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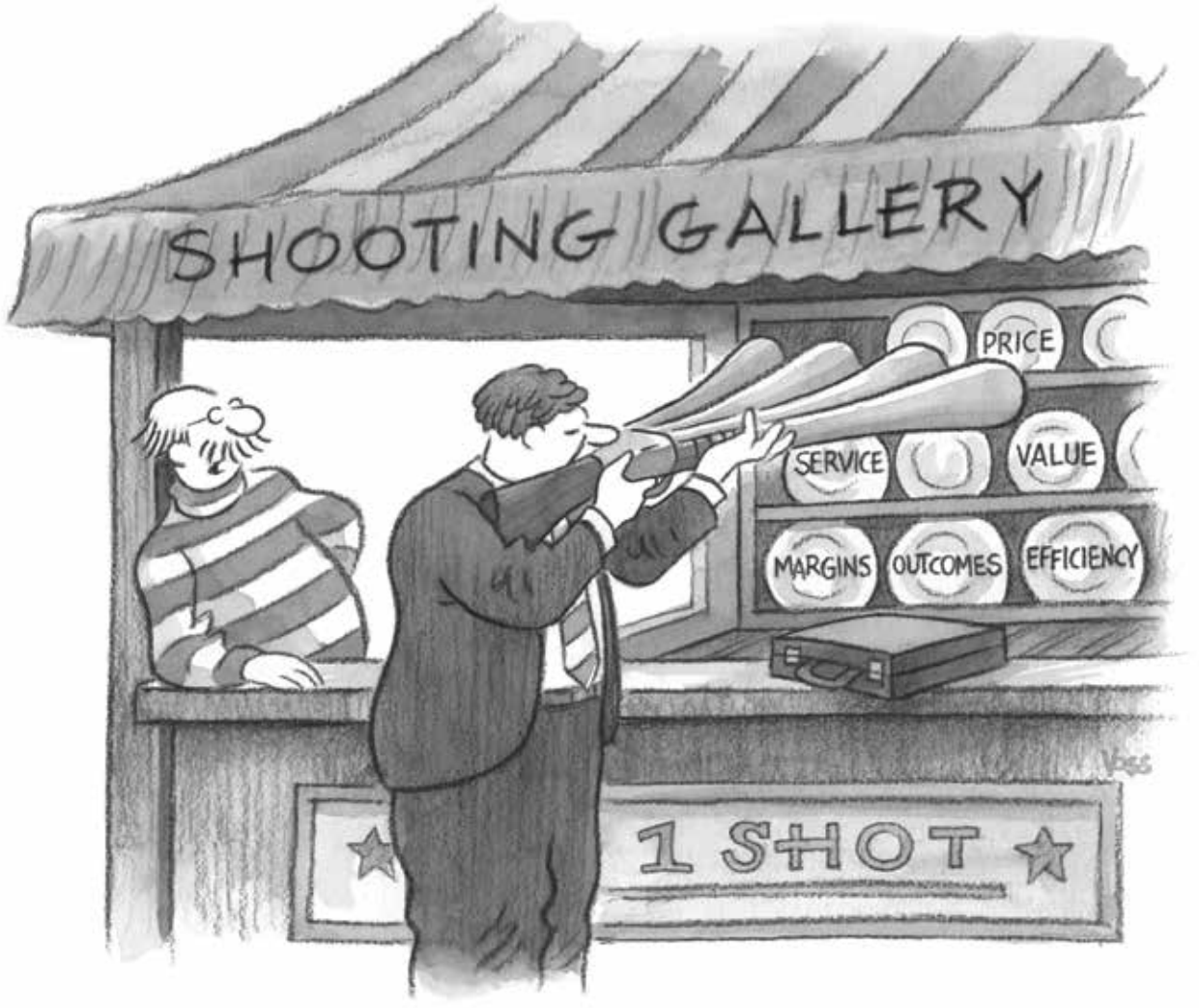

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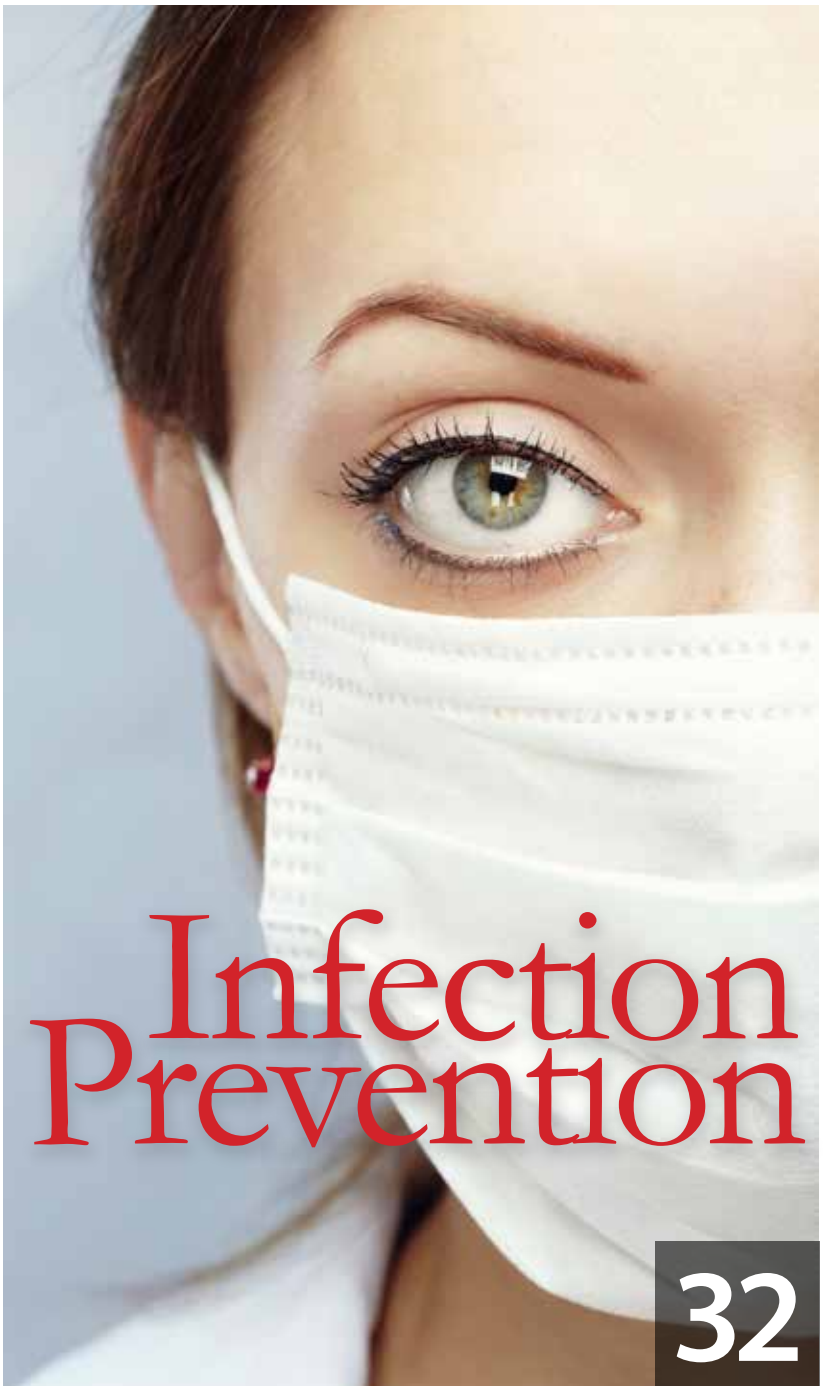

PUBLISHER'S LETTER

HIDA

DISTRIBUTOR PROFILE

DISTRIBUTION

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Tidy Up Your Territory

Scott Adams

As spring comes to an end, so does National Sales Meeting season for the industry, and the beginning of summer vacations come in to focus for you and your customers. It is a time to relax and recharge. It is also a good time to tidy up your territory.

Practices, urgent care centers, and health systems across the country will slow down a bit, providing you an opportunity to evaluate your business with them. There is no better time to talk about Infection Control, which is why we dedicated this issue to the topic.

In the busyness of our days, we often forget the importance this overall category brings to our sales. For example during my glove days, our director of marketing figured out the average practice spends 8.7 percent of their med/surg spend in the glove category. Put that into a sales plan and it equals one month of your sales for the year. Now do that with table paper, surface wipes, soaps, disinfectants, instrument cleaners, and safety products. Between each of these products you probably have a quarter or more worth of high-margin sales.

These are not exciting products – they are not a huge sale when looked at individually – but if you don't have the Infection Control business in your accounts, you're missing big dollars and allowing someone else in the door. Which means the next time that office bids out power tables, guess who you will be bidding against?

In honor of the Infection Control companies that sponsored this issue through content, my challenge to you this summer is, be jealous for this category in your accounts. Over the next few weeks, take time to ask for this business, product by product. By stopping, planning, and asking for the order, you won't be making one sale, you will be setting up an annuity in each of your accounts that pays dividends for years to come.

And a special thanks to the following companies for sponsoring Infection Prevention content this issue: Braun, Crosstex, GOJO, Henry Schein, PDI, and Georgia Pacific.

Dedicated to Distribution
R. Scott Adams

PS: *Repertoire* will be hosting Rep Summits again later this year. Please watch the Dail-e News for one in your area.

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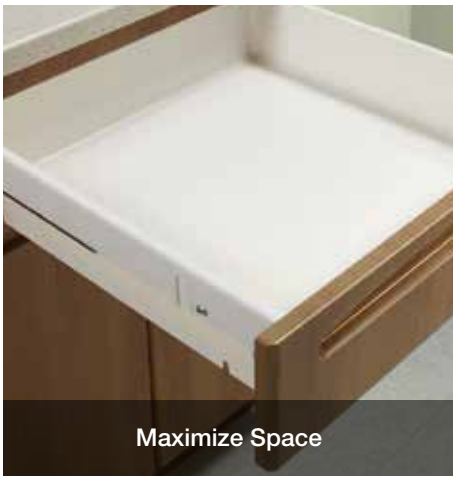
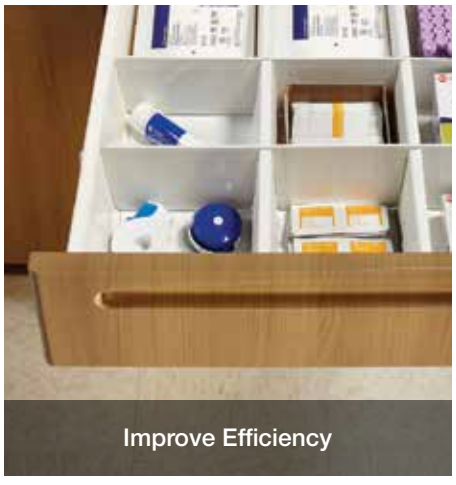


Maximize Space



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HIDA Health Reform Update

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

CMS releases payment rate proposals for hospitals, SNFs, IRFs

The Centers for Medicare & Medicaid Services (CMS) released its annual series of proposed payment regulations for hospitals, skilled nursing facilities (SNFs), and inpatient rehabilitation facilities (IRFs) in late April. Along with new rule and policy change proposals, CMS recommends overall payment increases for each market effective Oct. 1, 2015 (FY 2016), similar to its proposed changes in 2014.

These proposed policies carry immediate and long-term effects, so it's important to understand how these changes would affect your customers' operations if approved. Below are some highlights:

CMS recommends overall payment increases for hospitals, SNFs, and IRFs effective Oct. 1, 2015 (FY 2016).

Hospitals

- An average 1.1 percent annual payment increase
- Revised pneumonia measure for the Hospital Readmissions Reduction program for FY 2017
- Extraordinary circumstance exception added to the Hospital Readmissions Reduction Program in FY 2016 for hospitals that experience a disaster
- Value-Based Purchasing Program funding pool increase to 1.75 percent of total Medicare payments
- One new proposed measure for Value-Based Purchasing in 2021:
  - Hospital 30-day all-cause mortality rate for COPD
- Two measures removed for Value-Based Purchasing in FY 2018:
  - Influenza vaccination (CMS believes it is "topped" out)
  - Heart attack fibrolynic therapy received within 30 minutes (most patients receive percutaneous coronary intervention instead)
- No changes for the Infection Policy in FY 2016

SNFs

- Overall 1.4 percent increase in Medicare payments, or $500 million collectively:
  - Rural area payments would only increase by 0.8 percent, while urban area payments would increase by 1.5 percent
  - New England and Middle Atlantic facilities would receive the largest regional urban payment increases at 2.1 percent, while urban West North Central region payments would receive the lowest increase at 1.0 percent

- Three patient measures included in the SNF quality reporting program slated to begin Oct. 1, 2017:
  - Skin integrity and changes in skin integrity
  - Incidence of major falls
  - Functional status, cognitive function, and changes in function and cognitive function
- New all-cause, all-condition readmission measure added to the SNF Value-Based Purchasing Program set to begin Oct. 1, 2018; this program will link Medicare payment to performance by promoting the development and use of quality measures, such as those mentioned above

Inpatient Rehabilitation Facilities

- A 1.7 percent annual payment increase, or $130 million collectively, slightly less than the 2014 proposal
- Facility-level payment adjustment freeze that would continue for the second consecutive year
- Three quality metrics (similar to the new SNF quality metrics reported above) added to the IRF Quality Reporting Program, as well as the reporting programs for long-term care hospitals, and home health agencies.
- Requirement to publically disclose quality reporting program data beginning Oct. 1, 2016 (FY 2017)

HIDA Government Affairs has provided more detailed summaries (available at www.HIDA.org) of these proposed rules for sales reps and other supply chain professionals, and will update the summaries when the final payment regulations are released in early August.

CMS is expected to release a subsequent series of proposed payment rate proposals in the coming months for providers that are paid on a calendar year including physicians, laboratory, and home health agencies. These rules are finalized in the fall and will take effect on Jan. 1, 2016 (CY 2016).

For more information on these current and future market proposals, contact us at HIDAGovAffairs@hida.org.

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	DeWight Titus, F.D. Titus & Sons
	George Blowers, Welch Allyn
2002	Bob Barnes, Durr-Fillauer
	Karl Bays, American Hospital Supply
	Pat Kelly, PSS
	Ron Stephenson, Indiana University
2003	John McGuire Sr., Colonial Hospital Supply
	Haworth Parks, Parks Inc.
2004	Bill McKnight, McKnight Medical Communications
	George Ransdell, Ransdell Surgical
2005	Max Goodloe, General Medical
2006	Gil Minor III, Owens & Minor
2007	Elliott Werber, Bergen Brunswig Medical Corp.
2008	Lew Allyn, Welch Allyn
	Bill Allyn, Welch Allyn
2009	John Sasen, PSS
2010	John Moran, Welch Allyn
2011	Scott Fanning and Don Kitzmiller, Midmark
2012	Cindy Juhas, Hospital Associates and Ted Almon, Claflin Co.
2013	Rob Saron, Bovie Medical Corp.
2014	Bill McLaughlin, Sr. and Yates Farris, IMCO
2015	Brian Taylor MDSI

The ACO Med Way

Over the past 20 years, ACO Med Supply Inc. has built its company on a foundation of customer commitment and service excellence. The results speak for themselves.

The healthcare landscape has changed over the past 20 years, and the issues facing providers two decades ago are quite different from those today. Consequently, so are the issues facing their suppliers. But no matter how complex the healthcare scenario has become, high quality products and exceptional service continue to drive the industry. ACO Med Supply, a Charlotte, N.C.-based distributor, has held that mindset since opening its doors.

Sturdy roots

ACO Med Supply was established June 1, 1995, as an orthopaedic specialty distributor covering North Carolina, South Carolina and Virginia. In its early days, the company represented three orthopaedic soft goods manufacturers – DonJoy, Procare and Tecnol – and operated out of a 2,500-square-foot warehouse with two employees and a sales team of nine reps.

ACO Med Supply's decision early on to stay focused on the business aspect of physician care and medical practice permitted its clinical clientele to concentrate on patients, and enabled the company to expand exponentially. In 2009, the company moved into its current 52,000-square-foot warehouse, establishing itself as one of the largest distribution centers for orthopaedic products in the Southeast.

Today, it represents over 250 manufacturers, offers over 8,000 products, boasts $10 million in sales and is home to a sales, service and operation team of 70. "We have continued to add talent to our sales organization, allowing us to position our company for substantial growth," says Stuart Ross, owner. "We now have over 50 sales reps and sales associates, along with a team of field

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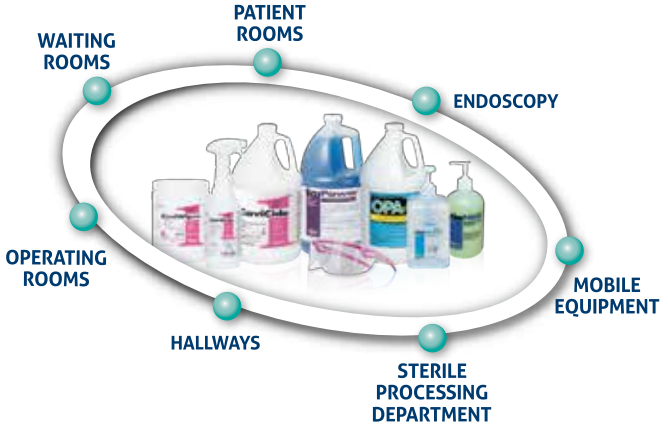

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service reps. And, our average rep tenure is now over 15 years of dedicated service.

