vol.23 no.11 • November 2015

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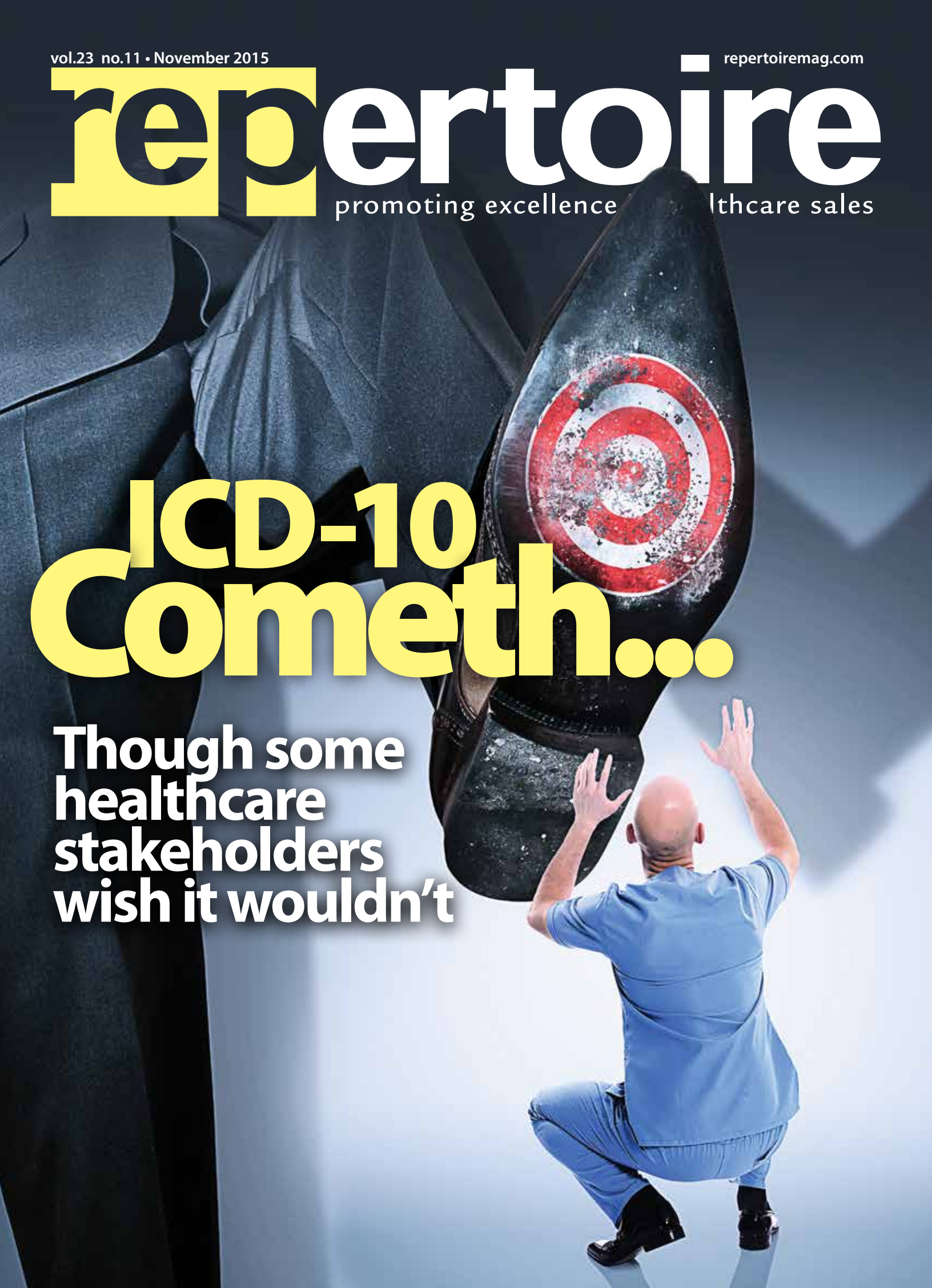

