life-threatening.

MRSA infections may affect the:

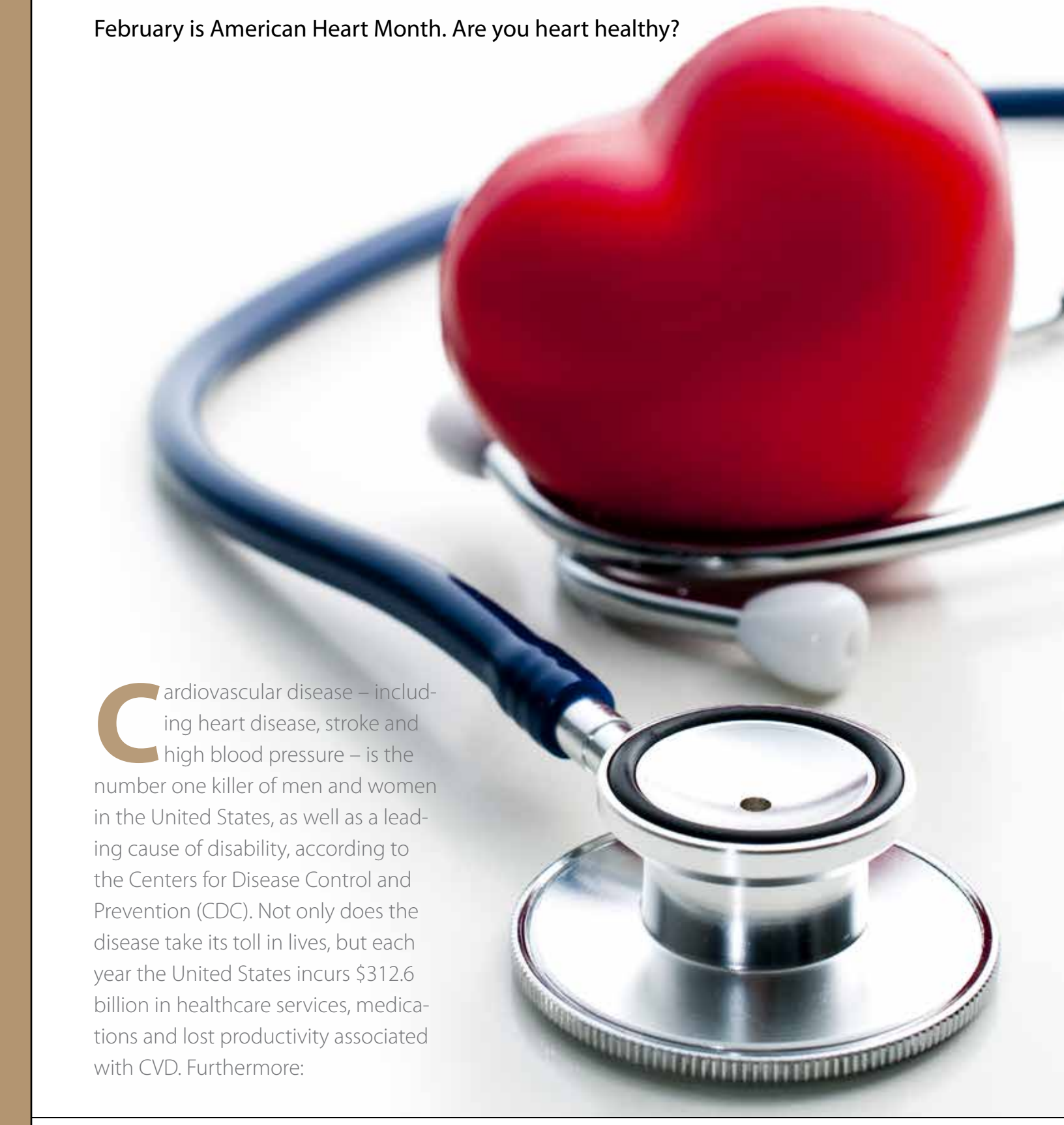
- Bloodstream
- Lungs
- Heart
- Bones
- Joints

MRSA skin infections look like a boil, pimple or spider bite that may be red, swollen, painful and infected with pus. These infections most commonly occur at sites where the skin has been broken by cuts or scrapes, or on areas of the skin covered by hair. They can be transmitted from one person to another by skin-to-skin contact or by touching contaminated objects.