"ACO has transformed to include a level of care, service and dedication second to none," Ross continues. "We believe we are one of only a few orthopaedic distributors that offer healthcare professionals and patients a diverse range of orthopaedic rehabilitation products addressing the complete spectrum of preventative, pre-operative, post-operative, clinical and home rehabilitation care.

"Our products are used by orthopaedic specialists, spine surgeons, primary care physicians, pain management specialists, physical therapists, podiatrists, chiropractors, athletic trainers and other healthcare professionals to treat patients with musculoskeletal conditions resulting from degenerative diseases, deformities, traumatic events and sports-related injuries," he continues. "In addition, many of our non-surgical medical devices and related accessories are used by professional athletes and patients for injury prevention and at-home physical therapy treatment. Our business model now provides a level of care directly to the patient, provider, facility and payor."

"ACO Med Supply's programs are designed to work for large offices, while others are customized for smaller satellite locations. We deal with Medicare, Medicaid, private insurance, and are accredited by Joint Commission as a DME Supplier. By offering numerous billing and purchasing solutions, we align ourselves with our customers in complete patient care."

– Stuart Ross

Smarter and better

Complex changes in healthcare over the past 20 years have taken a toll on some distributors. But, in spite of the economic, payer-related and other challenges it has encountered through the years, ACO has managed to find new, creative ways to continue to service its customers. "As the dynamics of healthcare continue to change for our customers we must be a total solution and partner that they can rely on to impact their success," says Ross. "ACO Med Supply's programs are designed to work for large offices, while others are customized for smaller satellite locations. We deal with Medicare, Medicaid, private insurance, and are accredited by Joint Commission as a DME Supplier. By offering numerous billing and purchasing solutions, we align ourselves with our customers in complete patient care."

That means staying in close touch with the customer's needs and continuing to provide "quality product and exceptional service" to meet those needs, he continues. "We have been – and continue to be – all about customer service, given our commitment to offering healthcare professionals and patients a diverse range of orthopaedic rehabilitation products," he says.

"Midlands Orthopaedics has partnered with ACO Med Supply for more than 10 years," says Ann Margaret McCraw, CEO, Midlands Orthopaedics, Columbia, S.C. "ACO has kept pace with us as our business model has evolved. Both ACO's leadership and local representatives have always strived to further our organizational goals even when they could have potentially benefited more by attempting to steer us in other directions. That unwavering support engenders a trust that rarely exists between clients and vendors."

"We still believe the best way to impact our customer is with our sales professionals face to face," says Ross. "ACO has grown to include pre-op, post-op and conservative care to provide a complete spectrum of care to the patient and provider. We have totally revamped our organizational team, which has allowed us to align with our customers' patient care services as well become more efficient in purchasing, warehousing, billing, and customer service.

"By aligning directly with our leading manufacturers and brands, we are able to run marketing and promotional campaigns to better serve our customer base and patient population." In addition, the company has worked closely with progressive business consultants who have helped build and grow the organization, including John Boyens, sales process development; Dave Zerfoss, executive coach, leadership training & Vistage; and Greg Johnson, health care branding and marketing.

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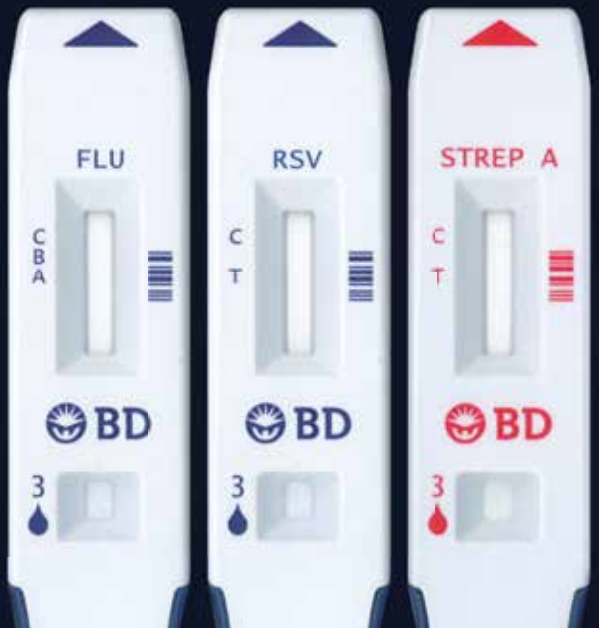

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*Respiratory Syncytial Virus.

Reference: 1. Data on File.

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Something to be proud of

Since its inception in 1995, ACO Med Supply Inc. has continued to pursue the highest level of service for its customers, and the company's efforts have paid off. Its awards include the following:

- **1995.** $3 million in sales for DonJoy / $1 million in sales for ACO Med.
- **1998.** $4 million in sales for DonJoy / $2.4 million in sales for ACO Med.
- **2000.** DonJoy Ortho "Greatest Growth Percentage."
- **2002.** Charlotte Business Journal Fast 50; NDC Exceptional Achievement award 20 percent growth or higher.
- **2004.** Pinnacle award for "Products Growth Champion-DonJoy distributor partner;" NDC Exceptional Achievement award 20 percent growth or higher; Charlotte Business Journal Fast 50
- **2005.** DonJoy distributor partner of the year; NDC Exceptional Achievement award 20 percent growth or higher; Charlotte Business Journal Fast 50.
- **2006.** DonJoy golden glove award; Charlotte Business Journal Fast 50.
- **2007.** $16 million in sales for DonJoy / $8.5 million in sales for ACO Med.
- **2008.** Distributor partner "largest total revenue growth;" Charlotte Business Journal Fast 50; NCATA gold sponsor.
- **2009.** NCATA gold sponsor; Charlotte Business Journal Fast 50.
- **2010.** DonJoy Distributor partner "Largest total revenue."
- **2012.** DJO Global MVP – South Area.
- **2013.** DJO Global Circle of Excellence; NDC Marketing Excellence; Motion 1 Platinum Record Sales award (over 1 million in sales).
- **2014:** $36.2 million in sales for DonJoy / $10.2 million in sales for ACO Med.

Enhanced orthopaedics, exceptional care

While ACO Med Supply has held true to its mission – to help orthopaedic professionals provide exceptional care – the company has grown to include a number of additional services as well. "Although the name (ACO is short for Atlantic Coast Orthopaedic) sounds like strictly an orthopaedic company, ACO Med Supply has grown to include divisions such as surgical supplies, rehab equipment, cold therapy and casting products, all while keeping the most advanced orthopaedic equipment to date," says Ross.

"Our vision is to be the largest and best post-operative provider of orthopaedic solutions and expertise in the country," he continues. To do so, they remain focused on their customers – orthopaedic surgeons, podiatrists, athletic trainers, rehabilitation specialists and more." The company strives to exceed its customers' expectations at all times, Ross adds.

Perhaps a turning point for ACO Med Supply has been its growing partnership with DJO Global Inc., one of the largest non-surgical orthopaedic rehabilitation device companies in the United States and among the largest globally. "DJO Global Inc. is a leading global provider of high-quality, orthopaedic devices, with a broad range of products used for rehabilitation, pain management and physical therapy," says Ross. "Our relationship as a DJO distributor has grown to over $36 million over the last 10 years [and enabled us] to provide complete patient care, from beginning to end.

"As a distributor for DJO Global, we have adopted the DJO Motion is Medicine business model," Ross continues: "Healing and wellness through the benefit of natural motion by prescribing motion, enables us to take control of our healthcare and choose a healthier path. Activity is the key to healthier lives, better outcomes and improved economics for all, and Motion is Medicine is a flexible, multidimensional approach to help patients, physicians and payers take steps to combat the individual and collective costs of pain, inactivity, disability and declining wellness caused by knee osteoarthritis, plantar fasciitis, rotator cuff injury, spine injury and more."

"ACO Med Supply is an award-winning distributor of medical supplies," says Ross. "We proudly service medical communities in North Carolina, South Carolina, Georgia, Tennessee and Virginia, and we continue to grow. Along with our Charlotte-area location, we are also affiliated with Miotech Sports Medicine, a Michigan-based DJO distributor. The past 20 years have provided ACO with the drive and the industry specifics to provide its customers with exceptional, face-to-face service. Ross and the ACO team look forward to many more years of providing dedicated service and creating value for their customers.

NDC

EXHIBITION

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NDC Exhibition and the 'Power of Partnership'

NuEdge Alliance LLC – new GPO for independents – launched


Mark Seitz


Distribution Sharks

Ted Almon

Larry Winget

The NDC Exhibition 2015: Power of Partnership delivered thought-provoking and collaborative insights for NDC's supply chain partners in attendance, reports the company. Returning to the Music City Center in Nashville, Tenn., March 29 – 31, this year's meeting engaged over 800 attendees and captured the purpose of this annual event – to foster strong, strategic partnerships and build on mutual successes.

A key addition to this year's program was the expansion of peer-to-peer forums for owners and executives. The meeting's enhanced format provided collaborative opportunities for distributor attendees to share ideas, experiences and insights to innovate their businesses. NDC member distributors moderated the Peer-to-Peer Roundtables, providing personal experiences encompassing a variety of market segments and topics including compensation, best practices and other successful strategies.

Mike Rockwell, vice president of Rockwell Medical Supply, Inc., commented, "I truly believe that the peer-to-peer sessions are the best way to help each other gain the knowledge, proper tools and strategies needed to succeed in this time of drastic change in our industry." These forums drove home the fact that NDC distributors are vigilant about continuing to learn from one another to improve strategies and processes to ensure continued success.

Ted Almon, president and CEO of The Claflin Company and NDC chairman

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of the board, commenced the opening session on Monday morning, offering opportunities for independent distributors in the post-reform era. Following Almon's presentation, keynote sponsor, the Midmark Corporation, celebrating its 100-year anniversary, introduced Larry Winget, the "pit bull of personal development." Winget delivered the keynote address, reminding attendees that the key to business lies in personal accountability and hard work – concepts that have become overlooked in today's over-complicated society.

GPO & Contracting Summit

Connecting distributor members with competitive pricing through the utilization of contracts, both local and GPO, is a large focus for NDC in 2015. To support this initiative, a significant portion of this year's program was dedicated to a "GPO & Contracting Summit," which provided attendees numerous opportunities and sessions to rediscover how to work with NDC to traverse the contracts and rebates process.

Hypnotist

NDC also welcomed several GPO partners and their affiliates, including Amerinet, MedAssets/MediGroup, Novation/Provista and Premier/CHAMPS, to present about the impact GPOs are making in the alternate and long-term-care/post-acute-care markets. Distributors learned about the services available through GPO affiliate programs to help navigate the complicated, but essential, pricing and paperwork process. Following these group presentations, distributors seized the opportunity to meet one-on-one with GPO/affiliate representatives to build new relationships and solidify existing partnerships.

NuEdge Alliance

Another major focus of the meeting was the launch of NuEdge Alliance, LLC, a new group purchasing organization dedicated to supporting all independent distributors regardless of affiliation. This endeavor focuses on delivering efficiency to healthcare providers through cost containment and exceptional service. By partnering with Novation and Provista, and aggregating the purchasing power of all independents, NuEdge will offer distributors, manufacturers and provider customers meaningful contracts applicable to non-acute care markets. NuEdge will provide best-in-class pricing and solutions, including no administrative fees on non-contract sales, and free membership to end-user customers as part of a simple on-boarding process. The new website and member portals will launch this summer.

"We are simply providing another tool that will enhance the competitive position of independent distributors," says Dave Rose, NDC vice president, business development. "It's about raising the bar and working together to find easier ways for independents to engage in GPO contracting. More important, NDC is focused on working with all GPO partners to develop creative solutions that make solid sense for all stakeholders. For example, we have also partnered with MedAssets in a unique way to offer NDC members access to Hoolos™, a new contract search and cross-referencing tool. At the end of the day, it really is about being proactive and innovative."

Award-winners

The GPO & Contracting Summit concluded as attendees gathered at the Awards Lunch to celebrate the accomplishments and partnerships at work between the distributors and manufacturers. Success stories from manufacturers such as Nestlé Health Sciences, Arkray and GOJO were shared among colleagues, reiterating the notion that independents remain a powerful force in the healthcare industry.

"In 2014, NDC distributors realized 28.6 percent growth across multiple markets in an industry that grew 2.6 percent overall," said Mike Carver, GOJO Industries. Success stories such as these energized attendees, confirming that opportunity still lies ahead for independent distribution.

NDC's Member of the Year Award, recognizing a member distributor demonstrating a strong commitment to NDC and its vendor partners, was awarded to Shared Service Systems, Omaha, Neb. Shared Service has been in business since 1969, joining the NDC family in 1994., "Shared Service Systems is a class act," says Colleen Stern, NDC vice president, medical sales. "They are exceptional

Award-winners

NDC Member of the Year: Shared Service Systems

NDC Vendor of the Year: PDI

Distributor Representative of the Year:
Roger Mezhibovsky, Med-Plus, Inc

Manufacturer Representative of the Year:
Cheryl Griffin, Nestlé Health Science

business partners for NDC and our manufacturers, and it is a pleasure to work with their team."

NDC's Vendor of the Year was awarded to PDI, a valued manufacturer partner to NDC for over 20 years and Premier Vendor since 2012. PDI has experienced phenomenal growth year after year and showcases a strong commitment to supporting NDC's distributor partners.

The Premier Vendor Exchange allowed NDC's Premier Vendor partners to host pre-scheduled meetings with distributor management teams. This setting was the perfect opportunity for participants to power up and take their strategic partnerships with healthcare's leading manufacturers to the next level.

Duncan McKinnon of Smith & Nephew was especially pleased with his teammates' response to the event. David Barozzino, director of sales, commented that the Premier Vendor Exchange was "outstanding and the highlight of the exhibition," while Shawn Bowman, national sales director, lauded the event as being "extremely productive and definitely time well spent."

Sales talk

HIDA President and CEO Matt Rowan opened the Sales Session, "Taking a Bite out of Triple Aim," with an overview of healthcare today and what to expect moving forward. Following his presentation, this interactive session took a page from the TV show, Shark Tank, and invited three distributor "sharks" to meet face-to face with leading manufacturers in the infection prevention and laboratory diagnostic categories. Presenters pitched their programs and provided attendees with critical information to lead meaningful discussions with customers concerning the core categories of the Triple Aim of Healthcare – population health, patient experience and per capita cost sales.

On Monday evening, colleagues gathered at the "Fun with Friends" networking event to relax and unwind after a day of education. Networking sponsor, BD Diagnostics, introduced comedic hypnotist, Michael Blaine, who took the stage along with audience volunteers representing the industry for a live demonstration of the power of suggestion. The results were hilarious and mesmerizing for spectators as well as participants, with all in attendance buzzing about the event well into the following day.

Tuesday's tradeshow showcased over 135 manufacturer companies introducing new products, services and solutions. Show specials, prizes and giveaways kept the show floor lively and distributor attendees charged up throughout the afternoon. The exhibition came to a close with the grand finale at the Wildhorse Saloon, in NDC tradition. Entertainment sponsors, Innovative Healthcare Corporation (IHC) and Roche Diagnostics, introduced Clare Dunn, independent recording artist, who entertained attendees with farm-girl roots and rock classics for an eclectic closing performance.

As the pressure for growth and development continues to build, NDC and their supply chain partners embrace opportunities to ensure a vibrant and sustainable future for independent distribution. The collaborative approach requires a genuine commitment from distributors, manufacturers and GPOs to work together, building the infrastructure for pragmatic leadership and managing change to achieve positive outcomes in healthcare. NDC's 2015 Exhibition was a testament to the collective impact determined individuals working together can make through the "Power of Partnership." rep

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A New Beginning

The decision to separate its group purchasing program from WNC Health Network, and start anew under the name Capstone, has led to continued success and cost savings for the purchasing coalition.

Tim Bugg

It's one thing to talk about minimizing contracting expenses. It's quite another to make it happen. And, sometimes that means a fresh start. When Capstone Health Alliance was founded in 2013, it had the advantage of being the product of a rich, successful history, and its executive leaders were well acquainted with the benefits of aggregation and collaboration. An offshoot of WNC Health Network, an Asheville, N.C.-based purchasing group that has been around since 2000, Capstone was started in October of 2013, when plans were formalized to separate the organization's group purchasing program from other WNCHN operating divisions.

Repertoire recently spoke with Capstone CEO and President Tim Bugg (formerly senior vice president of WNCHN) about the decision to form Capstone, and its mission and direction since breaking away from WNC Health Network.

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Repertoire: **Please tell me about the decision to form Capstone.**

Tim Bugg: Based on a variety of factors, including (but not limited to) the growth of the membership in the group purchasing program, in October of 2013, the WNC Health Network finalized plans to separate its group purchasing program from the other WNCHN operating divisions and launched Capstone Health Alliance. Capstone Health Alliance was structured to have both the flexibility and a dedicated board of directors' support to take the group purchasing initiatives to the next level. I, along with Mark Landau, Capstone senior vice president, recognized the benefits of aggregation and collaboration for a group of Western North Carolina hospitals and were responsible for the founding of the program. Throughout my career at Capstone, I have worked closely with hospital executives, supply chain leaders, national group purchasing organizations and various trade associations to remain closely tuned to the changing needs of not-for-profit hospitals. Based on these needs, I have led the efforts to modify and expand Capstone's membership reach and breadth of services to provide all Capstone members with top level service, contract opportunities, and cost savings.