# ICD-10 Cometh...

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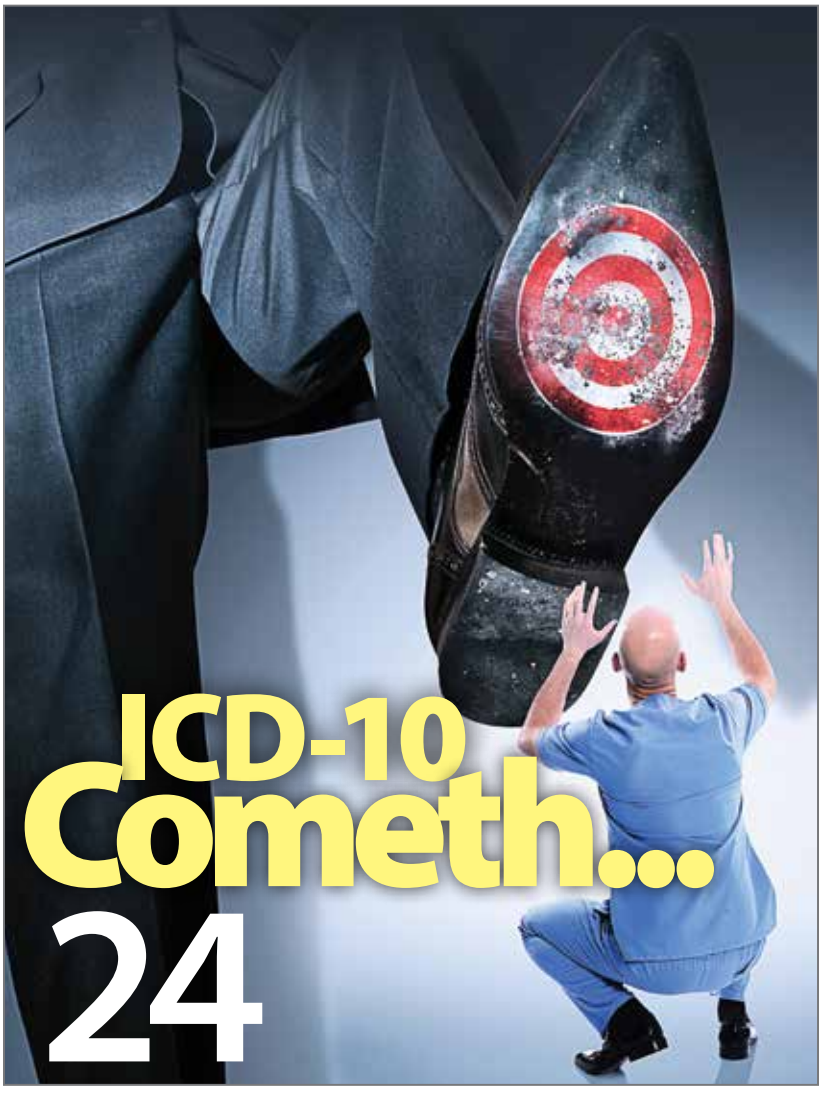

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**repertoire** magazine (ISSN 1520-7587) is published monthly by Medical Distribution Solutions Inc., 1735 N. Brown Rd. Ste. 140, Lawrenceville, GA 30043-8153.  Subscriptions: $49.00 per year for individuals; issues are sent free of charge to dealer representatives. If you would like to subscribe or notify us of address changes, please contact us at the above numbers or address. POSTMASTER: Send address changes to Repertoire, 1735 N. Brown Rd. Ste. 140, Lawrenceville, GA 30043-8153. **Please note:** The acceptance of advertising or products mentioned by contributing authors does not constitute endorsement by the publisher. Publisher cannot accept responsibility for the correctness of an opinion expressed by contributing authors. Periodicals Postage Paid at Lawrenceville, GA and at additional mailing offices.

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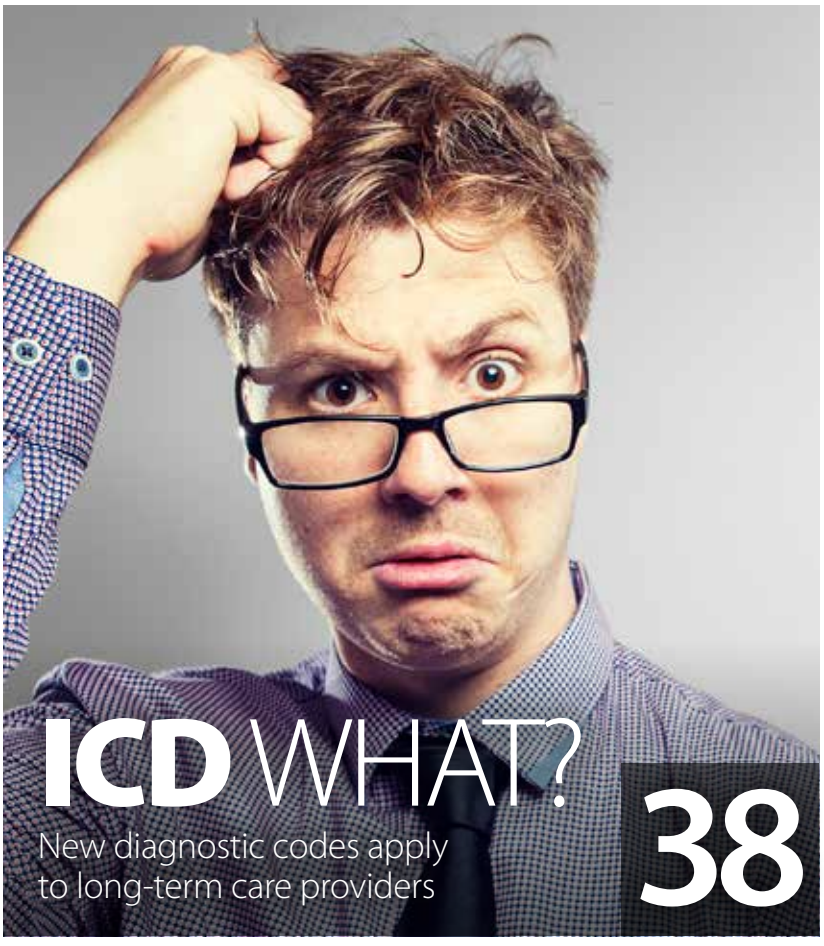
NOVEMBER 2015 • VOLUME 23 • ISSUE 11