Source: www.mayoclinic.org

Take Heart

February is American Heart Month. Are you heart healthy?



Cardiovascular disease – including heart disease, stroke and high blood pressure – is the number one killer of men and women in the United States, as well as a leading cause of disability, according to the Centers for Disease Control and Prevention (CDC). Not only does the disease take its toll in lives, but each year the United States incurs $312.6 billion in healthcare services, medications and lost productivity associated with CVD. Furthermore:

- Each year, about 720,000 Americans die of heart attacks, according to the CDC. Of these, 515,000 are a first heart attack and 205,000 occur in people who have already had a heart attack.
- About 615,000 people die from heart disease in the United States. The most common form of heart disease – coronary heart disease (or coronary artery disease) – occurs when plaque builds up in the arteries that supply blood to the heart. Coronary heart disease can cause heart attack, angina, heart failure and arrhythmias.

Cardiovascular disease does not affect all groups of people in the same way, according to the CDC. Men are more than twice as likely as women to die from preventable cardiovascular disease. Having a close relative with heart disease also increases one's risk, as do race and ethnicity. Nearly 44 percent of African-American men and 48 percent of African-American women have some form of cardiovascular disease.

Staying healthy

For a muscle about the size of the palm of one's hand, the heart has a huge job: to keep the body running by pumping oxygen-rich blood to the rest of the body, through the arteries, and bringing blood back to the heart through the veins. Over time, the heart and blood vessels endure changes. Some change is normal, and some, such as disease, can be damaging to people's health and place them at increased risk for heart attack.

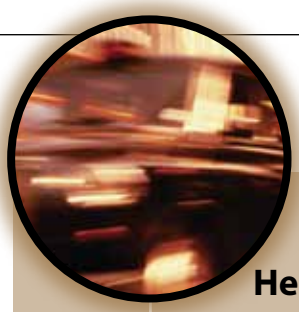
Cardiovascular disease usually is caused by atherosclerosis, a buildup of fatty plaques in the arteries, leading to narrowed, blocked or stiffened blood vessels that prevent the heart, brain and other parts of the body from receiving adequate blood. Maintaining a healthy diet and weight, exercising and refraining from smoking are key to reducing one's risk. In the case of people who have high blood pressure or diabetes, properly managing their disease can also help reduce their risk of developing cardiovascular disease. The Mayo Clinic offers eight steps to help prevent heart disease:

- **Control portion size.** Eating more low-calorie, nutrient-rich foods, such as fruits and vegetables, and less high-calorie, high-sodium foods, such as refined, processed foods, can positively impact both one's diet and one's waistline.
- **Eat more vegetables and fruits.** Vegetables and fruits, which are rich in dietary fiber, contain substances found in plants that may help prevent cardiovascular disease.
- **Select whole grains.** Whole grains are a good source of fiber and other nutrients that are said to play an important role in regulating blood pressure and heart health.
- **Limit unhealthy fats and cholesterol.** Reducing one's intake of saturated and trans fats can help reduce blood cholesterol and lower one's risk of coronary artery disease. High blood cholesterol levels reportedly can lead to atherosclerosis, or a buildup of plaque in the arteries.
- **Choose low-fat protein sources.** The Mayo Clinic recommends lean meat, poultry, fish, low-fat dairy products, and egg whites or egg substitutes. In addition, fish such as salmon, mackerel and herring, are high in omega-3 fatty acids, which can lower blood fats called triglycerides. Other sources of omega-3 fatty acids include flaxseed, walnuts, soybeans and canola oil.
- **Reduce sodium intake.** Eating a lot of sodium can contribute to high blood pressure, a risk factor for cardiovascular disease. The Mayo Clinic recommends that people 51 and older, African-Americans, and those who have been diagnosed with high blood pressure, kidney disease and diabetes, limit their sodium intake to 1,500 mg/day.
- **Plan ahead.** Knowing which foods help reduce one's risk of heart disease – and then planning accordingly – helps ensure people follow a heart-healthy diet.
- **Indulge.** If, every so often, people permit themselves to indulge in foods they enjoy, even if they are not heart healthy, they may be more likely to stick to an overall healthy plan, according to Mayo. And, a treat now and then won't derail one's healthy diet. REP