What may seem surprising in light of our continued growth is the fact that Capstone does not have any team member dedicated to membership and business development, and has grown primarily through word of mouth and member referrals.

Repertoire: **Since its start a year and a half ago, how has Capstone grown?**

Bugg: The Capstone Health Alliance acute care membership is currently comprised of 52 systems and 125 facilities spanning 12 states, with purchasing volume exceeding $4 billion. Capstone also has membership in the continuum of care market representing all classes of trade outside of traditional acute hospitals, and spans from health departments to home health, and everything in between. From [WNC Health Network's] modest beginnings of 16 Western North Carolina hospitals, [the purchasing coalition] grew steadily over the next nine years as the group expanded across North Carolina and South Carolina, and into Virginia. Capstone has been fortunate with several significant membership boosts and an expanded geographic footprint. Not only individual systems, but other regional groups, such as Synergy Health Group (Tennessee), Vantage Health Group (Pennsylvania), CHAMPS Group Purchasing (Ohio) and, most recently, Colonial Health Alliance (Maryland), have joined Capstone to bring immediate cost-savings and on-going benefits to their members. What may seem surprising in light of our continued growth is the fact that Capstone does not have any team member dedicated to membership and business development, and has grown primarily through word of mouth and member referrals.

Capstone works closely with Premier, its primary GPO partner, to present membership benefits covering not only cost savings, but also best practices and utilization initiatives. While there are no geographic or size limitations for membership, Capstone welcomes members who are supportive of its mission and vision for the alliance, and who are willing to contribute feedback and ideas, [with the] understanding that collaboration goes hand in hand with aggregation for the continued success of the group. In that vein, members have continued to benefit not only from the cost savings of the Capstone agreements, but from the peer networking and collaboration that occurs during frequent membership meetings. Members have expressed that the networking and the additional support provided by Capstone team members are as beneficial as the cost savings.

Repertoire: **What are the top initiatives Capstone has pursued in the last 12 months?**

Bugg: During the past year, Capstone has continued to focus on our core strengths of aggregation and collaboration to produce cost savings. By refining internal contracting processes, Capstone has been able to expand the number of aggregation agreements available to members by greater than 20 percent, effectively covering more contract categories as well as off-contract spend. In a separate effort, Capstone has developed relationships with several service and benefits providers and launched a new line of cost-savings options branded as the Powered By service lines. The Powered By relationships offer cost-savings options through non-traditional areas of aggregation, such as employee benefits, cyber liability insurance and medical malpractice. In its most notable effort, Capstone has continued to expand its resource management program that was developed two years ago, with a focus on PPI categories. As the resource management program has evolved, over $20 million in savings have been identified across a small number of categories. Capstone's resource management program is currently focused on two shared initiatives with Premier to implement cost savings, one which uses highly refined benchmarking information and the other which uses benchmarking data combined with a process to drive clinical support.

Capstone was founded on contracting through aggregation and scale, and this process will continue to be our core competency; however, to achieve meaningful collective impact, Capstone must use its power of aggregation and collaboration to work with hospital leadership to reduce cost in other non-traditional areas of the hospitals. Purchased services contracting has been a buzz word for many years in the industry, and many facilities have done a great job in minimizing these expenses, but Capstone believes there are deeper savings that can be realized and will be implementing member-led strategies in this area in 2015.

Repertoire: **What strategies do you expect to implement this year to help members become stronger?**

Bugg: Capstone has one primary goal: to reduce the overall expenses of the membership we serve. To meet this goal, we utilize collaboration and aggregation. The question then becomes, how will Capstone use this very simple strategy to impact expenses for our members in

all areas – from bedpans to benefits? In 2015, Capstone will continue to expand its 500+ contract portfolio in the areas of physician preference, purchased services and Powered By's. We anticipate that Capstone members will continue to benefit from the relationships that have been established with suppliers over the years, supplemented by the membership's growing volumes. Many of these suppliers have worked with Capstone since day one and have enjoyed the benefits of expanded exposure through [the organization].

In addition to our focus on negotiating meaningful agreements, Capstone will continue to expand on its current process of providing financial analysis to members to allow them to make data-driven decisions. Hospitals have stated clearly that they need accurate and timely data in order to make purchasing decisions, and not all hospitals have the systems or the staff to produce the analysis. Capstone also works with supplier partners to provide members with the clinical documentation that must support these decisions. Last but not least, our member communication and networking are keys to the success of any strategy we implement. Collective impact really comes from the collective party working together to achieve success. The belief and participation of our membership is what allows Capstone to be successful in moving the needle in the reduction of healthcare expense.

Capstone by definition is a GPO within a GPO, and it strives to provide as many opportunities for its members as possible. As I always say, Capstone cooks a lot of meals, and it's up to the members what they choose to eat.

Repertoire: **Please explain the process whereby your supply chain executives meet to make their decisions.**

Bugg: While many companies claim to be customer- or member-driven, all of Capstone's contracting processes are built around member involvement. Capstone's base contracting strategy relies on a rotating 14-member council with members who are representative of all system sizes and locations. The council meets monthly to evaluate new contract opportunities and provide feedback to the Capstone contracting team. In most cases, the entire membership is supportive of the recommendations from the council; however, there are provisions to modify the recommendations based on feedback from the entire membership. Capstone also conducts monthly membership meetings to review new agreements and to allow suppliers to present. Most members have one primary point of contact, who works with Capstone, but it is not uncommon for a member to have multiple staff members participating in Capstone initiatives.

Outside of the traditional supply chain departments, Capstone prides itself on having workgroups of professionals from pharmacy, laboratory, surgical services, value analysis, as well as in the development of a purchased services steering committee that will have the ability to flex into other departments, such as facilities, human resources, medical records, etc. Capstone by definition is a GPO within a GPO, and it strives to provide as many opportunities for its members as possible. As I always say, Capstone cooks a lot of meals, and it's up to the members what they choose to eat.

Repertoire: **Please describe Capstone's relationship with its GPO, Premier.**

Bugg: Capstone's strategic plan calls for alignment with one GPO, and Premier has been our GPO partner of choice since the beginning in 2000. Today, Capstone is an owner of Premier and believes Premier's vision and direction is the best to achieve results in this changing healthcare environment. There are times when we need to pick a winner, and for Capstone, Premier is that winner. We work very closely with Premier to offer members a full range of options covering not only contracting and aggregation, but benchmarking and utilization initiatives as well. We share a common

goal with Premier to work together to provide accurate and consistent information and cost reduction opportunities to our members, and to avoid duplication or conflicting information. This may sound like an overly simple goal. However, when considering the volume of information shared between Premier [and Capstone], or Capstone and its members, it is significant. Capstone always looks to the Premier contracted suppliers first when sourcing categories. But if the membership's needs cannot be met by the contracted suppliers, then Capstone will write local agreements. We are transparent with Premier and all suppliers in stating that we go where the needs of the membership take us.

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

Bugg: Four years ago, Capstone put its first region manager in the field. The [region manager's] primary purpose was to work inside our member locations – not just to promote Capstone agreements, but also to understand the unique needs of that member and help the member achieve results. The initial response from members was so positive that each Capstone member today has an assigned region manager who works with its facility. Region managers are also available to conduct financial analysis and to deliver savings summaries. The region manager serves as the primary point of contact for any needs the member may have on any Capstone initiative.

Repertoire: **Is it difficult to get buy-in to the organization's contracts from each of your facility's physicians and staff?**

Bugg: Let's understand the environment we are currently in. The paradigm has changed dramatically in healthcare. It's a new day. Capstone and its members understand this new era of reimbursement, and we must change our strategies to meet this challenge. Capstone is seeing changes in the clinical operations of the members we serve. Clinicians and physicians seem to be more open to evaluations, but every member continues to have its own process for gaining physician buy-in and evaluating clinical preference items. Our success comes from

The paradigm has changed dramatically in healthcare. It's a new day. Capstone and its members understand this new era of reimbursement, and we must change our strategies to meet this challenge. Capstone is seeing changes in the clinical operations of the members we serve. Clinicians and physicians seem to be more open to evaluations, but every member continues to have its own process for gaining physician buy-in and evaluating clinical preference items.

gathering as much input as possible from supply chain members prior to entering contract negotiations, and from being completely open and honest with suppliers about the opportunities before them. We will vet a supplier's products and service prior to promoting an agreement, but we make it clear to the supplier that it is up to them to sell it clinically. Capstone's end goal is to have our power of collaboration and aggregation work as well in the preference market as it does in the commodity market.

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

Bugg: Members have told us that Capstone serves as an excellent resource to their supply chain team, whether it be for completing financial analyses, implementing price activations, resolving price discrepancies, or escalating service issues. It is our goal to provide service to our members related to every aspect of a Capstone agreement, and really be an extension of their supply chain team. We rely on the knowledge and experience of our contracting staff to anticipate needs related to the agreements and work with suppliers to ensure our members are getting exceptional service. Our members also value the networking opportunities and time to share successes and challenges in a non-competitive environment.

Repertoire: **How do you envision Capstone in the next five years or so?**

Bugg: I would start with the understanding that [no one] can crystal ball the future and determine what healthcare as a whole will be like in five years. I have had many conversations with healthcare executives over the past year, and have found that forecasting and strategizing for more than three years is extremely difficult. In fact, I have found many executives have evolved from a three-year strategic plan to a single-year operational plan. With the understanding of the uncertainty of healthcare, I will commit that Capstone will continue to evolve with its membership to not only be relevant, but also a necessary partner in reduction of not just supply chain but all operational expenses. Capstone believes data-driven decision-making, outcomes-based purchasing, operational efficiency and utilization, best practice, and results-based accountability are a few key factors in healthcare's future. Capstone commits to be a leader in these areas to provide the necessary support and value to membership, which we serve. I believe healthcare is in for quite a ride over the next five years, and Capstone is ready and prepared to take the trip alongside our members. rep

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Infection Prevention

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Infections cause human suffering. They cost the healthcare system millions of dollars. And, in many cases, they are avoidable. This month, *Repertoire* reports on two infection-prevention-related issues that also have caught the public's eye: the reprocessing of medical devices and the rise of antibiotic resistance.

Too Much of a Good Thing?

Why relying heavily on antibiotics has contributed to the emergence of drug resistance in bacteria, and how healthcare stakeholders can respond

Since penicillin was discovered in 1928, antibiotics have been a "critical public health tool," according to the Obama Administration's recently published "National Action Plan for Combating Antibiotic-resistant Bacteria." But the emergence of drug resistance in bacteria is reversing their beneficial effects. The Centers for Disease Control and Prevention (CDC) estimates that drug-resistant bacteria cause 2 million illnesses and approximately 23,000 deaths each year in the United States alone.

That's the bad news. The worst news is, it's not the antibiotics themselves that are to blame. It's the people who prescribe them, and the people – i.e., patients – who want them.

"There is little doubt that antibiotics are overused in healthcare," says David Fleming, MD, MA, FACP, professor of medicine and chairman, Department of Medicine, University of Missouri School of Medicine, and immediate past president of the American College of Physicians.

"The typical situation is that patients often arrive in the physician's office asking for antibiotics for a 'cold' when, in actuality, many more times than not, they have allergic rhinitis or a viral syndrome in which antibiotics are not indicated. We use entirely too many antibiotics for conditions that do not need them, and this contributes to the increasing antibiotic resistance we are experiencing."

The solution is simple – and difficult. First, physicians should always practice evidence-based medicine, says Fleming. Second, they should take into consideration the patient's medical and personal needs and preferences before prescribing antibiotics. And third, "good and effective communication between patients and physicians is always the key to securing good outcomes."

Antibiotic resistance threats

The National Action Plan follows by two years a report from the Centers for Disease Control and Prevention titled "Antibiotic resistance threats in the United States, 2013."

In that document, CDC reported that each year in the United States, at least 2 million people acquire serious infections with bacteria that are resistant to one or more of the antibiotics designed to treat those infections, and that at least 23,000 people die each year as a direct result of these antibiotic-resistant infections. Many more die from other conditions that were complicated by an antibiotic-resistant infection.

In addition, the agency reported that almost 250,000 people each year require hospital care for *Clostridium difficile (C. difficile)* infections. In most of these infections, the use of antibiotics was a major contributing factor leading to the illness. At least 14,000 people die each year in the United States from *C. difficile* infections, according to the CDC. Many of these infections could have been prevented.

Problem is well-recognized

"It is very well recognized that incorrect prescribing offers little benefit and increases risk factors of exposing patients to incorrect and/or unnecessary antibiotics, resulting in numerous complications, including the development of antibiotic resistant infections and *Clostridium difficile* (CDI)," says Vicki G. Allen, MSN, RN, CIC, infection prevention coordinator Beaufort (S.C.) Memorial Hospital and vice chair of the communications committee of the Association for Professionals in Infection Control and Epidemiology, or APIC. "These complications can result in increased length of stay and readmissions, exposure to numerous other antibiotics to treat the resistant infections, and/or CDI. CDI often recurs and can progress to sepsis and death.

"There is also the consideration of general adverse events related to antibiotic use. Again, if the patient has

been incorrectly prescribed an antibiotic, or is taking one unnecessarily, it opens the risk to these types of events. Some hospitalized patients now have infections for which there are no antibiotics available to treat.

Gina Pugliese, RN, MS, FSHEA, vice president of Premier Inc's Premier Safety Institute, says, "There is overwhelming agreement by all of the stakeholders – world health leaders, governments, professional and healthcare-related organizations, the public health community, providers, industry, and researchers – that antimicrobial resistance is a global concern, with an urgent call for improving the use of existing antibiotics as a crucial step."

"Multiple reports have been issued describing the new forms of antibiotic resistance and the ease with which it is able to travel at incredible speed and cross international boundaries…." In fact, says Pugliese, world health leaders have described antibiotic- resistant microorganisms as "nightmare bacteria" that "pose a catastrophic threat" to people in every country in the world. "With a quick look at the statistics here in the United States, it would be very difficult for anyone to not recognize this as a major public health issue," she adds.

> "We use entirely too many antibiotics for conditions that do not need them, and this contributes to the increasing antibiotic resistance we are experiencing."
>
> **– David Fleming, MD, MA, FACP**

The use of antibiotics is the single most important factor leading to antibiotic resistance around the world, says Pugliese. Ironically, up to 50 percent of all the antibiotics prescribed for people are not needed or are not optimally effective as prescribed, she adds.

Antibiotics are also commonly used in food animals to prevent, control, and treat disease, and to promote the growth of food-producing animals, she points out. "The use of antibiotics for promoting growth is not necessary, and the practice should be phased out. Recent guidance from the U.S. Food and Drug Administration describes a pathway toward this goal. It is difficult to directly compare the amount of drugs used in food animals with the amount used in humans, but there is evidence that more antibiotics are used in food production."

The cost of antibiotic resistance

Human suffering aside, antibiotic resistance costs the U.S. healthcare system a lot of money, according to experts.

Says Pugliese, "In most cases, antibiotic-resistant infections require prolonged and/or costlier treatments, extend hospital stays, necessitate additional doctor visits and healthcare use, and result in greater disability and death compared with infections that are easily treatable with antibiotics." Estimates of the cost of antibiotic resistance in the United States vary, but have ranged as high as $20 billion in excess direct healthcare costs, with additional costs to society for lost productivity as high as $35 billion a year (2008 dollars), she adds.

In September 2014, the CDC and Premier Inc. released research on the widespread use of unnecessary and duplicative antibiotics in U.S. hospitals, and concluded it could lead to an estimated $163 million in excess costs. The study was published in the October 2014 issue of Infection Control and Hospital Epidemiology, the journal of the Society for Healthcare Epidemiology of America.

Researchers conducted a retrospective analysis of inpatient pharmacy data from more than 500 U.S. hospitals from 2008 to 2011 to identify the potential inappropriate usage of 23 intravenous antimicrobial combinations. Their analysis showed that 78 percent of hospitals administered potentially unnecessary combinations of antibiotics for two or more days, with a total of 32,507 cases of redundant antibiotics treatment.

Overall, these cases represented 148,589 days of potentially inappropriate antibiotic therapy, resulting in nearly $13 million in potentially avoidable healthcare costs from antimicrobial drugs, alone. If these cases were representative of all U.S. hospitals over the same time period, an estimated $163 million could have been saved through appropriate prescribing. These costs do not include other operational factors, such as the associated supply and labor costs, or patient safety complications.

In addition to antimicrobial resistance and excess costs, unnecessary intravenous combinations can increase the risk of adverse drug events, noted the researchers. Each drug has a risk of side effects, and combinations increase those risks as well as the risks for drug-drug interactions.

National Action Plan

The issue of antibiotic resistance isn't new. But the recently released National Action Plan by the White House has brought it front and center.

The plan outlines steps for implementing a national strategy for combating antibiotic-resistant bacteria, and addresses the policy recommendations of the President's Council of Advisors on Science and Technology. Although its primary purpose is to guide activities by the U.S. government, the plan is also designed to guide action by public health, healthcare, and veterinary partners. Implementation of the National Action Plan will also support a World Health Assembly resolution urging countries to take action at the national, regional, and local levels, according to the White House.