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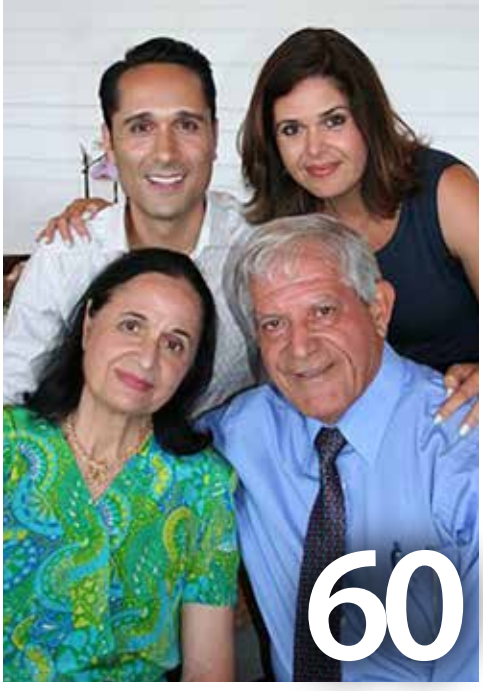


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1. Infusion Nurses Society (2011) Infusion Nursing Standards of Practice. Journal of Infusion Nursing Supplement, Vol. 34, no. 15, Std. 22, Practice criteria F.
2. Tosini, et al "Needlestick Injury Rates According to Different Types of Safety-Engineered Devices: Results of a French Multicenter Study", Infection Control and Hospital Epidemiology, Vol 31, No. 4, April 2010 (p. 402-407).

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# Your Customers Need You


Scott Adams

**For the past 12 months I** have been writing the Publisher's Letter for *Repertoire*. Every time I sit down to write, I think of when I asked *Repertoire* Co-Founder Brian Taylor how he wrote his letters to the many different audiences that read our magazine. His response was short and simple. "Scotty, I think of a rep that I know and I write the letter to him." It was great advice a year ago and great advice today.

When we were discussing topics and what our overriding message would be for 2015, we landed on the importance of the distribution salesperson. For the last 12 months, we have tried to keep you and what you do in the forefront of each issue.

In the November issue last year, I thanked you for what you do for our industry. What makes most of the industry work from upstream at the manufacturer level to downstream with the provider flows directly through your relationships. Your customers need you and trust you, and so do your manufacturing partners.

In this month's cover story, Mark Thill writes about one of the biggest changes to come along to providers in the past five years, ICD-10. I cannot think of a better example of your customers needing you to help them through this trying time. These changes will impact their revenue, ability to pay their staff, and keep their doors open. While this doesn't line up with selling a product directly, it lines up with them trusting you. I often get asked if I believe the distribution salesperson is as important today as five years ago. This month's cover story reinforces your importance. The providers need you more today than ever before.

Please take the time to read Mark's article and understand the ramifications of these changes on your customers, so you can help them through the next 12 months as they transition. These changes and trials affecting your customers provide the best opportunity for you to entrench your relationship with them.

Similar to last year, thank you to each of the manufacturers who support distribution by advertising in the pages of *Repertoire*. If it were not for you, this magazine would not exist. Thank you to each of the distributor reps for all you do day in and day out. Last but not least, thank you Mark and Laura Thill, Graham Garrison, Brent Cashman, Laura Gantert, Micah McGlinchey, and Katie Brunelle for all the behind-the-scenes work you do to produce this publication each month.

Happy Thanksgiving!

Dedicated to Distribution
***R. Scott Adams***

**PS:** Starting in 2016 we will launch *Repertoire* Post-Acute. This publication will be for reps calling on LTC, extended care, rehab facilities, telemedicine, home health, and DME.

**repertoire** is published monthly by **mdsi** 1735 N. Brown Rd., Suite 140, Lawrenceville, GA 30043, Phone: (800) 536-5312, FAX: (770) 709-5432; e-mail: info@mdsi.org; www.medicaldistribution.com

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# Owens & Minor celebrates a commitment to diversity at its 10th Annual Healthcare Supplier Diversity Symposium

By Rachel Cimino McCue

**More than 150 participants gathered in Richmond, Va., in** September to celebrate a decade of commitment to supplier diversity at the 10th Annual Healthcare Supplier Diversity Symposium (HSDS), hosted by Owens & Minor, Inc.

"Activate! Growth, Relationships and Change" was the theme of this year's symposium, as Owens & Minor, along with co-hosts, sponsors, and guests, celebrated a long-term commitment to improving and expanding supplier diversity in the healthcare marketplace. For the past 10 years, the Healthcare Supplier Diversity Symposium has assembled healthcare professionals representing minority-, women-, and veteran-owned enterprises (MWVBEs), as well as major healthcare providers, distributors, and industry-leading manufacturers.


Derreck Kayongo, co-founder of the Global Soap Project, and Tonnice Charles, Director, Category Management, and the organizer of this year's event. An inaugural golf tournament raised $5,000 for the Global Soap Project.

This year, symposium participants heard from a variety of subject-matter experts, including the 21st U.S. Secretary of Health and Human Services Kathleen Sebelius, who shared insights gained from leading the successful charge of President Obama's Affordable Care Act. "Where America stands globally depends on how we manage our costs and how we improve health results," Sebelius said. "The law that gets everyone into the system is helpful, but it's just a platform. Now we must pay attention to what happens once they're there. The attention needs to be given to quality."

Sebelius addressed the opportunities that opened up for small businesses after the Affordable Care Act was signed into law over five years ago. She encouraged business owners to look to technology as a means of improving their offerings to ultimately enhance the quality of care that each patient receives.

Derreck Kayongo, co-founder of the Global Soap Project, spoke about activating change, encouraging the audience to share their good fortune with others. Building on his story that began when he was a child refugee in Kenya, Kayongo told the audience how he co-founded The Global Soap Project, a non-profit organization that donates bars of repurposed hotel soap to vulnerable populations around the world.