Watch for symptoms

The sooner a heart attack is treated, the better the odds are of preventing or limiting damage to the heart muscle. The Centers for Disease Control and Prevention advises people to be aware of the five major symptoms of heart attack:

- Pain or discomfort in the jaw, neck or back.
- Weakness, light-headedness or faintness.
- Chest pain or discomfort.
- Pain or discomfort in the arms or shoulder.
- Shortness of breath.



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.

Smokeless oil on the horizon?

An oil change may mean something new in years to come. Go Green Smokeless Oil International, Inc. offers smokeless oil, which is formulated to help reduce greenhouse gases and smoke emissions from older vehicles. The company recently announced the grand opening of its new prototype concept in environmentally friendly lube centers, beginning with its Go Green Oil Change Center in Austin, Texas, which offers both smokeless and traditional oil changes. However, motor oils will include a re-refined synthetic blend, a full synthetic motor oil processed for accelerated biodegradation if introduced to the environment, and a bio-based full synthetic product formulated with non-crude oil base stocks. The Department of Energy (DOE) and The Environmental Protection Agency (EPA) estimate that approximately 400 million gallons of oil is spilled or illegally dumped into the environment every year. A single gallon of oil can pollute 1 million gallons of fresh water. When oil is leaked on streets and parking lots, it is washed into storm drains and into waterways. Go Green's goal is to accelerate the rate at which leaks and spills are biodegraded, ideally, before they reach local waterways.

Complaints about in-car electronic systems on rise

Problems with in-dash electronic systems are a growing problem for many automakers, according to *Consumer Reports* in a recent Annual Auto Reliability Survey. The report, which is based on data for about 1.1 million 2005-14 model-year vehicles leased or owned by *Consumer Reports* subscribers, including 248 models from 28 brands, attempts to predict the reliability of 2015 models currently in dealer showrooms by evaluating models from past years. Lexus led the rankings from owners who participated in the survey, followed by Toyota, Mazda, Honda, Audi, Buick, Subaru, Scion, Porsche and Kia – meaning that Japanese brand in-dash electronic systems prove most reliable. For a second consecutive year, General Motors has the most reliable brands among the Detroit automakers. Ford and Lincoln show improvement, and Chrysler's brands remain low by comparison. Models in their first year from Infiniti, Jeep, Fiat, Ram, Cadillac, Ford and Honda all have significant problem rates caused by glitches in their infotainment systems, or in-car electronics that provide navigation, smartphone connectivity, audio and more, according to *Consumer Reports*. For all cars included in

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the survey, in-car electronics generates more complaints from owners of 2014 models than any other survey category. Issues such as freezing screens, lagging touch controls, malfunctioning voice recognition and problems in pairing smartphones continue to be a problem. That said, *Consumer Reports* says automakers continue to improve their electronics technology.

Safe travels

The Hanover Insurance Group, Inc offers five tips for weatherproofing one's car before hitting the road this rainy spring:

- Check, change or top-off the oil, coolant, brake and transmission fluids. This helps important car systems to perform well.
- If the windshield wipers are not working well or are more than six months old, replace them. Bad windshield wipers make driving in the rain on unfamiliar roads more dangerous.
- Have the tires checked and, if necessary, rotated. Err on the side of caution by replacing any tires that look suspect to help prevent dangerous blow-outs.
- Check the headlights and taillights to make sure all are working. New bulbs are easy to install, inexpensive, and they help improve visibility and safety. And, in most states one can also receive a traffic violation for a non-working vehicle exterior light.
- Clean the windows on the inside and out to increase visibility. Especially when traveling on unfamiliar roads or in the dark, having good visibility is important.