The guts of the plan rest with its five goals.

Goal 1: Slow the emergence of resistant bacteria and prevent the spread of resistant infections. Activities include the optimal use of vaccines to prevent infections, implementation of healthcare policies and antibiotic stewardship programs that improve patient outcomes, and efforts to minimize the development of resistance by ensuring that each patient receives *the right antibiotic at the right time at the right dose for the right duration*. Prevention of resistance also requires rapid detection and control of outbreaks and regional efforts to control transmission across community and healthcare settings.

> "Some hospitalized patients now have infections for which there are no antibiotics available to treat."
>
> **– Vicki Allen, MSN, RN, CIC**

Goal 2: Strengthen national One-Health surveillance efforts. Improved detection and control of drug-resistant organisms will be achieved through an integrated "One-Health" approach, which integrates data from surveillance systems that monitor human pathogens with data from surveillance systems that monitor animal pathogens. Goal 2 activities will also enhance monitoring of antibiotic sales, usage, resistance, and management practices at multiple points along the food-production chain, from farms to processing plants to supermarkets.

Goal 3: Advance development and use of rapid and innovative diagnostic tests for identification and characterization of resistant bacteria. Improved diagnostics will help healthcare providers make optimal treatment decisions and assist public health officials in taking action to prevent and control disease, according to the plan.

Goal 4: Accelerate basic and applied research and development for new antibiotics, other therapeutics and vaccines.

Goal 5: Improve international collaboration and capacities for antibiotic-resistance prevention, surveillance, control and antibiotic research and development. Antibiotic resistance is a worldwide problem that cannot be addressed by one nation in isolation, according to the plan's authors.

By 2020, the Obama Administration hopes that implementation of the National Action Plan will lead to "major reductions in the incidence of urgent and serious threats, including carbapenem-resistant *Enterobacteriaceae* (CRE), methicillin- resistant *Staphylococcus aureus* (MRSA), and *Clostridium difficile*. The Administration hopes that the plan will also result in improved antibiotic stewardship in healthcare settings, prevention of the spread of drug-resistant threats, elimination of the use of medically important antibiotics for growth promotion in food animals, and expanded surveillance for drug-resistant bacteria in humans and animals.

Other significant outcomes could include creation of a regional public health laboratory network, establishment of a specimen repository and sequence database that can be accessed by industrial and academic researchers, development of new diagnostic tests through a national challenge, and development of two or more antibiotic drug candidates or non-traditional therapeutics for treatment of human disease. rep

Editor's note: "Antibiotic resistance threats in the United States, 2013," by the Centers for Disease Control and Prevention, can be viewed at www.cdc.gov/drugresistance/pdf/ar-threats-2013-508.pdf

The "National Action Plan for Combating Antibiotic-resistant Bacteria, March 2015," by the White House, can be viewed at www.whitehouse.gov/sites/default/files/docs/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf

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The problem... simply stated

Poor antibiotic prescribing harms patients, says the Centers for Disease Control and Prevention. Antibiotic prescribing practices vary widely and errors are common. Some facts to ponder:

About half of patients receive an antibiotic for at least one day during the course of an average hospital stay.

- The most common types of infections for which hospital clinicians write antibiotic prescriptions are lung infections (22 percent), urinary tract infections (14 percent), and suspected infections caused by drug-resistant Staphylococcus bacteria, such as MRSA (17 percent).
- About one out of three times, prescribing practices to treat urinary tract infections and prescriptions for the critical and common drug vancomycin included a potential error; either the antibiotic was prescribed without proper testing or evaluation, or it was administered for too long.
- Doctors in some hospitals prescribed up to three times as many antibiotics as doctors in similar areas of other hospitals. This difference suggests the need to improve prescribing practices.

Poor prescribing puts patients at risk, according to the CDC:

- Although antibiotics save lives (for example, in the prompt treatment of sepsis, a life-threatening infection), they can also put patients at risk for a *Clostridium difficile* infection, a deadly diarrhea that causes at least 250,000 infections and 14,000 deaths each year in hospitalized patients. Decreasing the use of antibiotics that most often lead to *C. difficile* infection by 30 percent (this is 5 percent of overall antibiotic use) could lead to 26 percent fewer of these deadly diarrheal infections.
- Patients getting powerful antibiotics that treat a broad range of infections are up to three times more likely to get another infection from an even more resistant germ.

Source: Centers for Disease Control and Prevention, www.cdc.gov/vitalsigns/antibiotic-prescribing-practices/index.html

Definition of terms

"Antibiotic resistance" results from mutations or ac-quisition of new genes in bacteria that reduce or eliminate the effectiveness of antibiotics. "Antimicrobial resistance" is a broader term that encompasses resistance to drugs to treat infections caused by many different types of pathogens, including bacteria, viruses (e.g., influenza and the human immunodeficiency virus, parasites (e.g., the parasitic protozoan that causes malaria), and fungi (e.g., Candida spp.). While all of these pathogens are dangerous to human health, the Obama Administration's National Action Plan for Combating Antibiotic-resistant Bacteria focuses on resistance in bacteria that present an urgent or serious threat to public health.

Source: National Action Plan for Combating Antibiotic-resistant Bacteria, www.whitehouse.gov/sites/default/files/docs/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf

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Targeting antibiotic-resistant bacteria

The Obama Administration has set the following targets for 2020:

For CDC-recognized urgent threats:

- Reduce by 50 percent the incidence of overall *Clostridium difficile* infection compared to estimates from 2011.
- Reduce by 60 percent carbapenem-resistant Enterobacteriaceae (CRE) infections acquired during hospitalization compared to estimates.
- Maintain the prevalence of ceftriaxone-resistant Neisseria gonorrhoeae below 2 percent compared to estimates from 2013.

For CDC-recognized serious threats:

- Reduce by 35 percent multidrug-resistant Pseudomonas spp. infections acquired during hospitalization compared to estimates from 2011.
- Reduce by at least 50 percent overall methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections by 2020 as compared to 2011.
- Reduce by 25 percent multidrug-resistant non-typhoidal Salmonella infections compared to estimates from 2010-2012.
- Reduce by 15 percent the number of multidrug-resistant TB infections.
- Reduce by at least 25 percent the rate of antibiotic-resistant invasive pneumococcal disease among <5-year-olds compared to estimates from 2008.
- Reduce by at least 25 percent the rate of antibiotic-resistant invasive pneumococcal disease among >65-year-olds compared to estimates from 2008.

Source: National Action Plan for Combating Antibiotic-resistant Bacteria, www.whitehouse.gov/sites/default/files/docs/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf

How serious are the threats?

The Centers for Disease Control and Prevention char-acterizes the seriousness of antibiotic resistance the following way:

Urgent threats

- *Clostridium difficile*
- Carbapenem-resistant Enterobacteriaceae (CRE)
- Drug-resistant *Neisseria gonorrhoeae*

Serious threats

- Multidrug-resistant *Acinetobacter*
- Drug-resistant *Campylobacter*
- Fluconazole-resistant *Candida* (a fungus)
- Extended spectrum β-lactamase producing Enterobacteriaceae (ESBLs)
- Vancomycin-resistant *Enterococcus* (VRE)
- Multidrug-resistant *Pseudomonas aeruginosa*
- Drug-resistant Non-typhoidal *Salmonella*
- Drug-resistant *Salmonella* Typhi
- Drug-resistant *Shigella*
- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Drug-resistant *Streptococcus pneumoniae*
- Drug-resistant tuberculosis

Concerning threats

- Vancomycin-resistant Staphylococcus aureus (VRSA)
- Erythromycin-resistant Group A Streptococcus
- Clindamycin-resistant Group B Streptococcus

Source: "Antibiotic-Resistant Threats in the United States, 2013," Centers for Disease Control and Prevention (www.cdc.gov/drugresistance/pdf/ar-threats-2013-508.pdf)

Are your customers part of a HEN?

Knowledge-sharing can help improve efforts to combat antibiotic resistance.

The Partnership for Patients initiative is a public-private partnership designed to improve the quality, safety and affordability of healthcare for all Americans. An important component of the initiative are so-called Hospital Engagement Networks. Focused primarily on making care safer and improving care transitions, HENs work at the regional, state, national or hospital system level to help identify solutions and disseminate them to other hospitals and providers. More than 3,700 hospitals participate in one of 26 HENs, according to the Centers for Medicare & Medicaid Services.

According to Centers for Medicare & Medicaid Services, Hospital Engagement Networks:

- Develop learning collaboratives for hospitals.
- Provide a wide array of initiatives and activities to improve patient safety.
- Conduct intensive training programs to help hospitals make patient care safer.
- Provide technical assistance to help hospitals achieve quality measurement goals.
- Establish and implement a system to track and monitor hospital progress in meeting quality improvement goals.
- Identify high-performing hospitals and their leaders to coach and serve as national faculty to other hospitals committed to achieving the Partnership goals.

Approximately 350 hospitals participate in Premier's QUEST quality improvement collaborative, as well as Premier's Partnership for Patients HEN, or Hospital Engagement Network, reports Gina Pugliese, RN, MS, FSHEA, vice president of Premier Inc's Premier Safety Institute. Together, they participate in performance improvement initiatives and use safety surveillance systems to drive antimicrobial stewardship techniques into patient safety practices, such as delivering early blood cultures and appropriate antibiotics to improve sepsis care, she says.

To find out if your hospital customers are part of a HEN, go to http://partnershipforpatients.cms.gov/about-the-partnership/hospital-engagement-networks/thehospitalengagementnetworks.html.

Antibiotic resistance: An outpatient problem too

Improving antibiotic usage in the acute-care setting is an important component of the battle against antibiotic resistance. But much can be done in the outpatient setting – including the physicians' office – as well. The government will soon demand that physicians step up to the plate.

"There is little doubt that antibiotics are overused in healthcare," says David Fleming, MD, MA, FACP, professor of medicine and chairman, Department of Medicine, University of Missouri School of Medicine, and immediate past president of the American College of Physicians. "The typical situation is that patients often arrive in the physician's office asking for antibiotics for a 'cold' when, in actuality, many more times than not, they have allergic rhinitis or a viral syndrome in which antibiotics are not indicated."

"Multiple studies have noted that ear, sinus, or upper respiratory tract infections are common reasons for inappropriate antibiotic use in outpatient settings," the researchers noted.

A study published in the July 22, 2013, issue of *JAMA Internal Medicine* found that 82 percent of patients who acquired Clostridium difficile – the most common cause of healthcare-associated infectious diarrhea – in the community had either a recent outpatient healthcare exposure or an inpatient healthcare exposure without an overnight say. The study was based on surveillance in eight U.S. states from 2009 through 2011.

Outpatient settings such as physicians' offices, emergency departments, and dialysis facilities can be the source of C difficile acquisition by exposure to contaminated environmental surfaces, as well as the prescription of antibiotics that disrupt the lower intestinal microbiota, wrote the researchers,

In their study, 64 percent of patients with CDI received outpatient antibiotics within 12 weeks before infection, the most common indications being ear, sinus, or upper respiratory tract infection or a dental procedure. "Multiple studies have noted that ear, sinus, or upper respiratory tract infections are common reasons for inappropriate antibiotic use in outpatient settings," the researchers noted.

Stewardship plans are ineffective

Antibiotic stewardship programs can help. But "the fact that we are having a national call to action underscores the reality that, in general, such stewardship plans are ineffective," says Fleming.

Some providers may be harboring misconceptions about such programs, he says. One such misconception is that they are designed primarily for cost-savings, "when in actuality they are designed to engender high-value care, where quality outcomes as well as cost control are equally encouraged." Another is that antibiotic resistance is primarily market-driven, "when, in reality, [it is] most often driven by patient expectations due to misperception and communication breakdown with the physician and healthcare system."

To combat antibiotic resistance, physicians should always practice evidence-based medicine, he says. They should take into consideration the patient's medical and personal needs and preferences before prescribing antibiotics. And they should strive for good and effective communication with their patients, which, he says, "is always the key to securing good outcomes."

National Action Plan

The Obama Administration's National Action Plan for Combating Antibiotic-resistant Bacteria addresses the outpatient arena and sets the following three-year goal: The Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the Agency for Healthcare Research and Quality and other organizations will issue guidance on antibiotic stewardship and best practices for ambulatory surgery centers, dialysis centers, nursing homes and other long-term care facilities, doctors' offices and other outpatient settings, pharmacies, emergency departments, and medical departments at correctional facilities.

In addition, the plan calls for CMS to expand the Physician Quality Reporting System (PQRS) to include quality measures that discourage inappropriate antibiotic use to treat non-bacterial infections.

Needed: Next- generation diagnostics

Healthcare practitioners agree that antibiotic resistance can be reduced simply by "just saying no" to patients who request antibiotics for simple viral conditions, like a cold. But healthcare providers could use some help from developers of technology, including diagnostics.

The Obama Administration's recently announced "National Action Plan for Combating Antibiotic-resistant Bacteria" calls for researchers to use new technologies – including whole genome sequencing, metagenomics, and bioinformatic approaches – to develop point-of-need diagnostic tests to distinguish rapidly between bacterial and viral infections and identify bacterial drug susceptibilities.

Waltham, Mass.-based diagnostic manufacturer Alere is onboard.

'A critical tool'

"The National Action Plan contains a number of goals and objectives that, when achieved, will help to slow the spread of antibiotic-resistant bacteria," says Seth Radus, vice president, government affairs, Alere. "Incentives for expanded availability of existing rapid point-of-care tests and for the development of new tests will be instrumental in achieving this goal.

"Rapid point-of-care tests are a critical tool that healthcare providers can use in combating antibiotic-resistant bacteria," he continues. "They provide essential information to the provider about whether their patient has a virus or a bacterial infection. This knowledge, in conjunction with signs and symptoms, inform the healthcare provider about whether an antibiotic prescription is appropriate and, if so, which antibiotic to prescribe."

Alere already has next-generation tools on the market to help providers make sound diagnostic and treatment decisions, according to Radus.

"The Alere i platform allows the physician to generate a 15-minute molecular flu result and an eight-minute Strep A result," he says. "The Alere i platform is CLIA-waived for flu, so the test can be performed near the patient and a result generated and shared with the patient prior to the patient leaving the physician office.

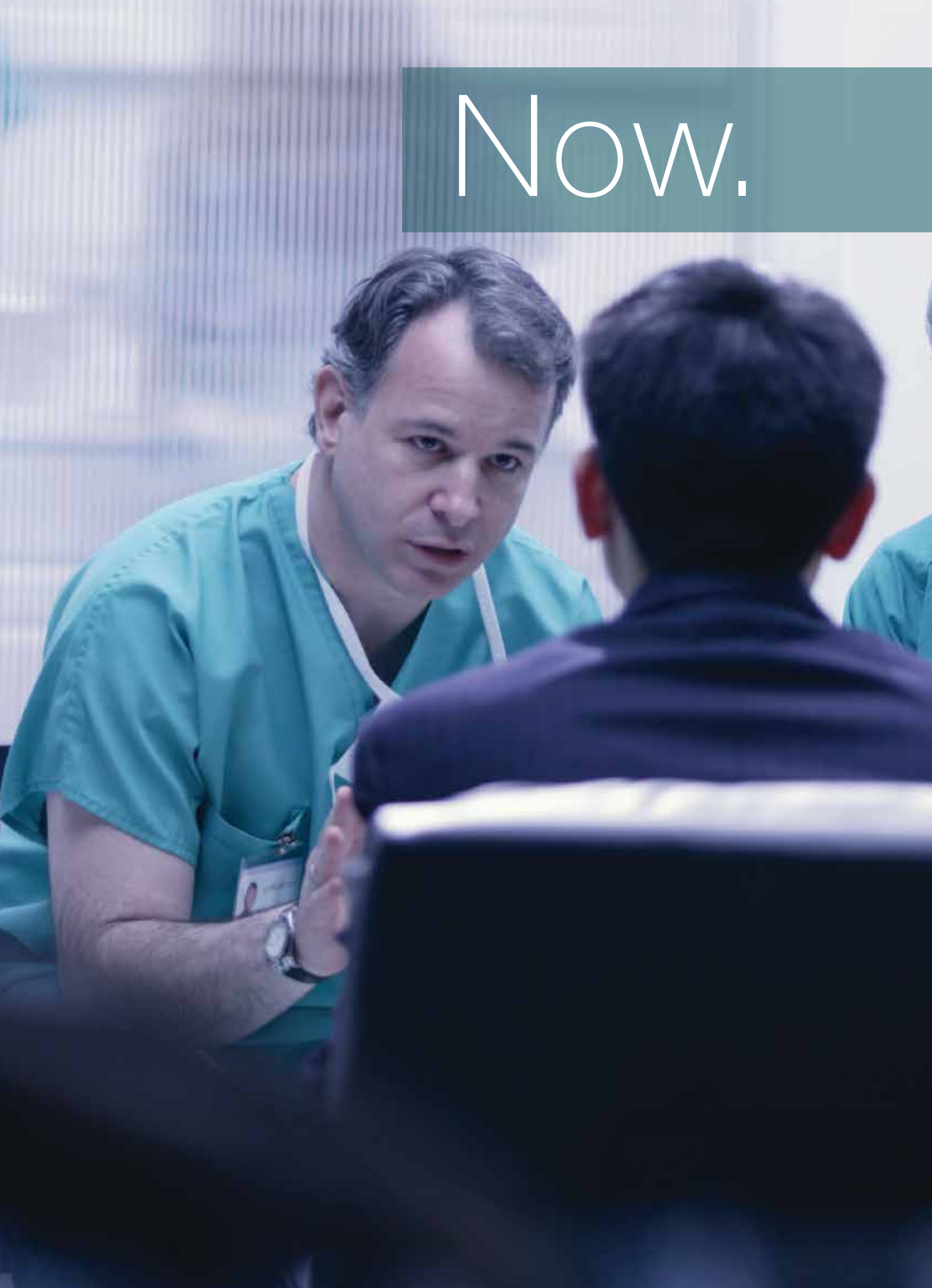
"The Alere i Strep A – which recently received marketing clearance from the FDA – and Flu test will help the physician provide the correct treatment result: for a Strep A infection, an antibiotic, and for flu, an antiviral.