"In activating change, you have to pay attention to events around you," he said. "What is new? What is changing? How do you do business responsibly while still making money?" Owens & Minor donated proceeds totaling $5,000 from an inaugural golf tournament to Global Soap.

## Angela Wilkes recognized

A highlight of this year's Symposium was the presentation of the annual Earl G. Reubel Award, which Owens & Minor established to honor the life and legacy of the late Earl G. Reubel, co-founder of Virginia-based Kerma Medical Products, Inc. The 2015 recipient – Angela T. Wilkes of

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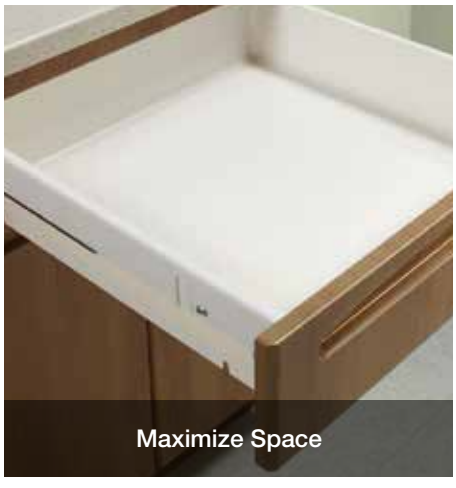

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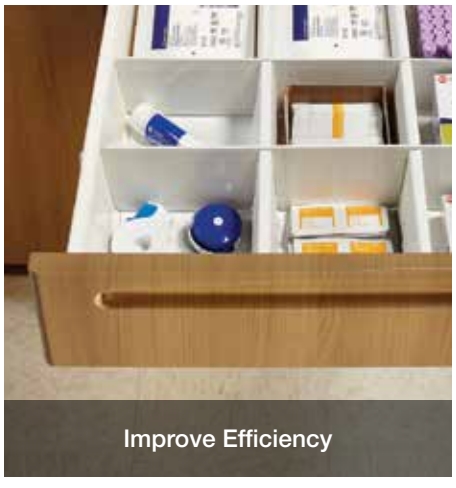
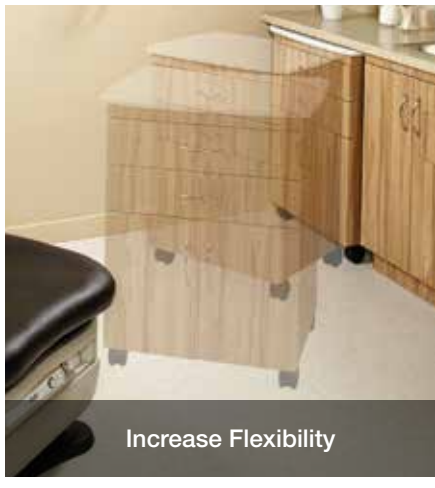


Improve Efficiency



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Angela T. Wilkes and Associates – spearheaded the supplier diversity efforts at Owens & Minor for 14 years, establishing the Symposium in 2005 and acting as its driving force until 2014. Following Wilkes's recent retirement, Dr. Dannellia Green was named director of supplier diversity. G. Gilmer Minor, III, chairman emeritus of Owens & Minor, presented Wilkes with the award.

"There is no point in trying to put Angela in a box," said Minor. "She defined diversity at Owens & Minor and was a champion for diversity in our industry. It is an honor to present the award to her, as she was always doing things right and, at the same time, doing the right things."

**(L to r): G. Gilmer Minor, III, chairman emeritus of Owens & Minor; Joe Reubel, president of Kerma Medical; Angela Wilkes, president of A.T. Wilkes and Associates, and recipient of the 2015 Earl G. Reubel Award for Supplier Diversity; Andrea Reubel-Walker, director of marketing and national key accounts, Kerma Medical; Derreck Kayongo, co-founder of the Global Soap Project.**


**Marty Maarter, Owens & Minor's Director of Strategic Supplier Programs presents a $5,000 check to Derreck Kayongo, co-founder of the Global Soap Project, at the 10th Annual Healthcare Supplier Diversity Symposium, hosted by Owens & Minor.**

Over the two days, guests were engaged in a number of panels and workshops featuring Owens & Minor President & CEO P. Cody Phipps, President of McKesson Medical-Surgical Stanton McComb, and President of the Health Industry Distributors Association Matthew Rowan, along with senior leadership from DuPont and National Minority Supplier Development Council, Inc.®

This ten-year milestone for the Healthcare Supplier Diversity Symposium was reached with the support and dedication of Owens & Minor and the assistance of Carolinas-Virginia Minority Supplier Development Council, the Healthcare Supplier Diversity Alliance, and the National Association of Health Services Executives.

More than 25 major corporate sponsors contributed to the success of the event, including VCU Health Medical and

**Angela Wilkes, president of A.T. Wilkes and Associates, with G. Gilmer Minor, III, chairman emeritus of Owens & Minor**

B. Braun Medical, Inc. Other corporate supporters included: Amerinet, Becton Dickinson and Company, Dell Computer, Medtronic, Kerma Medical Products, Inc., SourceMark, LLC, and the Healthcare Supplier Diversity Alliance.