Hanover offers customers year-round maintenance apps to help diagnose car problems, locate mechanics, provide recall notices, and generate repair cost estimates.

Better safe than sorry

Winter may be winding down, but one can never be too safe when it comes to cold-weather driving. Michigan-based Meemic Insurance offers 10 Safety Tips for Winter Driving:

- Clear snow and ice from all windows, lights, hood and roof for maximum visibility and to avoid having ice and snow fly off your vehicle.
- Before starting out, turn on the lights to increase visibility to other motorists.
- Posted speed limits are for dry pavement. Decrease speed on icy, snow-covered roads and allow extra distance between you and other vehicles.
- Watch the traffic well ahead for extra reaction time. Always drive defensively and give yourself a cushion of time to deal with wintery conditions.
- Stay at least 200 feet behind maintenance vehicles and snowplows, and don't pass on the right. Use extreme caution when passing in a passing lane.
- Avoid abrupt lane changes. There may be a snow ridge between lanes, and the passing lane may be in worse shape than the driving lane.
- Brake early and gently to avoid skidding. It takes more time and distance to stop in adverse conditions. If your wheels start to lock up, ease off the brake and don't pump the anti-lock brakes.
- Watch for signs alerting you to slippery bridge decks and other areas prone to becoming slick, even when the rest of the pavement is in good condition.
- Don't use cruise control or overdrive in wintery conditions. Even a slight depression of your brakes to deactivate can cause loss of control on hidden slippery patches.
- Do not assume your vehicle can handle all conditions. Four-wheel and front-wheel drive vehicles encounter trouble on winter roads, just like other vehicles. The false sense of security these vehicles offer can leave you less prepared to deal with emergency situations.

Going green in 2015

BMW's i3, an electric car built with a lightweight carbon fiber passenger cell and an aluminum drive module, has been named *Green Car Journal*'s 2015 Green Car of the Year®. The first all-electric vehicle to win *Green Car Journal*'s Green Car of the Year®, the i3 benefits from BMW's years-long 'project i' initiative, which focuses on future mobility and strategies for sustainable transportation. Designed as a battery electric car, the i3 features an optional REx gasoline engine-generator, which enables an extended driving range with electricity created on board. Green Car of the Year winners are selected based on their potential to make an impact on improving air quality, reducing greenhouse gases and promoting transportation efficiency. rep

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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.

A speaker that hears

The Aether Cone – a sphere-shaped Wi-Fi speaker with voice recognition – may provide you with the perfect music listening experience after a tough day at work, provided you don't mind its hefty price ($399) or the fact that it's only usable with a single music streaming service, Rdio. Rdio is linked to the free Aether app; however, once the device is set up with iPhone (iOS 7 or later) or Apple computer, it no longer requires the app. And, on the plus side, the portable speaker (2.9 pounds and no more than six inches wide) features Nuance's voice-recognition technology and can play your requests, eventually even learning your musical tastes. The cone reportedly comprehends requests beginning with "play," followed by the name of the artist, or the song and artist.

Whistle while you work

Tablets aren't just for work. The E FUN Nextbook 8-inch tablet with Windows 8.1 is designed for entertainment as well, according to the manufacturer. The device features a mini HDMI output, enabling it to

connect to one's television. Videos, games and mobile apps downloaded to the tablet may be viewed on a larger, high-definition television screen. Netflix, Hulu and other online services can be streamed to any TV directly from the tablet, as well, without the need for a separate device, such as a Roku or Apple TV. Or, users can watch YouTube videos or surf the Web on their screen. Pairing the tablet with a microUSB adapter and an Xbox controller enables users to take their gaming to the next level. Or, they can use the tablet as a dedicated e-reader. Nook, Kindle and other eBook apps are available to download from the Microsoft Store, giving users free access to more than 3 million books, magazines and newspapers, according to the manufacturer. On a similar note, the Nextbook 8-inch tablet comes preloaded with Xbox Music, providing access to free radio and free music streaming.