> "Rapid point-of-care tests are a critical tool that healthcare providers can use in combating antibiotic-resistant bacteria."
>
> **– Seth Radus**

With regards to drug susceptibility testing, those tests are in development. Incentives, such as those in the National Action Plan, when implemented, will encourage further development of these types of products."

The company is currently under contract with the Biomedical Advanced Research and Development Authority (BARDA), which lies within the Office of the Assistant Secretary for Preparedness and Response in the U.S. Department of Health and Human Services, for the development of a next-generation version of the Alere i influenza test, says Radus. "The funds from this contract are assisting us in the development of a low-cost, rapid point-of-care test that can be deployed in the community for use during pandemic influenza outbreaks."

Editor's note: To learn more about the President's "National Action Plan for Combating Antibiotic-resistant Bacteria," go to www.whitehouse.gov/sites/default/files/docs/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf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Who's keeping track?

Without good data, who's to say whether U.S. provid-ers' programs to curb inappropriate antibiotic usage are having any effect? That's a problem.

"There are numerous measures of antimicrobial use, and until we have an agreed-upon measure to provide standardized data, we will not be able to assess the effectiveness of our antibiotic stewardship programs [ASPs] on a national scale," says Gina Pugliese, RN, MS, FSHEA, vice president of Premier Inc.'s Premier Safety Institute.

"We need additional research to identify sound outcomes measures to evaluate the effectiveness of the components of ASPs. At present there are many structural components – e.g., 'Do you have an ASP in place? – and process components – e.g., 'percentage compliance with an antibiotic time-out at 48 hours post-initiation of antibiotic therapy' measures. In other words, to identify the critical components, we need quantitatively validated, evidence-based, prioritized 'drivers' of the best outcomes from ASP models."

Work is underway at the federal and state level to generate the data needed to achieve that goal. One vehicle is the Centers for Disease Control and Prevention's National Healthcare Safety Network Antimicrobial Use and Resistance (NHSN AUR) module.

Said to be the nation's most widely used healthcare-associated-infection (HAI) tracking system, the NHSN provides facilities, states, regions, and the nation with data needed to:

- Identify infection prevention problems by facility, state, or specific quality improvement project.
- Benchmark progress of infection prevention efforts.
- Comply with state and federal public reporting mandates.
- Drive national progress toward elimination of healthcare-associated infections.

NHSN now serves over 13,000 medical facilities tracking HAIs.

"NHSN AUR "has a standardized measure, and will be very helpful in achieving this goal of measuring our success with appropriate [antimicrobial] use and resistance," says Pugliese. "Experts will be needed in each state to facilitate this and provide support and technical expertise and assistance to hospitals to assure success," she adds.

Software can help

Meanwhile, the federal government is pushing providers and software developers to improve the quality and quantity of data on antibiotic resistance.

For example, the Obama Administration's National Action Plan for Combating Antibiotic-resistant Bacteria, issued in March, calls for CMS to develop a tool to help software developers certify electronic health records and other health IT software for recording and submitting antimicrobial usage data. The plan also calls on CMS to complete an analysis of standards and terminologies for antimicrobial usage reporting to ensure alignment between NHSN reporting and CMS's Hospital Inpatient Quality Reporting (Hospital IQR) program reporting.

In addition, the National Action Plan identifies the following milestones for reporting antibiotic usage in inpatient settings:

Within one year:

- CDC will finalize arrangements for the purchase of proprietary data on inpatient antibiotic use to supplement NHSN data until a larger number of hospitals begin to use the NHSN module for antibiotic use reporting.
- CDC will work with healthcare and public health partners to propose new healthcare-facility antibiotic use measures to the National Quality Forum.

Within three years:

- CDC will use data collected through the NHSN AU module to provide annual national estimates of aggregated inpatient antibiotic use and feedback to healthcare facilities on antibiotic use, indicating whether antibiotic use rates are above or below the national average.

> "Until we have an agreed-upon measure to provide standardized data, we will not be able to assess the effectiveness of our antibiotic stewardship programs."
>
> **– Gina Pugliese**

- CDC will establish routine reporting of antibiotic use and resistance data from select hospital systems via the NHSN AU and AR modules.
- The Department of Defense will centralize its reporting of inpatient antibiotic use to NHSN.

Within five years:

- CDC will provide estimates of inappropriate inpatient antibiotic prescribing rates by state and region, and use this data to target and prioritize intervention efforts.

Editor's note: To learn more about the CDC's NHSN Antimicrobial Use and Resistance (AUR) Module, go to www.cdc.gov/nhsn/PDFs/training/AUR-training.pdf

"The National Action Plan for Combating Antibiotic-resistant Bacteria, March 2015" can be viewed at www.whitehouse.gov/sites/default/files/docs/national_action_plan_for_combating_antibotic-resistant_bacteria.pdf

Reprocessing guidelines are sign of the times

FDA document addresses concerns about complex, difficult-to-process instruments

It was four years in the making. But in March, the U.S. Food and Drug Administration issued its long-awaited final guidance document on reprocessing reusable medical devices – the first such update since 1996.

The document underscores the importance of manufacturers designing reusable medical devices with reprocessing in mind, and providing crystal-clear instructions to providers on how to clean, disinfect and sterilize them. It also draws attention to the need for providers to place well-trained, well-qualified people in reprocessing areas.

"This is the most comprehensive set of guidelines on reprocessing available to this point," says Donna Swenson, president and CEO, Sterile Processing Quality Services Inc., Stickney, Ill. "If you read them, and if you've been involved with AAMI [the Association for the Advancement of Medical Instrumentation] and other organizations, you can see that they really have been listening to what the various stakeholders had to say."

> "This is the most comprehensive set of guidelines on reprocessing available to this point."
>
> **– Donna Swenson**

The guidance document reflects the dramatic changes in medical instrumentation and research on reprocessing that has taken place since 1996, says Susan Klacik, central sterile services manager, St. Elizabeth Health Center, Youngstown, Ohio, and the International Association of Healthcare Central Service Materiel Management (IAHCSMM) representative to AAMI committees. It also points to the need for medical device manufacturers and hospital central sterile departments to partner with each other in the name of patient safety. "Our objectives are strategically aligned," she says. "We both want medical devices to perform exactly as designed – each and every time."

Complexity of today's devices

The complexity of medical instrumentation – and hence, the difficulty of ensuring its cleanliness and safety – was one of the primary reasons the FDA began work several years ago updating its 1996 guidance document titled "Labeling Reusable Medical Devices for Reprocessing in Healthcare Facilities," noted Geetha Jayan, PhD, senior science health advisor, Office of the Center Director of the FDA, during a webinar.

The new document, "Reprocessing Medical Devices in Healthcare Settings: Validation Methods and Labeling," does a few things, she said:

- Provides recommendations to medical device manufacturers for developing reprocessing instruction that can be easily understood and followed by users.
- Outlines the FDA's current recommendations to manufacturers on how to conduct scientifically sound testing to validate reprocessing methods and instructions.
- Describes measures the FDA is taking to enhance its oversight of the reprocessing of reusable devices.

The document also emphasizes the importance of designing devices that are less challenging to reprocess than some of those on the market today. It also provides recommendations on the "human factors" that can affect device reprocessing, including the ability of healthcare workers to clean and sterilize devices in the everyday work environment.

"In recent years, there has been an evolution toward the development of more complex devices with designs that are more difficult to reprocess," said Elaine Mayhall, PhD, scientific review, Infection Control Devices Branch, Division of Anesthesiology General Hospital Respiratory

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& Infectious Diseases, Office of Device Evaluation in the FDA, during the webinar. "However, there have also been significant advances in the knowledge and technology involved in reprocessing reusable medical devices. The recommendations in this guidance reflect the scientific advances in these areas."

Reprocessing instructions

The guidance document – a draft of which was issued for public comment in May 2011 – includes six criteria manufacturers must meet to ensure that providers understand and correctly follow reprocessing instructions.

Criterion 1: The reprocessing instructions should reflect the intended use of the device. Appropriate instructions depend on the physical design of the device, the intended use of the device, and whether it has direct or indirect contact with the patient. They also should reflect the type and extent of soiling and contamination to which the device is likely to be exposed during clinical use. Reprocessing methods are also dependent on the use of disinfectants or other chemicals that might leave harmful residues or adversely affect device materials or performance if inadequately rinsed, and any risk to the patient or the user.

"If the FDA decides these devices are no longer acceptable because the cleaning instructions aren't adequate, hospitals would have to start replacing them."

– Donna Swenson

Criterion 2: Reprocessing instructions for reusable devices should advise users to thoroughly clean the device. Adequate sterilization or disinfection depends on the thoroughness of cleaning. If a device cannot be cleaned, it cannot be disinfected or sterilized.

Criterion 3: Reprocessing instructions should indicate the appropriate microbicidal process for the device. The microbicidal process recommended is dependent upon the intended use of the device and is described by the Spaulding Classification for critical, semi-critical, and noncritical medical devices. (Critical devices are those introduced directly into the bloodstream or that contact a normally sterile tissue or body space during use. Semi-critical devices contact intact mucous membranes or non-intact skin, but do not ordinarily penetrate tissues or otherwise enter normally sterile areas of the body. Noncritical devices contact only intact skin but do not penetrate it.)

Criterion 4: Reprocessing instructions should be technically feasible and include only devices and accessories that are legally marketed. The equipment and accessories needed to implement the instructions should be available for users to obtain. Also, the type of sterilizer, with manufacturer-validated sterilization cycle parameters and accessories, should be available to users.

Criterion 5: Reprocessing instructions should be comprehensive and include information about: special accessories and special protection needed during reprocessing; point of use processing or pre-cleaning instructions; disassembly and reassembly instructions, including step-by-step instructions with visual aids; the method of cleaning, including a list of parameters; the cleaning agent or the class of cleaning agent used in the manufacturer's validation testing; instructions for rinsing the device following cleaning; the type and quality of water that should be used and the duration, volume, and temperature of the water; lubricating agent, if required; instructions for drying the device after processing and before storage; method of disinfection or sterilization, including the validated cycle parameters and accessories that should be used; instructions for reducing sterilant residuals following sterilization by ethylene oxide, hydrogen peroxide, or other processes that may leave sterilant residuals on the device; and more.

Criterion 6: Reprocessing instructions should be understandable. The instructions should be clear and legible. They should be presented in a logical, sequential order, from the initial processing step through the terminal processing step, and should be described using simple language. Charts, diagrams, and pictures that can be posted in a workstation are helpful.

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Are instructions 'technically feasible?'

Klacik applauded the FDA and the guidance document for a number of reasons. First, the document says that reprocessing instructions should be technically feasible and include devices and accessories that are legally marketed, she points out. That will eliminate one problematic area – that is, medical device instructions that call for extended sterilization cycles, even if the sterilizer (or indicators and CS wrap) has not been validated for the longer cycle.

Second, the document makes clear that manufacturers must plainly list everything needed to properly clean and sterilize their devices, down to what brush size should be used in lumens. "This helps me when a new product comes to the healthcare facility," she points out. "CS should be able to look at the instructions to ask, 'Can I service it? Can I thoroughly clean it? Do I have the right size brushes? The right ultrasonic cleaner? Do I have everything I need to process it?'"

Third, the guidance document discusses the handling of instruments at the point of use, most often, the OR. "That's important, because a lot of things begin at the point of use," says Klacik. For example, it has been documented that biofilm starts to form in as little as five minutes after use, she points out. Ideally, lumens should be flushed and gross debris wiped off before then.

Fourth, the guidance document stresses the importance of proper cleaning, and the importance of providing educational resources to those reprocessing their devices.

Fifth, the document talks about validation of reprocessing instructions. "Validation has to be done under the worst-case scenario," that means inoculating with soils that mimic actual use and in the most difficult circumstances, she says. Instructions must also take into consideration "real life" conditions. "In the decontamination room, we wear thick utility gloves, personal protective equipment and gowns," she points out. Tactile sensation is diminished, and glasses can fog up, as the work is often performed in crowded workspaces. Manufacturers must take all this into account when developing reprocessing instructions.

"Using simulated studies will identify difficulties in cleaning in the "real world,'" she says. "The difficulties cleaning the duodenoscope is an example of an instrument that is extremely complex to clean, requiring specialized training with proven competency with direct observation to ensure the tech performs the required flushing and raising and lowering of the elevator during cleaning. This scope also requires specific types of cleaning brushes."

'Revolutionary'

Swenson points to what she considers to be a revolutionary aspect of the FDA document.

Typically, when the agency issues a guidance document, it addresses activities that should take place "from this point forward," but leaves intact instructions for what has already transpired. "But there is something in this document that makes it a little bit different," she says.

In the new guidance document, the FDA says that reprocessing instructions for some older, legally marketed reusable devices may not be consistent with state-of-the-art science. Therefore, the provider following those instructions can't ensure that their reusable devices are clean and safe to use after reprocessing.

"Never before have previous devices been considered adulterated," Swenson points out. "They are approved, they are on the market and they are legally sold. New technology may come along and make the device obsolete, but if people are still using it, there was nothing to make them stop using it. But if the FDA is saying these devices could be considered adulterated or misbranded – that is, the labeling doesn't bear adequate directions for reuse – it could potentially tell companies that their products have to be removed from the market.

"This makes a big difference to the hospital too," she adds. "If the FDA decides these devices are no longer acceptable because the cleaning instructions aren't adequate, hospitals would have to start replacing them. Having talked to FDA people in the past, they have been of the opinion that eventually, hospitals would stop using outdated devices, which would be phased out. But that hasn't happened in a lot of cases. You still see first-generation laparoscopic devices out there.

"But this particular section of the document appears to say that if science moves beyond some of these older devices, then when the FDA inspects the manufacturer, they may ask, 'What are you doing about that?' Also, FDA shares information with other agencies, she says. And although the FDA does not directly regulate hospitals, other regulatory agencies may ask hospitals, "Why are you continuing to use devices that aren't acceptable any longer?'"

Editor's note: "Reprocessing Medical Devices in Health Care Settings: Validation Methods and Labeling Final Guidance - March 24, 2015," is available at www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/UCM253010.pdf

Duodenoscope issues capture public's attention

Every so often, even the most arcane aspects of health-care operations – such as the reprocessing of medical devices – capture the public's attention.

So it was that in February, following reports of injuries and deaths attributed to inadequate processing of duodenoscopes, the U.S. Food and Drug Administration issued a "Safety Communication," warning healthcare providers and the public that even the most meticulous attention paid to cleaning and disinfecting the scopes may not be enough to protect patients from infection passed on by other users. One month later, on March 12, the Centers for Disease Control and Prevention issued an interim protocol for facilities that want to test their duodenoscopes for contamination with bacteria after cleaning and disinfection.

Perhaps the most alarming thing about the duodenoscope affair was that outbreaks of infection appeared to have occurred even in cases where healthcare providers followed manufacturers' instructions for reprocessing them.

500,000 procedures each year

Duodenoscopes are flexible, lighted tubes that are threaded through the mouth, throat, and stomach into the top of the small intestine (duodenum), explained William Maisel, MD, MPH, deputy director for science and chief scientist, FDA Center for Devices and Radiological Health, on an FDA blog in February.

The scopes are used in more than 500,000 procedures, called endoscopic retrograde cholangiopancreatography – or ERCP – in the United States each year, he said. ECRP is the least invasive way of draining fluids from pancreatic and biliary ducts blocked by tumors, gallstones or other conditions. The duodenoscope is a more complex instrument than other endoscopes and can be more difficult to clean and disinfect.

In its Safety Communication, the FDA said it is closely monitoring the association between reprocessed duodenoscopes and the transmission of infectious agents, including multidrug-resistant bacterial infections caused by carbapenem-resistant Enterobacteriaceae (CRE) and Escherichia coli. From January 2013 through December 2014, the agency received 75 medical device reports encompassing approximately 135 patients in the United States relating to possible microbial transmission from reprocessed duodenoscopes.

> "I don't agree with culturing scopes or instruments unless you have a specific reason for doing so."
>
> **– Donna Swenson**

The agency issued its alert after UCLA's Ronald Reagan Medical Center in Los Angeles reported in February that seven patients who had undergone procedures with duodenoscopes had been infected with CRE. Two of those patients died, and an additional 179 were notified that they may have been exposed.