"At Owens & Minor, we serve healthcare markets that are highly diverse," said Phipps. "In a quest to do that well, we provide energetic support for diversity in the healthcare supply chain. We are committed to expanding opportunities, making connections, and driving innovation in healthcare – and that takes people from various backgrounds with diverse perspectives. As our market evolves, we are determined to tap the best partners, teammates, and ideas so that we thrive in a complex and changing market." rep

Rachel Cimino McCue is communications specialist at Owens & Minor.


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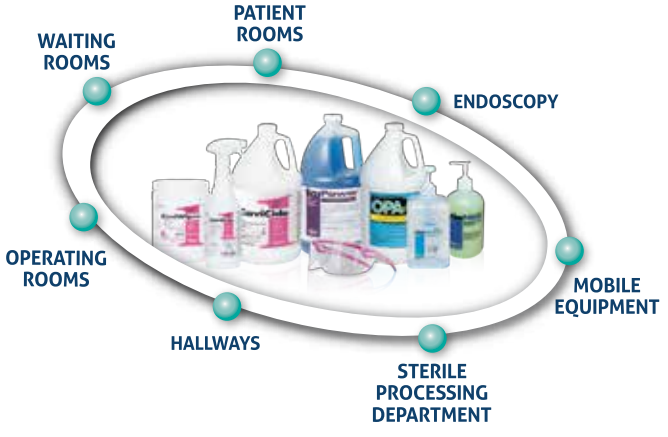


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# Something New at HIDA

## Innovation at the forefront of HIDA's 2015 Streamlining Healthcare Conference

**The Health Industry Distributors Association launched** three Innovation Pavilions at the HIDA 2015 Streamlining Healthcare Conference in Dallas, Texas, this fall. Located on the trade show floor, the pavilions offered product knowledge and information from manufacturers in the infection prevention, home care, and skin/wound care markets. Each pavilion seated 30 people, and product specialists from companies such as PDI Inc., SCA Americas, DUKAL and others mixed live demos with quick presentations and Q&A sessions. AMS Sales Training Program reps could earn up to three AMS points for attending.

The HIDA conference attracted 1,100 distributor, manufacturer, GPO and provider attendees, representing 269 individual organizations. More than 2,100 business partner meetings were conducted.

At the conference, HIDA hosted a new interactive workshop for sales professionals. Titled "The Committed Relationship: Building Stronger Manufacturer-Distributor Partnerships," the workshop offered tips from manufacturer executives and leading reps on ways to get more sales support from trading partners. The panel discussion and Q&A forum attracted more than 125 people.

Todd Ross


HIDA repeated the Small Business Roundtable for independent distributor owners. This year's topics included profit improvement, cutting costs out of operations, and restructuring sales forces. In addition, the association held its Contract Administration Workshop, which is tied to HIDA's Pricing Accuracy Initiative. Discussion topics included standardizing contract communications and improving customer identification accuracy.

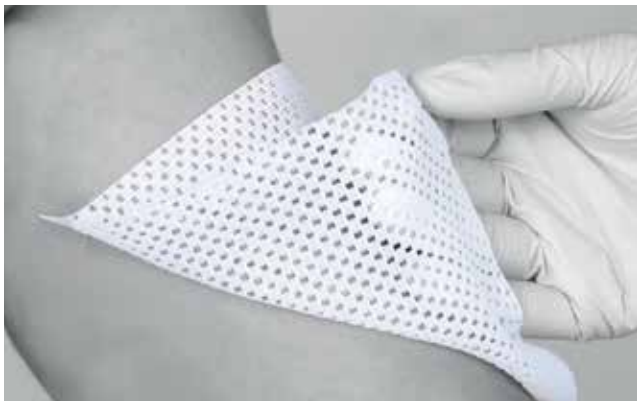
The association also brought back its Distributor Expo, which gives exhibitors and attendees an opportunity to meet with key distributor executives. Almost 40 companies participated this year, and HIDA plans to reprise the Expo next year.

Todd Ross, Preferred Medical, was announced as HIDA's 2016 Board of Directors chairman, effective Jan. 1. Mark Zacur, Fisher HealthCare, remains chairman through 2015.

"The 2015 HIDA Streamlining Healthcare Conference highlighted the value of distribution and reinforced the importance of in-person meetings," said HIDA President and CEO Matthew Rowan. "This year's turnout and caliber of attendees who exhibited, came to our expos, and interacted with trading partners was better than ever. Our members love the strategic networking and education this event provides and all of our meeting spaces sold out."

HIDA 2016 Streamlining Healthcare will take place Sept. 27-29 at the Hyatt Regency O'Hare in Chicago.

# Innovative Wound Care Solutions



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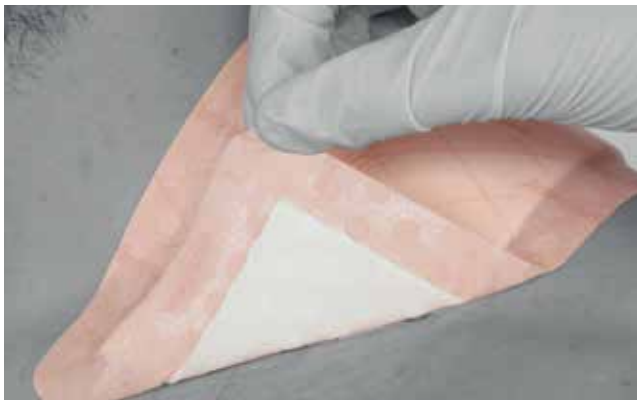