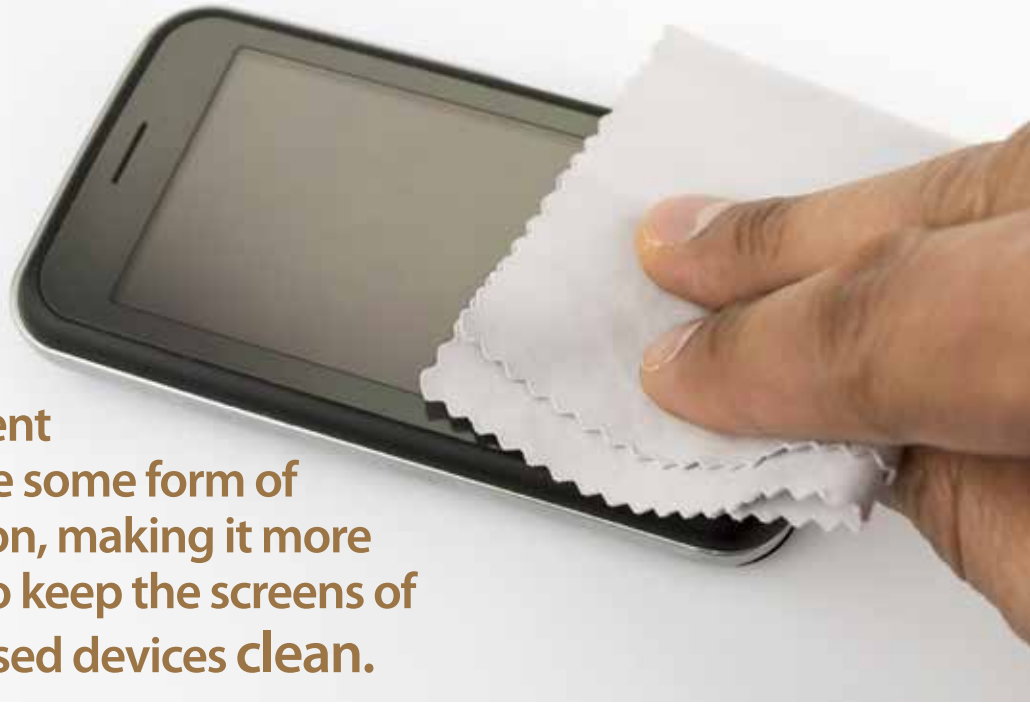
Safe online shopping, for you and your customers

Online shopping can be a convenience – until one becomes a victim of cybercrime. CompTIA, an IT security company, offers shoppers some common sense tips for a safe online shopping experience.

- Before providing personal information and credit card data, make sure that the website's URL starts with https:// and displays a small locked padlock icon. This identifies the website as having a Secure Socket Layer (SSL) Certificate.
- While some email shopping offers are legitimate, many others are a cover for cybercriminals and scam artists. The adage, "If it sounds too good to be true, it probably is," applies to all shopping, including online. Before they click on a suspicious link, shoppers should check the Internet to see if the company and product are for real.
- For any card that has a PIN associated with it, shoppers are advised to change their PIN if they have been using the same one for a long time. Longer, harder-to-guess pins are recommended.
- Shoppers should avoid shopping on open Wi-Fi networks. Even if these networks have a password, they are not as safe as one might think.
- Shoppers should set up automated alerts on bank and credit cards to track purchases.