Culturing could be costly

Writing on the CDC blog in mid-March, Michael Bell, MD, deputy director of CDC's Division of Healthcare Quality Promotion, wrote that the agency's interim protocol can help providers detect contamination, whether due to lack of adherence to manufacturer-recommended reprocessing practices or any other reason, and to prompt follow-up action to protect patients if needed.

The protocol suggests techniques for inspection and manual cleaning and drying of duodenoscopes (as well as other flexible endoscopes that have an elevator mechanism), as well as remedial actions to be taken if any duodenoscope is found to be contaminated.

In the protocol, the CDC notes that some facilities routinely culture their scopes to assess the adequacy of reprocessing. "Holding duodenoscopes out of use while surveillance culture results are pending could be considered, especially if performing surveillance cultures after each use," wrote Bell. "Any duodenoscope found to be contaminated should not be returned to use" until appropriate steps are taken.

That portion of the document has led to consternation among some providers, a point Bell acknowledged in the CDC blog when he wrote: "We recognize that there are both pros and cons associated with using screening cultures. There can be concerns about cost, as using this method will mean that the duodenoscopes will not be available for use while waiting for the results of the cultures. This could mean that a facility would need to buy additional scopes in order to be sure they have the equipment available when needed. Additionally, the failure to grow bacteria from the areas sampled may not guarantee that there are no bacteria present anywhere on the scope."

Is culturing necessary?

"I don't agree with culturing scopes or instruments unless you have a specific reason for doing so – e.g., a cluster infection, and you're trying to figure out the source," says Donna Swenson, president and CEO, Sterile Processing Quality Services Inc., Stickney, Ill. According to Swenson:

- Culturing is expensive. It's expensive to run the test and to obtain the additional instrumentation needed while waiting for results.
- Culturing comes with its own set of issues. "You have to be sure that whoever is doing the culture isn't contaminating the device."
- Other methods are available to test for cleanliness, including the well-established technique of flushing lumens with hydrogen peroxide and looking for foam.

"People need to develop a comprehensive program, and look at water quality, temperature, the chemicals being used and whether they are being dosed correctly," she says. "If you would do all of these things and then verify the cleaning of the actual devices, I don't see why you would need to do culturing."

Staff training and competency

The duodenoscope issue and CDC protocol demonstrate the importance of training and certification of personnel responsible for reprocessing medical devices, says Susan Klacik, central sterile services manager, St. Elizabeth Health Center, Youngstown, Ohio, and the International Association of Healthcare Central Service Materiel Management (IAHCSMM) representative to Association for the Advancement of Medical Instrumentation (AAMI) committees. "The design of these scopes makes thorough cleaning difficult and requires a true expertise with demonstrated competency to perform this complex task with the specified cleaning brushes," she says.

> "We recognize that there are both pros and cons associated with using screening cultures. There can be concerns about cost."
>
> **– Michael Bell**

In fact, the CDC recommends that competencies be assessed at initiation of employee duties and at least annually and anytime a breach is identified or when a new technique or equipment is introduced. "Competency verification should include direct observation in addition to other assessments per facility policy (e.g., written tests)," says the CDC protocol. "Personnel responsible for reprocessing endoscopes are encouraged to seek certification [in sterile services]."

The good news, says Klacik, is that central sterile processing personnel have access to better information and training than ever before. "We're evolving," she says, and suppliers of medical devices can help by providing educational programs, graphics, posters and other sources of information about reprocessing. "We're like a sponge," says Klacik. "We'll take all the information we can get."

Editor's note: The Interim Duodenoscope Surveillance Protocol: Interim Protocol for Healthcare Facilities Regarding Surveillance for Bacterial Contamination of Duodenoscopes after Reprocessing" is at www.cdc.gov/hai/organisms/cre/cre-duodenoscope-surveillance-protocol.html

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- "Is there a concern for wasted product?"
- "Is first-stick success important?"

The Introcan Safety IV Catheters' double flashback technology allows visualization of both needle and catheter vein entry. The initial visual of blood in the flashback chamber indicates needle entry into the vein. A secondary flashback occurs in the catheter as it is advanced, confirming accurate placement and facilitating first stick success.

Final points

B. Braun provides value-added products with customers and their patients always in mind. In addition to preventing needlestick injuries and facilitating first-stick success, the Introcan Safety IV Catheters are small by design. The smaller, lighter components will save room in sharps containers, generating less waste for the facility and providing additional savings.

Sponsored by B. Braun.

Recent studies[1, 2] confirm that passive safety designs offer 2-3 times better protection against accidental needlesticks than active designs. INS Standards also recommend the use of passive safety devices.[1] Tosini W, et al. " Needlestick Injury Rates According to Different Types of Safety Engineered Devices: Results of a French Multicenter Study", Infection Control and Hospital Epidemiology, April 2010. Vol 31, Number 4

[2]Shimatani M, et al. "Comparison of the Needlestick Injuries Due to Active and Passive Design Safety Intravenous Catheters", Poster Presentation APIC 2011. Submitted for publication 2011

MDSI's REGIONAL DISTRIBUTION SUMMITS

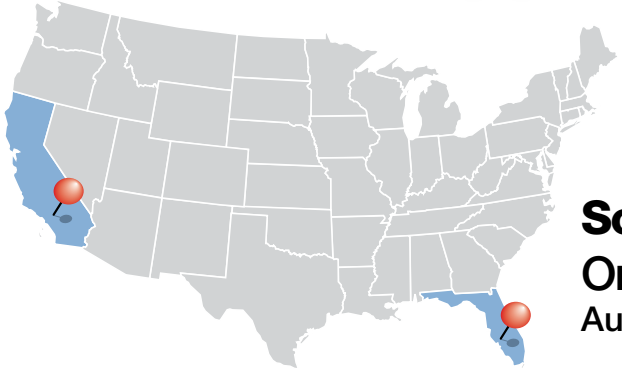
Starting in August 2015

You will hear from 3 different local IDNs, GPOs, ACOs and Urgent Care Centers in an open panel discussion format.

Who should attend: **local med-surg distribution and manufacturer reps.**

COME HEAR THE VOICE OF THE CUSTOMER!

Don't miss out on this opportunity!



Southern California
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For more information contact Anna McCormick 770.263.5280 • amccormick@mdsi.org

www.repertoiremag.com/events

Crosstex/SPSmedical

Healthcare providers throughout the world are steadily recognizing that better awareness and prevention of healthcare associated infections not only saves lives, but ultimately saves money and drives greater efficiencies in the healthcare system. It takes unique expertise, commitment, skills and enhanced products to do this correctly, and growing numbers of providers are devoting additional resources to this important area. Crosstex/SPSmedical seeks to continue developing novel products that address these critical issues as we believe infection prevention and control markets will continue to grow for years to come.

Secure Fit® Technology Face Masks from Crosstex/SPSmedical are an example of such a novel product. Secure Fit® Technology Face Masks are proven to provide up to three times greater protection over other

face masks*. Secure Fit® Technology Face Masks feature aluminum nose and chin pieces that can be adjusted to fit the shape and size of any face, while significantly reducing the gapping on the sides and bottom of the mask, reducing exposure to airborne particulates and aerosols by more than three times that of a standard earloop face mask. Secure Fit® Technology Face Masks are made in the USA and come in all three ASTM levels. *Study on file

Greater efficiency, lower costs, better outcomes

Secure Fit® Technology Face Masks are considerably less expensive than respirators, provide better breathability, better fit and better feel than that of a surgical tie-on mask, are made in the USA, and are readily available in all three ASTM levels.

Probing sales questions

- "Doctor, what type(s) of exposure do you experience when interacting with patients?"
- "Tell me about the appropriateness of your current masks for these exposures."
- "What ASTM level is your current decontamination mask?"
- "Do you feel protected when you are wearing your mask?"

Potential objections

"Ear loop face masks do not offer the same level of protection as surgical tie-on masks."

Rep response: "This is not true. Secure Fit® Technology Face Masks come in ASTM levels 1-3. ASTM level 3 masks provide the highest level of protection from aerosols and fluid sprays. The Secure Fit® technology conforms to any size or shape face giving a custom fit. This reduces gapping around the chin and cheeks for a better fit and increased protection."

"Our current decontamination mask is on contract and is less expensive."

Rep response: "Yes, but does it provide the protection needed for staff? What ASTM level is your current mask?" Often, the masks used are minimum performance masks. A Secure Fit mask that meets ASTM level 1-3 criteria will provide the protection needed while cleaning contaminated instruments.

Final points

Crosstex/SPSmedical recognizes that protection, comfort and fit are the most important roles for face masks in the healthcare market. This is why our Secure Fit® Technology Face Masks are made from only the highest quality materials and tested to ensure premium performance, which protects healthcare workers and patients alike.

See how safe really feels: Compare a fitted mask with Secure Fit® Technology to a standard mask. Request a FREE sample of up to four different styles. Visit www.crosstex.com/facemasks or call 800-722-1529.

Sponsored by Crosstex/SPSmedical.

PROVEN TO PROVIDE 3X GREATER PROTECTION OVER OTHER MASKS.*

It's a fact: No standard mask protects you better than fitted Secure Fit® Technology face masks. Featuring dual aluminum strips — above the nose and under the chin — our patent-pending design eliminates gaps, increases protection and greatly reduces fogging while maximizing breathability and comfort. No wonder users gave Secure Fit® the top rating in every category in a national mask survey.

SEE HOW SAFE REALLY FEELS:

Visit **Crosstex.com/facemasks** to view the Face-to-Face Challenge or request a free sample.

CROSSTEX® A CANTEL MEDICAL COMPANY SPS medical

MADE IN USA

*Data from Aerosol Mechanics Laboratory. G.C. Smaldone, Stony Brook University Medical Center, New York.

Georgia-Pacific Professional

Ensuring your clients' hygiene compliance in their fa-cilities represents a meaningful opportunity not only to advocate for health and hygiene compliance, but also to develop and cultivate your client relationships. Here's why:

Did you know that healthcare-associated infections (HAIs) affect 1.7 million patients each year in the United States? That this is 5-10 percent of hospitalizations? That this accounts for about 99,000 deaths? HAIs can be acquired at any healthcare facility, and they add nearly $20 billion to healthcare costs annually, according to the Centers for Disease Control and Prevention.

As healthcare sales professionals and client advocates, you can help your clients prevent HAI transmission. Ensuring that clients follow proper hand hygiene techniques is the most important and least expensive way to do this; but on average only 40 percent of all healthcare workers practice proper hand hygiene.

How do Georgia-Pacific Professional products help promote hygiene and help reduce cross-contamination?

One method to help your clients reduce cross-contamination is to upgrade to touchless dispensers. Using Georgia-Pacific Professional automated no-touch product dispensers, and no-touch towel dispensers for single-use disposable paper towels, helps reduce potential opportunities for cross-contamination. Georgia-Pacific Professional soap and hand sanitizer dispensers also help reduce the risk of cross-contamination with a closed system consisting of the bag, pump and nozzle.

Using Georgia-Pacific Professional automated no-touch product dispensers, and no-touch towel dispensers for single-use disposable paper towels, helps reduce potential opportunities for cross-contamination.

Everyone wins by promoting hygiene: your clients, their patients and employees. By advocating hand hygiene, you are positioning yourself as a resource who will provide meaningful solutions to issues your clients care about in the management of their healthcare facilities, as well as helping them become more hygienic and efficient. In addition to building a deeper client relationship, by selling Georgia-Pacific Professional products, you are also laying the groundwork for continued sales and commissions far into the future.

Sponsored by Georgia-Pacific Professional

MORE COMMISSION OPPORTUNITIES

SofPull® Automatic Touchless Towel Dispenser

When you think about housekeeping solutions for medical practices, think **Georgia-Pacific Professional.**
Our products are leaders in innovation, cost-in-use and hygiene.
And best of all, by selling our dispenser products, you're laying the groundwork for continued sales and commissions far into the future.

SofPull® Regular Capacity Centerpull Towel Dispenser

Georgia-Pacific® Manual Soap/Sanitizer Dispenser

Compact® Side-By-Side Double Roll Bathroom Tissue Dispenser

gppro.com

GP Georgia-Pacific Professional

GOJO Industries

The PURELL ES™ Everywhere System is designed to fit where your customers need it. It is the smallest, most versatile and appealing PURELL® System in the market offering unparalleled placement access and customer convenience. The system is designed to fit in places that are unable to accommodate traditional dispensers or where bottles are commonly found. It features a ready-to-install preassembled base, contains almost twice as much product as a standard eight-fluid ounce bottle and allows for easy, at-a-glance monitoring of product level for easy servicing.

"Hand hygiene needs to be accessible," says Joey Suntken, GOJO North American Acute Care Market Director. "The PURELL ES™ Everywhere System's sturdy, one-hand dispensing makes hand sanitizing easy and more accessible. Its small size allows your customers to place it in smaller, high-traffic spaces, such as registration and reception areas where other solutions cannot fit, and replace bottles that can get moved or knocked over. And, increasing the accessibility of hand sanitizer can help increase its usage and help reduce the spread of illness-causing germs."

The PURELL ES™ Everywhere System is ideal for patient care rooms, the nurse's station, treatment carts, registration areas, emergency medical services, break rooms and offices. It can be placed where it is needed to help keep staff and patients healthy.

Benefits

The PURELL ES™ Everywhere Systems offers these unique benefits:

- **Easy set-up.** The kit includes a preassembled base and refill cartridge with 3M™ Command™ strips for trouble free placements.
- **Easy-change refill cartridges.** Refill cartridge securely attaches to the base, which reliably mounts to surfaces.
- **Trouble-free performance.** Base constructed of robust plastic for long-term reliability and backed by the GOJO Lifetime Guarantee.
- **Efficiency.** Refill contains almost twice as much product as standard 236 mL PURELL® pump bottle.
- **At-a-glance monitoring.** Entire refill exposed for at-a-glance monitoring of product level and easy servicing.
- **Effectiveness in a single actuation.** Delivers an efficacious amount of PURELL with each actuation.
- **Easy recognition.** Clear, gem-shaped refill cartridge has the familiar look of the PURELL brand everyone knows and trusts.
- **Versatile mounting accessories.** Wall mount, horizontal surface mount and rail mount accessories allow for innovative placement options almost everywhere sanitizer is needed.

The PURELL ES™ Everywhere System is our latest advancement as part of a complete line of GOJO products and programs that meet the health and well-being needs in healthcare. Learn more at Healthcare.GOJO.com.

Sponsored by GOJO Industries, Inc.

THE PURELL ES™ EVERYWHERE SYSTEM

HAND HYGIENE WHERE YOU NEED IT!

The new PURELL ES Everywhere System makes hand hygiene accessible where you need it. Small, stylish and versatile, the PURELL ES Everywhere System is ideal for placement where traditional dispensers won't fit or bottles aren't secure. Place it where it's needed to keep staff and patients healthy.

Learn more at Healthcare.GOJO.com

GOJO® | Purell®

PDI

Patients with cancer and autoimmune disorders may be prescribed infusion therapies administered via intravenous route. Infusion therapy can take place at a physician's office, hospital or ambulatory care facility. These patients can have weakened immune systems, and it is critically important to reduce their risk of contracting a healthcare-associated infection (HAI). In addition, outpatient surgery centers are also focused on preventing HAIs as surgical procedures are moving away from the traditional hospital setting.

The Prevantics® product line is a comprehensive, evidence-based solution that addresses the vascular access continuum of care. The newest addition, Prevantics® Device Swab:

- Is specifically indicated for the disinfection of needleless sites prior to use.
- Contains the first and only 3.15 percent Chlorhexidine Gluconate and 70 percent isopropyl alcohol formulation.
- Has a quick five-second scrub time and five-second dry time to help with staff compliance.

Greater efficiency

Bloodstream infections continue to be a leading cause of mortality and morbidity for patients with invasive catheters. As physician practices and surgery centers are being purchased by hospital systems, it is becoming increasingly important for these facilities to be compliant with the CDC guidelines for infection prevention in outpatient settings.

By using Prevantics® Skin Antiseptics for pre-injection and pre-operative skin preparation, Prevantics® Device Swab for disinfecting a needleless access site prior to use, practicing hand hygiene, and adhering to aseptic technique when accessing devices, the risk for these serious HAIs can be mitigated.

Probing sales questions

- "What type of skin antiseptic are you using prior to minor surgical procedures or injections?"
- "Do you measure your rates for blood culture contamination and bloodstream infections acquired in your clinic?"
- "If yes, what protocols do you encourage your staff to follow to keep your rates as low as possible?"

Potential objections

Prevantics Skin Antiseptics: I use alcohol or povidone-iodine to prepare a patient's skin prior to an injection or a minor surgical procedure.

- Chlorhexidine solution is preferred for skin antisepsis by the CDC.
- All Prevantics® products contain 3.15 percent CHG and 70 percent IPA.
- The Swabstick and Maxi Swabstick are FDA-approved for preoperative indications, pre-activated and ready-to-use with no glass to break and, unlike alcohol or povidone-iodine, provide seven days of continued antimicrobial activity.
- The Swab has a pre-injection indication and an intuitive prep-pad design.

Prevantics Device Swab: I use alcohol prep pads to disinfect needleless access sites before infusing medication in an oncology or rheumatology office.