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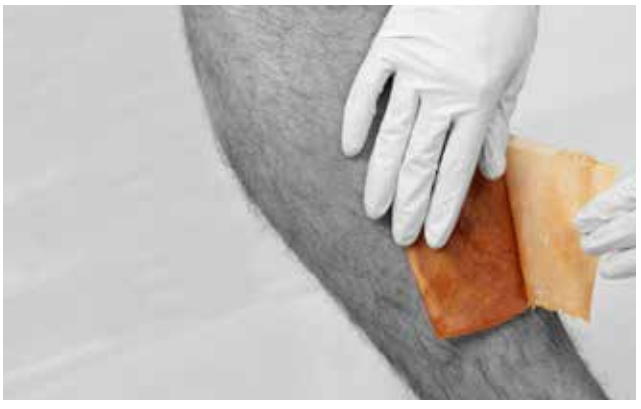

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# Manufacturer and distributor reps: Committed to each other

**Some takeaways from "The Committed Relationship:** Building Stronger Manufacturer-Distributor Partnerships," a workshop at the HIDA 2015 Streamlining Conference.

- The best manufacturer reps are those who communicate with distributors and know their world, e.g., inventory carrying costs and total price disclosure (including freight costs) from an operations standpoint. Manufacturers also need to talk pricing with distributors before engaging customers; pre-call planning is a must.
- Both sides agreed there's a fine balance between being engaging and annoying. A hundred emails or 20 calls per week aren't going to get anyone's attention and will turn them off.
- Distributor reps are guided by decisions, i.e., directives made in corporate offices. This topic should always be covered in any pre-call conversation between manufacturers and distributors.
- There's greater opportunity for manufacturer reps to assert themselves in the non-acute space, since these customers come to distributors for product suggestions and recommendations more often.
- One of the best ways to get a distributor rep's attention is to not just bring them leads, but to bring them quality leads.
- A good manufacturer rep's goal should be to multiply his or her knowledge base among distributor partners and get them all speaking the same language about products. Some suggested ways to do this are through webinars, email blasts, teleconferencing, formal training sessions, or even informal breakfast clubs with groups of reps to pool knowledge.
- To gain credibility, the manufacturer rep's authenticity is more important than his or her authority. Manufacturers should spend time on their company's value-adds and clinical education, since this should help show why or how their company's product is aligned with distributor interests and goals, and should lead to building more business.

**Source:** Health Industry Distributors Association

# Market reports

**The Health Industry Distributors Association released** its most recent market reports for the acute care, extended care and physician office markets.

"I am especially pleased with the way our Market Reports came together this year," said Gina M. Smith, CMRP, HIDA's director of healthcare research and analytics. "We tried to organize the content to make the markets and their various sub-markets easy to understand for the novice, while still bringing depth and original content to all audiences."

## Some highlights:

- The 2015 Acute Care Market Report shows that from 2013 to 2014, parenteral products led the top five acute-care categories (in dollar sales) in greatest year-over-year market share growth at 11.33 percent. For the third year in a row, all top five product categories by reported dollar sales – parenteral; kits, packs, and trays; wound staples and sutures; respiratory; and gloves – remained the same.
- The 2015 Extended Care Market Report discusses key trends and opportunities facing the long-term care market, such as the significant growth in home care product sales and the number of home health agencies, said Smith. The report includes original HIDA survey research of skilled nursing facility administrators, who report their spending for incontinence products is roughly double that of any other supply category.
- The 2015 Physician Office Market Report provides a snapshot of more than a dozen key topics affecting physicians. The number of retail clinics has grown by more than sevenfold since 2007, for example, and the increasing effects of consumerism on healthcare will continue to make these sites viable competitors to traditional providers.

For more information on the market reports, contact Gina Smith at 703-838-6116 or gsmith@hida.org

# Yates Farris honored at HIDA

**Yates Farris, vice president, primary care markets,** IMCO, received the 2015 John F. Sasen Leadership Award at the 2015 HIDA Streamlining Healthcare Conference in Dallas. The award recognizes exceptional individuals who demonstrate leadership qualities, commitment, and service to the healthcare products distribution industry.

Born in Charlotte, N.C., and raised in Bessemer City, N.C., Farris joined Winchester Surgical Supply in Charlotte in 1964. After 17 years in the field, he was Winchester's sales manager/vice president when the company was sold to PSS in 1995. He joined IMCO that same year.

Yates Farris (center) accepts 2015 John F. Sasen Leadership Award from HIDA Senior Vice President Elizabeth Hilla and HIDA President & CEO Matthew Rowan

"Yates is the embodiment of leadership excellence," said HIDA President and CEO Matthew J. Rowan. "HIDA is proud to recognize his more than 50 years of service and commitment to distribution with this award."

Farris has been a member of HIDA's Physician Advisory Council since 2001, serving as chairman for three years. In 2013, he was awarded the Professional Women in Healthcare's Jana Quinn Inspirational Award, presented annually to healthcare professionals who excel in their career as well as life. In 2014, Farris was inducted into MDSI's Medical Distribution Hall of Fame, which recognizes outstanding individuals who have played a key role in bringing the industry to where it is today.