Enjoy the view

To complement the bigger, sharper displays on the latest Apple devices, OtterBox has introduced Alpha Glass screen protectors for the iPhone 6 and iPhone 6 Plus. The fortified glass screen protectors are available for both devices in clear and privacy. Made of anti-scratch and shatterproof material, Alpha Glass is built to protect the device's touch screen while helping to preserve



Research from the London School of Hygiene and Tropical Medicine at the University of London indicates that 82 percent of mobile phones have some form of bacterial contamination, making it more important than ever to keep the screens of our most frequently used devices clean.

clarity. And, the tinted screen effect helps keep the screen contents darkened to everyone but the device user. To install Alpha Glass, users require an included alcohol wipe, microfiber cleaning cloth and all of the tools needed for a bubble-free application. Custom fit to the iPhone 6 and iPhone 6 Plus, Alpha Glass products are available for $29.95 in stand-alone and case-compatible options.

New heart monitor is in time for American Heart Month

Mio Global recently introduced FUSE, a device that combines the features of a heart rate monitor, sports watch and all-day activity tracker. The device, said to have a 0.99 correlation to EKG (electrocardiogram), monitors one's

heart rate, step count, distance, speed, pace and calorie burn. It is compatible with smartphones, bike computers, GPS watches, and other sport devices, and transmits heart rate data via Bluetooth® Smart 4.0 and ANT+. Unlike sports devices, FUSE works with third-party apps, giving users control over how they can track, store, and review workout data. It is available in two sizes in Crimson and Aqua colors, and retails at $149.

Streak free, germ free

Smudged and filthy cell phone screens don't merely look bad. They are germ-infested, according to experts. Research from the London School of Hygiene and Tropical Medicine at the University of London indicates that 82 percent of mobile phones have some form of bacterial contamination, making it more important than ever to keep the screens of our most frequently used devices clean. Toronto, Canada-based WHOOSH! offers Screen Shine Duo+, a non-toxic, streak-free screen cleaning solution that is reportedly safe for every device screen and is designed to keep screens clean of fingerprints and smudges. It is available at Apple.com and in Apple stores for a suggested retail price of $19.95.

3D printing that's user safe and environmentally friendly

3D printing is getting better and better, say manufacturers. The Toronto, Ontario-based Poieo3D.com has introduced the Poieo3D Printer, which has no sharp edges, hot plates or unsafe lasers. Instead, a large window illuminated by a cool-running white LED showcases each 3D-printed creation as it forms, one layer at a time. The Poieo3D Printer is environmentally-friendly as well, according to Poieo3D.com. The printing process employs filaments of biodegradable print material derived from renewable plant-based resources. Unlike petroleum-based plastics, this material reportedly does not give off foul-smelling fumes when the printer is used, making it safe for office, home or classroom use. ET

Letter to the Editor:

I read with interest the very well-written article by Joseph Rini entitled "It's a great time to be a manufacturers rep" [November 2014 *Repertoire*], and I cannot agree more with the points that Joe makes regarding the many changes that have already taken place, or that are yet to come, in the healthcare industry.

Certainly, the Affordable Care Act has been a primary catalyst in bringing about many of these changes, but there are many other areas within the supply chain that are causing everyone – particularly those of us on the supply side – to review every aspect of sales, marketing and delivery of products. The independent medical representative can be, is, and should be an important part of the process.

HIRA – Health Industry Representatives Association – is the only association within the healthcare industry that is solely devoted to the independent medical representative and the companies who choose to market their products through this group of seasoned, knowledgeable and experienced individuals. Through our ongoing educational programs, Annual Conference and ever-expanding industry network, we are working hard to ensure that our members meet and exceed the requirements and standards that Joe so ably discussed in his article. Nowhere else can you find the sales organization that can deliver as effectively as the independent rep, who only gets paid when he or she sells something.

To learn more about HIRA, its membership, and its programs, please go to our website hira@hira.org.

Charlie Higgins
Executive Director
HIRA

Henry Schein acquires ADS Florida LLC

Henry Schein Inc (Melville, N.Y.) acquired ADS Florida LLC (Naples, Fla.) and its parent company, Professional Transitions Inc (Naples, Fla.). The acquisition expands the geographic reach of Henry Schein's practice transitions offerings to dental practice owners looking to buy or sell their practice. ADS Florida will become part of Henry Schein Financial Services LLC, a wholly-owned subsidiary of Henry Schein Inc. In addition to practice transitions, HSFS offers an array of business solutions for healthcare practitioners, including equipment leasing and financing, and patient and practice credit card services. Terms of the transaction were not disclosed.