- The CDC guidelines state, "Some studies have shown that disinfection of the devices with Chlorhexidine/Alcohol solutions appears to be the most effective in reducing colonization."
- The Prevantics Device Swab contains the first and only 3.15 percent CHG and 70 percent IPA solution authorized by the FDA to disinfect needleless access sites and has a five-second scrub/five-second dry time to help with staff compliance.

Unique to the market, the Prevantics® product portfolio contains PDI's proprietary formula, 3.15 percent Chlorhexidine Gluconate (CHG) and 70 percent isopropyl alcohol, and is a comprehensive approach to infection prevention for the entire vascular access process.

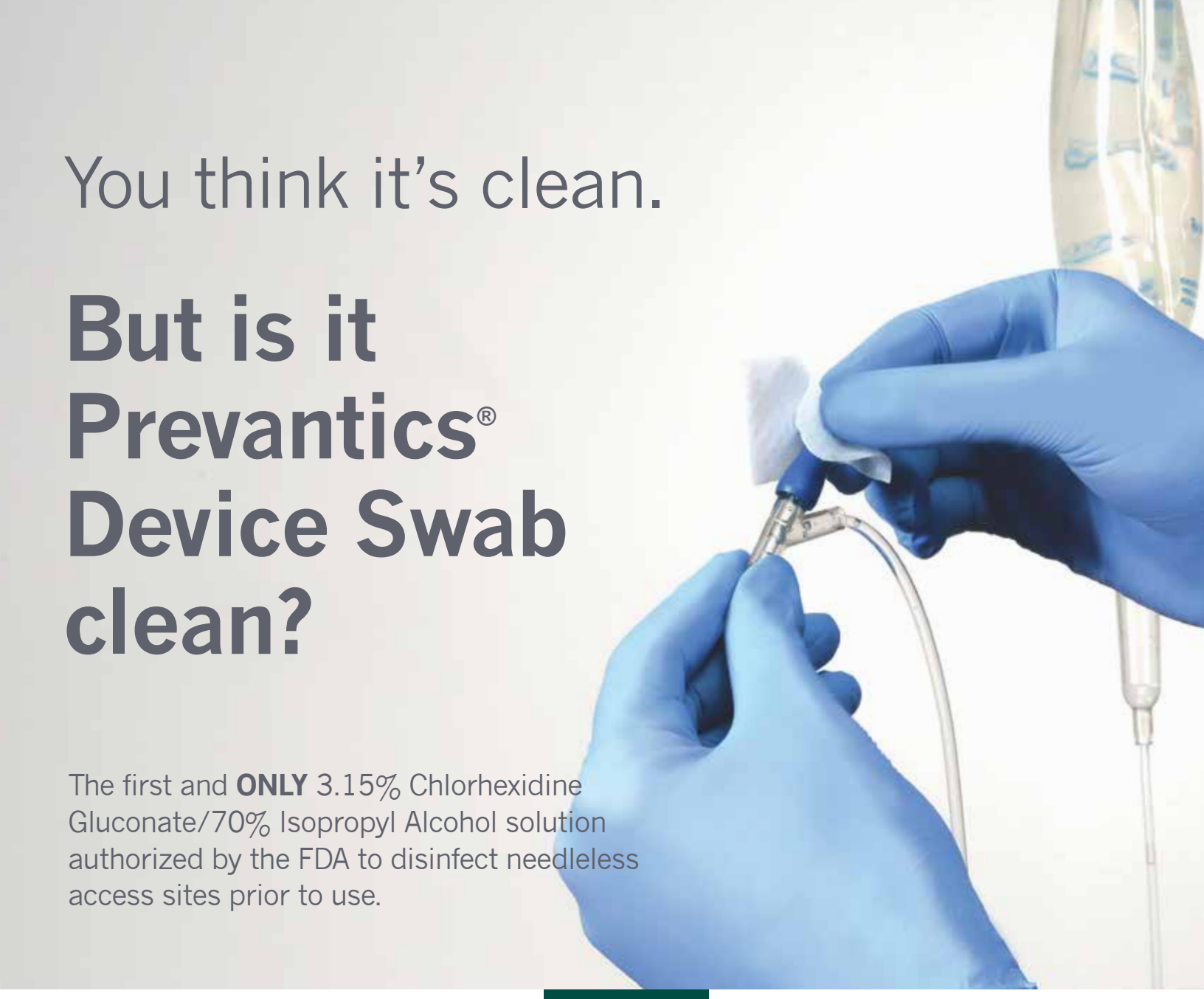
A wide selection of infection prevention and Prevantics educational materials, including in-service videos, instructions-for-use posters, webinars and whitepapers, are available at www.pdihc.com.

[1] Data on file, study report 140304-250

[2] CDC HAI Prevalence Survey. Magill, S.S., Edwards, J.R., Bamberg, W., et al. Multistate Point-Prevalence Survey of Health Care–Associated Infections. N Engl J Med 2014;370:1198-208.

You think it's clean.

But is it Prevantics® Device Swab clean?



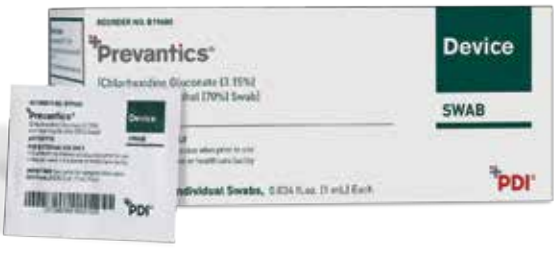
The first and **ONLY** 3.15% Chlorhexidine Gluconate/70% Isopropyl Alcohol solution authorized by the FDA to disinfect needleless access sites prior to use.

Prevantics®

Device

SWAB

- 5 second scrub time and 5 second dry time
- Randomized study[1] has shown that disinfection of the devices with a Chlorhexidine/Alcohol solution appears to be most effective in reducing colonization as cited in the CDC Guidelines.[2]



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.

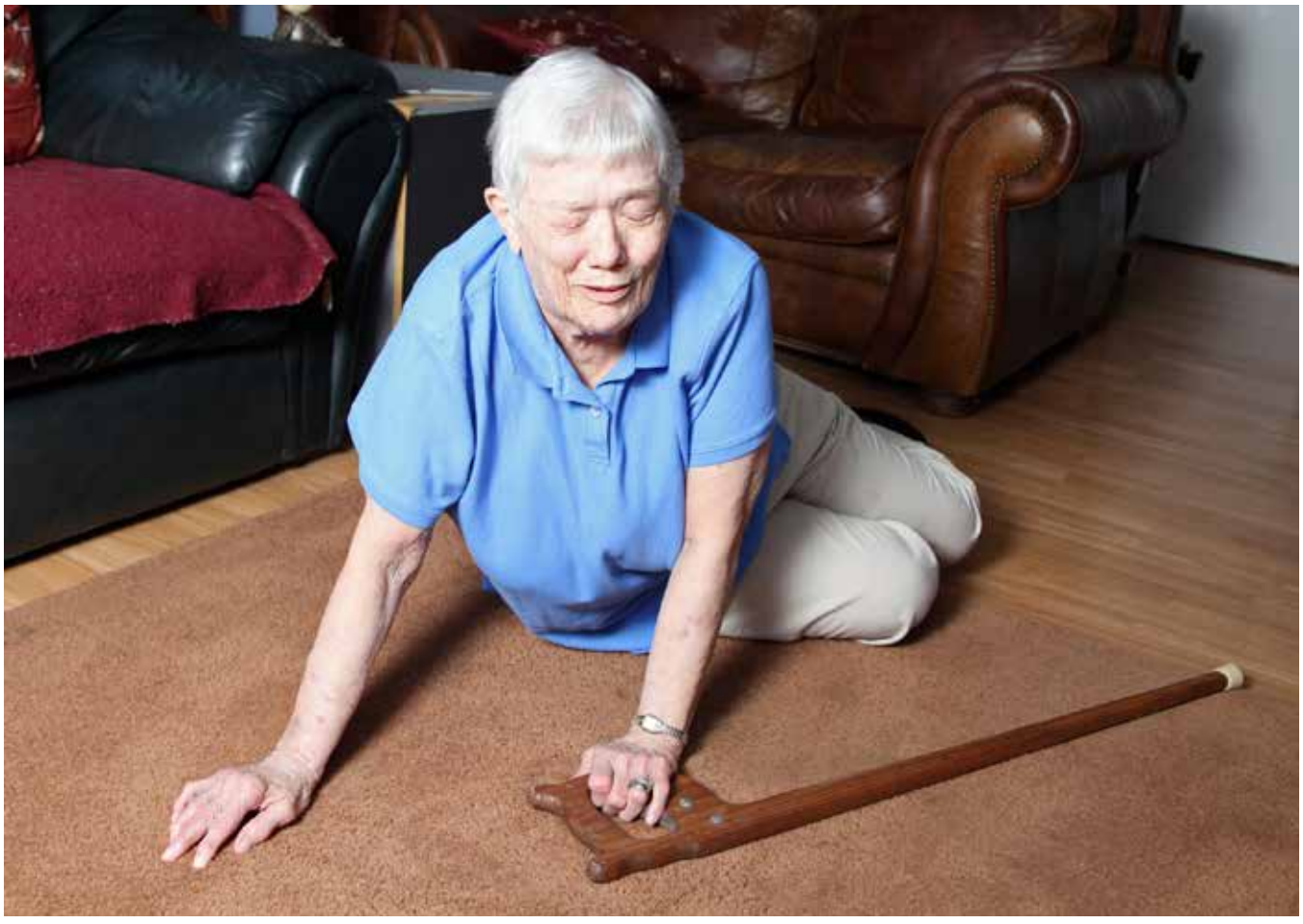
[2]2011 Guidelines for the Prevention of Intravascular Catheter-Related Infections, Healthcare Infection Control Practices Advisory Committee, US Centers for Disease Control and Prevention, 2011.

PDI10147833

PDI®
BE THE DIFFERENCE

Preventing Falls

Fall-associated injuries and death continue to be a problem among the elderly and, especially, among nursing home residents.



Our long-term care customers are facing a $34 billion problem, according to the Centers for Disease Control and Prevention (CDC). In spite of increased attention to injuries and death associated with falls among people aged 65 and older, falls continue to be a problem – particularly for nursing home residents. About 1,800 older adults living in nursing homes die each year from fall-related injuries, and those who survive often sustain injuries resulting in permanent disability and reduced quality of life. Consider the following:

- One in three adults aged 65 and older falls each year. Of these individuals, 20 to 30 percent suffer moderate to severe injuries that make it hard for them to get around or live independently, and increase their risk of early death.
- Older adults are hospitalized for fall-related injuries five times more often than they are for injuries from other causes.
- Emergency departments treat about 2.5 million nonfatal fall injuries among older adults each year. Of these patients, about 734,000 must be hospitalized.
- More than 1.4 million people 65 and older live in nursing homes.

- Each year, a typical nursing home with 100 beds reports 100 to 200 falls. (Many falls go unreported.)
- Between half and three-quarters of nursing home residents fall each year.
- About 1,800 people living in nursing homes die from falls each year.
- About 10 to 20 percent of nursing home falls cause serious injuries, while 2 to 6 percent cause fractures.

Falls result in disability, functional decline and reduced quality of life, and a fear of falling can cause further loss of function, depression, feelings of helplessness and social isolation, according to the CDC. Falling can be a sign of other health problems, as well. People in nursing homes are generally older and frailer than older adults living in the community. They often have more chronic conditions, and have more difficulty walking. In addition, they tend to have thought or memory problems, difficulty with daily activities and they require help getting around or taking care of themselves – factors that are all linked to falling.

Most commonly, muscle weakness and walking or gait problems lead to falls among residents. So do environmental hazards, such as wet floors, poor lighting, incorrect bed height and improperly fitted or maintained wheelchairs.

Causes and prevention

There are a number of reasons why falls are so prevalent in nursing homes. Most commonly, muscle weakness and walking or gait problems lead to falls among residents. So do environmental hazards, such as wet floors, poor lighting, incorrect bed height and improperly fitted or maintained wheelchairs. Medications – particularly drugs that affect the central nervous system, such as sedatives and anti-anxiety drugs – can increase the risk of falls and fall-related injuries. In fact, the risk of falling is significantly elevated during the three days following any change in these types of medications. Finally, when residents have difficulty moving from one place to another (for example, from the bed to a chair), or when they suffer from poor foot care, poorly fitting shoes, and improper or incorrect use of walking aids, they are at increased risk of falling.

Distributor sales reps can provide a service for their long-term care customers by drawing attention to preventive measures to reduce falls among their residents. The CDC recommends several safety tips, while at the same time making it clear that restraints do not lower the risk of falls or fall injuries and should not be used as a fall prevention strategy. In fact, restraints can actually increase the risk of fall-related injuries and deaths. Furthermore, limiting a patient's or resident's freedom to move around leads to muscle weakness and reduces physical function. Instead, the CDC suggests following the following strategies:

- Assess patients after a fall to identify and address risk factors and treat the underlying medical conditions.
- Educate staff about fall risk factors and prevention strategies.
- Review prescribed medicines to assess their potential risks and benefits and to minimize use.
- Make changes in the nursing home environment to make it easier for residents to move around safely. Examples include installing grab bars, adding raised toilet seats, lowering bed heights and installing handrails in the hallways.
- Provide patients with hip pads, which can help prevent a hip fracture if a fall occurs.
- Promote exercise programs, which can help improve balance, strength, walking ability and physical function among nursing home residents.
- Teach residents who are not cognitively impaired behavioral strategies to avoid potentially hazardous situations.

Not only are nursing home falls an ongoing problem, they can be a recurring one. Indeed, nursing home residents often fall more than once, says the CDC. By helping your accounts get this issue on their radar, they are more likely to take steps to intervene. rep

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

Automotive-related news

Do you dare?

Are you an at-risk driver? Driver-monitoring programs and devices can help you determine whether you are – or are not. But, the decision to participate may come at a risk in itself. Progressive, a driver's insurance company that is currently testing such a program in the state of Missouri, presents one such example. The company says it will impose a surcharge on aggressive drivers using its Snapshot device, according to The Chicago Tribune. The Snapshot device, when installed in a car, gathers information. Drivers who sign up for the program will receive an initial discount. However, Progressive will charge higher rates (a surcharge equal to or less than 10 percent of their current rate) for the worst drivers in the program. That said, not every insurance company plans to impose a surcharge on drivers who participate in their driver-monitoring program. Allstate's Drivewise program has no surcharge, and State Farm's Drive Safe & Save program is a discount program.

Who's in control?

For sales reps who spend much time on the road, driving defensively has never been more important. It seems it's not just texting that leads to so many car accidents. A lot goes on behind the wheel, according to a recent survey by Eerie Insurance, highlighted by the Chicago Tribune. Drivers surveyed reported engaging in a range of distracting and potentially dangerous behaviors, including the following:

- **Romantic encounters:** 15 percent
- **Combing or styling hair:** 15 percent
- **Changing clothes:** nine percent
- **Applying makeup:** eight percent
- **Brushing or flossing:** four percent
- **Taking selfies:** three percent
- **Changing drivers:** three percent
- **Going to the bathroom** (That's right)**:** three percent

Drivers surveyed also reported putting in contact lenses or eyedrops, curling eyelashes, scratching off lottery tickets and playing the guitar while driving.

Plan ahead

The calendar says June, but the National Highway Traffic Safety Administration (NHTSA) want drivers to start thinking about next winter. For those living in areas where salt is used to clear the roads of snow and ice, it's important to wash the underside of their car. Following a five-year investigation into rusting pipes that carry brake fluid in about five million older Chevrolet, Cadillac and GMC pickups and SUVs, the agency blamed the problem on road salt and lack of washing. The investigation began after a man in Ohio complained that the pipes carrying brake fluid on his 2003 Chevy Silverado rusted and leaked, causing a reduction in braking power.

80 percent of millennials have used their mobile devices to help them with at least one car purchase, compared to just 46 percent of people age 35 and over.

Younger and wiser

A recent study by car buying platform Edmunds.com suggests that younger, tech-savvy consumers are relying on their mobile devices to become better educated during the car shopping process. According to the study, 73 percent of people 18-34 years old believe they are savvier car buyers than their parents. More than half say they advise friends and family about their car purchases, compared to 37 percent of older Americans. The study reports that this age group tends to rely on mobile devices for vehicle reviews, sales and pricing. In fact, 80 percent of millennials have used their mobile devices to help them with at least one car purchase, compared to just 46 percent of people age 35 and over. That said, this group continues to value the in-dealership experience, according to the study. Sixty-four percent say they prefer face-to-face interaction with dealers as opposed to remote communications, and 96 percent say it's important to test drive a car before they buy it.

Best value

Who's not looking for a good value? If you are in the market for a new car, you may want to consider the 2015 Jeep® Wrangler, which has received the Vincentric Best Value for the compact/mid-size SUV segment. New features include a standard eight-speaker audio system and improved sound bar; an optional Premium Alpine Audio Package that includes nine Alpine speakers, a new subwoofer and a 552-watt amplifier. Starting U.S. MSRP of $22,795.

If you are in the market for a new car, you may want to consider the 2015 Jeep® Wrangler, which has received the Vincentric Best Value for the compact/mid-size SUV segment.