The award is named after the late John Sasen, whose healthcare career spanned more than 40 years, beginning with Clay Adams, a division of BD. Sasen joined PSS founder Pat Kelly at PSS in 1989 and ultimately became executive vice president and chief marketing officer of PSS World Medical. He died in 2013, just as he was preparing to meld the marketing efforts of PSS with those of McKesson Medical-Surgical, which acquired PSS in February 2013. rep

# **Sam Robb:** True inspiration

**Sam Robb, director of customer development for SCA** Personal Care, was awarded the Professional Women in Healthcare's Jana Quinn Inspirational Award at the HIDA 2015 Streamlining Healthcare Conference in Dallas, Texas. Robb is the seventh recipient of the award, named after Jana Quinn, a marketing manager in distribution and manufacturing, who died of cancer in 2007.

"Every year, PWH celebrates the memory of one of our founders, Jana Quinn, by recognizing someone in our industry – woman or man – who inspires us and leads by example," said Heather Llorca-Kropp, chairperson of PWH and vice president of marketing communications and channel management, DUKAL Corp., in her remarks at the award ceremony. "We received many good nominations, but one person clearly stood out. The comments from co-workers and industry colleagues not only touched on his inspirational qualities, but spotlighted his passion for the great industry we serve."

A graduate of Saint Joseph's University in Philadelphia with a bachelor's degree in accounting, Robb has worked in the medical/surgical, janitorial, paper, industrial food service, office products and wholesale distribution industries for more than 30 years. From 1981 to 2004, he worked for Kimberly-Clark Professional and Kimberly-Clark Health Care as executive director of health care and then healthcare national accounts. In 2004, he joined Georgia-Pacific as vice president of distribution, a position he held for three years. He operated a consulting company, The Robb Group, prior to joining SCA Personal Care in 2014. He currently sits on the board of HIDA.


Sam Robb

"The comments from co-workers and industry colleagues not only touched on his inspirational qualities, but spotlighted his passion for the great industry we serve."

## Passion for the industry

Citing several nominations for Robb, Llorca-Kropp said, "One person illustrates it this way: In any industry, you can find two types of people – those who complete the task of the day, and those who have a true passion for the product, the people, the competition and the community of people who make up the broader scope.

"[Sam] has been successful because he embodies the latter," she said. "He is a strong supporter of distribution as a business strategy for manufacturers. He values the importance of partnership and is committed to finding resourceful ways to provide solutions to customers' pain points."

Llorca-Kropp quoted another nominator: "He was the best boss I ever had, but now he has moved to a best friend. He is a great mentor. When he identified a weakness or an incident where I did something wrong, he approached me in a way that allowed me to understand and change. He simply asked me to take a step back, look at what I was doing, and think about the outcome."

And, just as was Jana Quinn, Robb is well-known in the healthcare industry, she continued. "Sam is a character," said one nominator. "When you attend a tradeshow and share the company you are with, you inevitably get asked the question, 'Oh, do you know Sam?!"

### Passion for life

Jana Quinn was a family person, who showed courage, grace and love of family and friends before and during her battle with cancer, said Llorca-Kropp. "She was an inspiration to others." Like her, Robb is a family person who also understands personal struggles.

"His only son, Sam, was diagnosed with bone cancer at the tender age of 16. He was a budding athlete, excelling at basketball, football and baseball. He endured multiple surgeries, months of chemotherapy and tragically, at 20 years old, died during a surgery to remove a tumor that had emerged on his lung. He is gone but will never be forgotten. His mantra, 'Fightin' Till the Last Breath,' lives on in all who knew him."

Said one nominator, "His internal sorrow did not make him bitter, but instead developed into an understanding that presents itself as an outward pouring of kindness and sensitivity to others."

Following his son's death, Robb created the Sam Robb Fund, to support the Sam Robb Fellow at the Aflac Cancer Center and Blood Disorders Services of Children's Healthcare of Atlanta and Emory University of School of Medicine. Funds also are used to support Open Arms, a program through which CURE Childhood Cancer staff and volunteers provide and serve meals to hospitalized childhood cancer patients and their families.

"Sam Robb is a true inspiration," said Llorca-Kropp. rep

## Past recipients of Jana Quinn Inspirational Award

**2015:** Sam Robb, SCA Personal Care

**2014:** Colleen Stern, NDC

**2013:** Alex Caldwell, The Claflin Company

**2012:** Yates Farris, Independent Medical Co-Op

**2011:** Jackie Jones, NDC

**2010:** Anne Eiting-Klamar, Midmark Corp.

**2009:** John Moran, Welch Allyn

By Elizabeth Hilla

# Distributor Sales Strategies from HIDA

## How to get ahead of customer price objections

**Last month, this column talked about the time and** money healthcare providers may be wasting when they shop for medical supply or equipment discounts on their own. Let's face it: a top priority for anyone is to save money, but this can easily cloud your customer's better judgment if they are only focusing on price and don't consider the total value you provide as a service solutions partner.

No amount of convincing will ever completely remove the fact that your customers have the freedom to price shop any time they want. But there are proactive steps you can take to limit the allure of discount-seeking and help you answer potential price objections before they're even raised.

Put in the time beforehand and compare your prices to competitors' to gain a better understanding of the market.

- **Embrace objections:** Savvy customers should always question your prices, so you must be prepared to demonstrate your value proposition at any given time. It's okay to agree with these objections, but then immediately follow that up with justification for why your services may cost more than a lower-priced option. Chances are, your customer isn't thinking about all of the factors that can influence a product's total cost to them – equipment assembly, item pre-sorting, product education, shipping costs and coordination – and may need a quick reminder that their time, and their employees' time, is much more valuable than any savings they can gain on item price alone.