Welch Allyn celebrates its 100th anniversary

Welch Allyn (Skaneateles Falls, N.Y.) announced that 2015 marks its 100th anniversary. "When we introduced the world's first direct-illuminating ophthalmoscope in 1915, it fundamentally changed the way physicians diagnose diseases and care for patients," the company said in a release. "We've come a long way since then, but our vision remains the same – help transform care wherever patients and healthcare professionals connect, with measurable improvement in value, so all can thrive. We invite you to take a step back in time with us, visit the new www.welchallyn.com site, and see what 100 years of medical device innovation looks like from the eyes of the pioneers who helped build our legacy and shape an industry. Read the blog, watch videos, check out our photo gallery and interactive timeline, and see just how far a century of care has taken us."

CMS announces 89 ACOs join Medicare Shared Savings Program

More than 7.2 million patients will now be served by accountable care organizations (ACOs) with the addition of 89 new participants in the CMS (Baltimore, Md.) Medicare Shared Savings Program (MSSP) on January 1, 2015. Along with their predecessors, the new ACOs will earn a percentage of savings for hitting quality-of-care and patient health benchmarks. They will also share in some of the risk, which could lead to penalties if patient health falls below program standards. The Medicare Shared Savings Program has already realized $417 million in savings between the MSSP and the Pioneer ACO Program, a separate program for organizations with more experience in coordinated care. The full list of new ACOs is available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-ACOs-2015-Starters.pdf

Abbott Labs completes acquisition of Topera Inc

Abbott Laboratories (Abbott Park, Ill.) completed its acquisition of Topera Inc (Menlo Park, Calif.), a private, medical device company focused on developing electrophysiology technologies to improve the diagnosis and treatment of atrial fibrillation. Abbott acquired all outstanding equity of Topera for $250 million upfront, plus potential future payments tied to performance milestones.

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Bovie Medical Corporation sets new standard on ESU generator warranty

Effective January 1, 2015, Bovie Medical Corporation (Clearwater, Fla.) doubled its standard warranty on all electrosurgery generator (ESU) products from two years to four years. The four-year standard warranty is available on all Bovie brand ESUs including Aaron, Icon, and IDS. For more information on Bovie electrosurgery products, visit www.boviemed.com.

Healthcare job growth rebounds in 2014

According to the U.S. government, healthcare job growth rebounded in 2014 with near-average hiring after five years of below-average growth. The fourth quarter show an increase over Q3, with the addition of 36,000 jobs a month on average. That's compared with Q3 average monthly hires of 27,000 employees. Healthcare ended the year with 14.9 million workers, accounting for roughly 1 out of 10 U.S. jobs.

Midmark announces addition of new casework project manager to medical division

Midmark Corporation announced the addition of Ron Brazas to the medical division salesforce as project manager. He will report to Dave Cantwell, national sales manager, casework products and services, and will be responsible for continuing the growth of Midmark Clinical Solutions and the new Synthesis™ Casework Collection. Brazas will be responsible for casework products and services in North Carolina, South Carolina, Georgia, Alabama and Florida. He comes to Midmark from Carter & Sloope, Inc. where he held the position of project engineer. His extensive experience in design, project development and construction management will make him a valuable asset for Midmark and its customers. Brazas holds a Bachelor of Science degree with a specialty in environmental engineering from Mercer University in Macon, Ga., and is a state board certified professional engineer.

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100 years ago, Welch Allyn developed the first direct-illuminating ophthalmoscope and forever changed the way doctors see their patients. The spirit of innovation has remained a cornerstone of our mission throughout the years. Join us as we celebrate and look forward to the exciting things to come in 2015 and our next 100 years!

Join our 100 year celebration of Welch Allyn history and enter for your chance to win an Apple® iPad mini™ each month at **www.welchallyn.com/100Years**

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