More of a good thing

In the electric/plug-in hybrid category, Kia Motors America's Soul EV has been named the 2015 Vincentric Best Value in America award winner. Vincentric measures cost of ownership using eight different cost factors: depreciation, fees and taxes, financing, fuel, insurance, maintenance, opportunity cost, and repairs. Utilizing this methodology, the company identifies which vehicles have lower-than-expected ownership costs relative to comparable offerings. The statistical process evaluates each vehicle across all 50 states and Washington, D.C.

Affordable and efficient

For information on great sedan buys, visit Kelley Blue Book's KBB.com list of 10 Best Sedans Under $25,000. The list, which features 2015 model-year sedans considered to be affordable and efficiency, includes the Honda Accord, Hyundai Sonata, Toyota Camry, Honda Civic, Mazda Mazda3, Ford Fusion, Subaru Legacy, Nissan Altima, Chrysler 200 and Subaru Impreza.

Buckle up

If you are of the notion that buckling up is a nuisance, you may be happy to learn that, thanks to new technology, the task may be…less of a task. TRW Automotive Holdings Corp. recently announced its next-generation seat belt buckle – the RNS5s – said to offer reduced weight and smaller dimensions than previous systems. The buckle, which is approximately 15 percent lighter and 20 percent smaller in packaging volume, is designed for front and rear seat applications using buckles and/or anchor pre-tensioners.

A sight to see

Philips has introduced Vision LED Lights, designed to improve drivers' vision by delivering better and more dynamic lighting for applications such as brake and taillights, back up lights, side markers, fog lights and license plate lights. Guaranteed for up to 12 years, the lights are reported to be resistant to extreme heat and vibration, meaning drivers will be likely to replace their vehicle long before their LED lights. The right lighting can improve driver visibility and safety, according to Philips, which recommends drivers take the following precautions as well:

- Get vision checkups
- Take steps to improve driver reaction time, such as getting enough sleep and exercise
- Keep the vehicle well maintained. Maintenance should include regular cleaning of headlight lenses, sideview mirrors and interior glass and mirrors to prevent compromised vision

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.

Technology news

Wise up

The country is getting smarter, according to Research and Markets' recent report, Global Smart Wearable Healthcare Devices and Services Market 2015-2019.

According to the report, the global smart wearable healthcare devices and services market is expected to grow more than 30 percent from 2015 through 2019, as they continue to play a greater role in tele-home healthcare. The devices, which are designed to help physicians monitor patients remotely and provide proper treatment, are worn or attached to a user's body to monitor the changes in various organs and body parts. Examples include smart watches, wearable hands, smart diapers, wristbands, pedometers and bionic suits. Often, they are used to monitor heart rate and cardiac function, body temperature, and daily activity, as well as provide sleep statistics and track calories. In addition, the devices can be synced with the user's smartphone and tablet. An increase in aging populations and chronic diseases is expected to lead to an increased demand for smart wearable healthcare devices, states the report, particularly given the rise in chronic diseases such as diabetes, arthritis, cancer, obesity, heart diseases, asthma and COPD. That said, privacy issues and data security remain a key concern for consumers, particularly since the devices are small and can be misplaced. A lost device can be hacked, leading to security breaches and misuse of personal health-related information. Key vendors include Apple, AT&T, EE, Google, Samsung Electronics, Sprint, Telefonica, T-Mobile and more.

Welcome to 3D

Why should your customers settle for a flat set of CT scans when a 3D hologram is possible? Holographic Optical Technologies, a holographic medical imaging company, recently introduced the Voxbox (8-inch display) and Voxbox Pro (22-inch display). The systems are designed to allow consumers to view fully three-dimensional holograms at home. The holograms project out towards the observer in front of the portable Voxbox screen, and viewers can reach into them to intuitively understand their information. The company has also announced its hologram production service, whereby users can submit nearly any set of 3D data to be made into a Voxgram hologram, such as a set of CT scans obtained from a doctor, a user-created 3D model, or a 3D character downloaded from the Internet. Whereas the Voxbox viewer can be used to display holograms on a desk or mounted on a wall, the larger

The holograms project out towards the observer in front of the portable Voxbox screen, and viewers can reach into them to intuitively understand their information.

Gaining mindshare is like catching the wind!

mdsi

You have to be in front of it.

FOR MORE INFORMATION CONTACT:

MICAH MCGUINCHEY
770-263-6248
e-mail micah@mdsi.org

SUE BRUNELLE
770-263-6250
e-mail sbrunelle@mdsi.org

Voxbox Pro is a medical-grade display, designed to be used by physicians to view medical holograms.

Call – or text – home

Smartphone users rely heavily on their phone – but not necessarily for making calls. Informate Mobile Intelligence, a monthly report dedicated to tracking and measuring consumer use of smartphones in 12 countries, points out that while cell phone use is increasing, more often than not, communications are in the form of texts. After measuring smartphone users' engagement on calls, texting and chat/VOIP, the firm reports that the average American makes or answers six phone calls per day, sends and receives 32 texts, and spends 14 minutes on chat/VOIP. Essentially, smartphone users in the United States spend about 26 minutes a day texting. In fact, compared with other countries, U.S. smartphone users reportedly have the highest average rate of monthly data consumption (19 gigabytes).

Patient-engagement solution

TeleHealth Services, a provider of hospital televisions and interactive patient-engagement solutions, has announced through its partnership with Samsung Electronics America, Inc., the completion of SmarTigr, a patient-engagement solution. To help hospitals and health systems improve both the patient experience and patient-provider communication, the SmarTigr utilizes the smart TV functionality of the Samsung healthcare televisions, combined with the clinical features of TeleHealth's iTigr patient-engagement solution. The goal is to lower the cost of hospital-patient interactive systems while expanding both clinical and non-clinical applications available, including electronic whiteboards, patient portal registration, internet access, and additional patient education and entertainment options.

Activity tracker

Omron Healthcare, Inc., a manufacturer of personal wellness products, has announced the Alvita Wireless Activity Tracker, a tool designed to help people remain motivated to maintain their fitness goals. The device is designed to allow users to transfer fitness data wirelessly to their smartphone with the free Omron Fitness app. Featuring Bluetooth® Smart technology, the tracker records steps, aerobic steps, distance and calories burned, enabling users to set realistic goals and check progress along the way. At less than a square inch in size, it is compatible with several systems and devices, including iPhone® 4S & higher; iPad® 3 & higher; iOS 7+; Samsung Galaxy S® III & higher; and Android™ OS 4.3+ when the free Omron Fitness mobile app is installed. The tracker displays the current day's activity on an LCD screen with the tap of a finger, and stores up to 14 days in the device. (MSRP $59.99)

To help hospitals and health systems improve both the patient experience and patient-provider communication, the SmarTigr utilizes the smart TV functionality of the Samsung healthcare televisions, combined with the clinical features of TeleHealth's iTigr patient-engagement solution.

Fore!

Epson America Inc. now offers its M-Tracer™ golf swing analyzer through Epson.com, the Leadbetter Golf Academy and golf specialty retailers (MSRP of $299). The club-mounted golf swing analyzer is said to be lightweight and is designed to capture the golf swing at 1,000 samples per second, sending data to an iOS or Android smartphone in real-time via Bluetooth®. The system's built-in Inertial Measurement Unit derived from Epson's industrial sensors enables it to track and record the swing path of the club, club-head speed, club-head path and face angle at the time of impact, tempo and more. The M-Tracer smartphone app shows the golfer's full swing path in 3D, with the ability to rotate the view and compare one's swing against previously recorded swings or that of a pro-level golfer. The app also provides comprehensive graphical analysis of the impact zone, shaft rotation, club speed and swing tempo, and offers a built-in freeze frame option halfway-back and at-the-top positions. rep

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Make no bones about it. . .

. . .Healthy bones matter.

You may have missed National Osteoporosis Awareness & Prevention Month in May. But, healthy bones are something to celebrate for the rest of your life. Summer is a good time to help your accounts help their patients stay bone healthy as well.

Failing to maintain healthy bones – and avoid osteoporosis, or low bone mass and porous bones – can lead to breaks, particularly of the hip, spine and wrist. Not only are these serious complications of osteoporosis, they are expensive as well. Osteoporosis is responsible for 2 million broken bones and $19 billion in related costs every year, according to the National Osteoporosis Foundation. By 2025, experts predict the disease will be responsible for approximately 3 million fractures and $25.3 billion in costs each year.

Vitamin D improves calcium absorption into the body. Often people get adequate amounts of vitamin D from sunlight, but depending on where one lives, or if one regularly uses sunscreen, this is not necessarily true.

The facts about osteoporosis

Osteoporosis is a disease of the bones that occurs when one loses too much bone, makes too little bone, or both. As a result, the bones become weak and may break from a minor fall. In more serious cases, bones can break from simple actions, like sneezing or bumping into furniture. About 54 million Americans have osteoporosis and low bone mass, notes the National Osteoporosis Foundation. Studies suggest that approximately one in two women and up to one in four men age 50 and older will break a bone due to osteoporosis.

Some risk factors, such as the following, cannot be controlled:

- Being over age 50
- Being female
- Menopause
- Family history of osteoporosis
- Low body weight/being small and thin
- Broken bones or height loss

Other risk factors are controllable:

- Calcium or vitamin D deficiency
- Diet lacking in fruit and vegetables
- Diet high in protein, sodium and caffeine
- Inactive lifestyle
- Smoking
- Excessive alcohol consumption
- Weight loss

In addition, certain diseases and medications (e.g., too much thyroid hormone) can also increase one's risk of osteoporosis.

Preventing bone loss

Osteoporosis medications range from bisphosphonates to hormone-related therapy and other medications. Regular exercise, a calcium-rich diet and calcium supplements can also slow down bone mass loss. According to the Mayo Clinic, men and women between the ages of 18 and 50 need 1,000 milligrams of calcium a day. This daily amount increases to 1,200 milligrams when women turn 50 and men turn 70. The Institute of Medicine recommends that total calcium intake, from supplements and diet combined, should not exceed 2,000 milligrams daily for people older than 50.

Vitamin D improves calcium absorption into the body. Often people get adequate amounts of vitamin D from sunlight, but depending on where one lives, or if one regularly uses sunscreen, this is not necessarily true. While researchers have yet to determine the optimal daily dose of vitamin D, the general recommendation for adults is 600 to 800 international units (IU) daily, through food or supplements. If one's blood levels of vitamin D are low, the doctor may suggest higher doses. Teens and adults can safely take up to 4,000 international units (IU) a day.

In addition to improvements to one's diet and adding vitamins and supplements, exercise can be instrumental in helping build strong bones or slow bone loss.

Mayo recommends combining strength-training exercises with weight-bearing exercises. Strength training helps strengthen muscles and bones in the arms and upper spine, and weight-bearing exercises – such as walking, jogging, running, stair climbing, skipping rope, skiing and impact-producing sports – affect mainly the bones in the legs, hips and lower spine.

While low-impact exercises, such as swimming, cycling and exercising on machines such as elliptical trainers provide a good cardiovascular workout, they are not considered as helpful for improving bone health as weight-bearing exercises are.

As the weather continues to warm up, and people spend more time outdoors, there is greater opportunity for exercise. It's also a good time for distributor sales reps to remind their accounts to educate their patients about taking preventive steps now. rep

Medical distribution companies send aid to relief efforts in Nepal

Henry Schein Inc committed $500,000 in product donations to support relief efforts for victims of the earthquake in Nepal. In addition, the company has opened the Henry Schein Cares Nepal Disaster Relief Fund through the Henry Schein Cares Foundation. Contributions made to this fund will be applied directly and completely to support relief organizations' efforts. Henry Schein's medical donations will include more than two million surgical masks, a million pairs of gloves, and thousands of bandages. The company will also donate thousands of toothbrushes and toothpaste in response to a specific request for these hygiene products.

Medline Industries Inc, in partnership with Project C.U.R.E., has sent nearly 4,000 bottles of Sterillium surgical hand rub to healthcare workers in Kathmandu, Nepal to help workers care for the sick and vulnerable. Additionally, through the Medline Foundation, monetary assistance is being provided to Nepal via donations to UNICEF and the American Red Cross.

BD (Becton, Dickson and Company) is contributing $700,000 in cash and product donations to assist those affected by the earthquake in Nepal. BD's commitment will be shared among six of its trusted partners: AmeriCares, Direct Relief, Heart to Heart International, Project HOPE, Save the Children, and UNICEF. The commitment includes $50,000 in matching funds to match donations made by associates to AmeriCares and the U.S. Fund for UNICEF. Given its proximity to Nepal, AmeriCares India is playing a critical role to bring supplies, relief workers (including medical personnel and logistics experts) to Nepal and coordinate aid delivery. The agency is collaborating closely with BD India to provide emergency medical and primary care, ensure access to critical medicines and supplies and re-establish health services in impacted areas.

Midmark announces Jordan Gafford as sales representative


Jordan Gafford

Midmark Corporation recently announced Jordan Gafford as sales representative for its diagnostic product line. In his new role, Gafford will be responsible for working in the medical and healthcare sector with customers and distribution partners in Kentucky, Indiana and a portion of Illinois, providing sales support and service. He will report directly to Jeff Daner, regional sales manager. Gafford brings substantial sales experience from Cintas Corporation, and was most recently a sales representative for Midmark's animal health division, where he was awarded top growth performer in 2012. In this position, he successfully built relationships with distribution partners, initiating and closing capital equipment deals. He was also responsible for educating and training veterinarians on clinical and financial implementation of eight capital equipment lines.

FDA launches new website to track medical devices

The FDA launched its online Global Unique Device Identification Database, AccessGUDID, which allows consumers to track medical devices using unique identifiers through company-submitted information. The goal is for consumers, healthcare providers, and manufacturers to be able to identify and report side effects associated with a device. The website also aims to be an important resource when a recall is issued, hopefully allowing the issue to be handled more effectively. The FDA reports about 50,000 serious adverse events associated with medical devices each year, leading to roughly 3,000 deaths.

CMS launches star rating system for hospitals

CMS announced a star rating system for hospitals that is based on HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores. The patient experience ratings, in which a hospital earns anywhere from zero to five stars, come before an overall rating system expected to launch in 2016 that will be based on the full range of quality measures now published on the CMS Hospital Compare website. The hospital ratings will be updated quarterly. The first set of overall patient experience ratings are based on discharge data from July 2013 through June 2014. An official for the American Hospital Association (AHA) (Chicago, IL) stated that though star ratings could be an effective way to make quality information easier to understand, there is "a risk of oversimplifying the complexity of quality care or misinterpreting what is important to a particular patient."

MTMC, Pelstar / Health o meter® Professional Scales collaborate to establish Strategic Account Manager position

Nationwide sales organization, Med Tech / Med Care Associates (MTMC), and medical scale manufacturer, Pelstar LLC / Health o meter® Professional Scales, announced they are collaborating on a progressive sales strategy with the establishment of a Strategic Account Manager position at MTMC. The Strategic Account Manager will work closely with the MTMC and Health o meter® Professional Sales Teams to assist key accounts in the management of their supply chain activities. Working together on this new joint initiative allows end-users to take advantage of the highly skilled professional advisors at MTMC for the products and services of Health o meter Professional Scales and other MTMC product lines in a cost efficient and highly effective manner. To learn more about MTMC and Health o meter Professional Scales visit www.medtechassociates.com and www.homscales.com.


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By Randy Chittum, PhD

When Complexity Complicates Things

Moving forward when there is no simple solution to a problem

In the last column we dealt with uncertainty. In this column, we will tackle complexity. Let's start with what complexity means.

We might think of complexity as representing situations where there is no simple relationship between cause and effect. While our understanding of that relationship is often wrong, it is at least simple. When things become complex there are more variables than we can account for. This is different from uncertainty where an answer may be known but I don't know it.

The real dilemma for leaders is that even when things are complex (and uncertain for that matter) we are still expected to act, and achieve. How do we choose a path?

Ways forward

One way forward is to be clear about our values. Margaret Wheatley tells us that our values must be expressed in action. We have espoused values that are aspirational and "values-in-action" that are, in a sense our real values. Those values might be harder to uncover. The reason that values are powerful when dealing with complexity is that they provide a field around which we, and others, can self-organize.

Another way forward is to be clear about our vision as co-created by a team or an organization without being overly attached to outcomes. An outcome attachment may be too narrow to be effective in an ever-changing and complex world. Vision, on the other hand, lends itself to adaptation. Some of you in sales just fell out of your chairs laughing at the idea of no (or fewer) outcomes. I simply draw your attention to two things. First, not being attached to outcomes is not the same thing as not having them. This means that I can have them but shift or let go when they no longer make sense. Some of you are still laughing. One more thing then – consider that while we are overly focused on outcomes and targets we may well be missing the bigger opportunity.

In their new book "Simple Habits for Complex Times," Jennifer Garvey Berger and Keith Johnston offer a very useful distinction. They suggest that we can manage the probable or lead the possible. Of course we may find ourselves doing both, but ask yourself, where are you oriented? Do you live in the probable or the possible? Is your leadership life organized around analysis and prediction? Or is it organized around imagination and seeing more, and further?

My sense from talking to leaders every day is that we have plenty of people who are managing the probable. You can pick them out because they are often frustrated by how much things change. What we don't have is enough people imagining and creating. If you want to separate yourself and your organization, conduct a safe (Jennifer and Keith call this "safe to fail" as opposed to failsafe) experiment. You might just change the future instead of predicting it. rep

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