- **Do your homework:** During a product demonstration, have you ever had a customer ask, "Didn't I just see that for $500 less on the Internet?" If you don't have a good grasp of the environment in which you sell, you may find yourself coming up short when trying to answer these types of questions. Put in the time beforehand and compare your prices to competitors' to gain a better understanding of the market. A prepared sales rep will be able to respond to these objections quickly but confidently, demonstrating product expertise and customer value.

- **Know your customer, know yourself:** Just as no two providers are the same, no two distributors are alike. Don't assume your customer knows everything about your organization and the services you provide, especially if they weren't involved in the original or subsequent negotiations between your company and theirs. Your customer may take for granted that all medical products come prepackaged regardless of supplier, for example, or you may presume they're already well aware of the total value you provide over others when, in fact, they're not. Sometimes clarifying these facts just once with a customer is enough to assure them that they've made the right business partner choice.

No matter what you do or say, your customers will always want to look for a better deal. But if you proactively work with them to address their concerns before they start shopping elsewhere, you will soon find your customers chasing discounts less often. rep

# **HIDA Health** Reform Update

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

### Long awaited proposed lab rule prohibits most from reporting

In late September, the Centers for Medicare & Medicaid Services (CMS) released the annual Clinical Laboratory Fee Schedule (CLFS) proposed rule, which provides the first glimpse into the agency's thinking on what labs should report private payer data to CMS. Per the Protecting Access to Medicare Act of 2014 (PAMA), CMS is required to collect private payer data in 2016 and use it to reset Medicare payments in 2017.

However, in its proposed rule, CMS defines applicable laboratories – those that must report private payer data – as facilities that are paid $50,000 per year or more on the CLFS. By establishing the $50,000 per year payment threshold, CMS expects most, if not all, hospital labs to be excluded from the "applicable laboratory" designation. More than 90 percent of physician offices and more than 50 percent of independent labs will also be omitted from reporting private payment data based on the low expenditure measure.

Initial reaction from the industry has been one of concern as prohibiting the majority of labs from reporting will not provide accurate data from across the market. CMS will be using this data to update Medicare reimbursement rates for the CLFS that take effect in 2017 and are expected to result in significant cuts for your customers.

"So who is going to report this data, and will it be actually representative of the market?" you may be asking yourself. CMS has justified its proposal, estimating that the applicable independent labs required to submit private payer data in 2016 (less than 50 percent of the market) account for more than 99 percent – nearly all – of CLFS independent lab spending. Those figures are slightly lower for applicable physicians and physician office labs (less than 10 percent of the market), which are estimated to account for approximately 96 percent of CLFS spending for this sector. Several blood tests often conducted in a physician's office are paid under the CLFS – such as lipid panels to check cholesterol levels – so prohibiting these labs from reporting could carry unforeseen ramifications.

Medicare pays approximately $8 billion per year for clinical diagnostic laboratory test (CLDT) reimbursement under the CLFS. Under PAMA, test reimbursement amounts cannot drop more than 10 percent compared to the previous year's payment amount from 2017 to 2019, and cannot drop more than 15 percent for the subsequent three years through 2022.

More than 90 percent of physician offices and more than 50 percent of independent labs will also be omitted from reporting private payment data based on the low expenditure measure.

If you would like more information on the CLFS proposed rule, I invite you to visit HIDA's Government Affairs page at www.HIDA.org, where we summarize the rule's major policy and customer impacts. As always, you can also contact us at HIDAGovAffairs@hida.org with additional questions. rep

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# **Contracting** Executive Profile

## Ed Hardin, System vice president, CHRISTUS Health

**In December 2011, Ed Hardin left his position at ROi, a** subsidiary of Mercy (St. Louis, Mo.), and joined CHRISTUS Health as system vice president. His supply chain management responsibilities include all supplies and drug spend, as well as approximately 60 percent of purchased services spend.

***Repertoire:*** **What has been the most challenging and rewarding project you have been involved in recently?**

**Ed Hardin:** I have been focused on the development of our Vendor Relationship Management (VRM) strategy, including the formation of our Partner Advisory Council (PAC), which serves as the most visible and unique piece of our VRM strategy. The PAC is a group complemented by 25 of CHRISTUS Health's most strategic vendors. Each of these vendors must dedicate a single individual – ideally, an executive with little to no transactional responsibilities – to CHRISTUS Health, and meet with CHRISTUS Health on a quarterly basis. At its inception, the PAC was the only group like it in the industry, and there was initially a lot of skepticism whether it would drive value for CHRISTUS Health. However, we are in our third year, and the PAC has become wildly successful due to the many incredible individuals who saw the value of collaboration and committed their time, energy and thought leadership to make happen. Today, the PAC remains unique to the industry, but it's a part of who CHRISTUS Health is; because of that, it is changing how the industry approaches VRM.

**CHRISTUS Health consists of more than 60 acute care and non-acute care sites across U.S. and Latin American operations, including Texas, Louisiana, New Mexico, Mexico, and Chile; 4,500 beds; $1.3 billion in supplies, drugs and purchased services; spend is managed by CHRISTUS Health supply chain management.**

***Repertoire:*** **Please describe a project you look forward to implementing in the next year or two.**

**Hardin:** We are taking our Partner Advisory Council international. Beginning in August, we will introduce qualified PAC members to our Latin American facilities, [and see whether they are ready] to do business in Latin America. We plan to use the PAC concept as a way to truly integrate our supply chain, including standardizing the use of the same products and services.

***Repertoire:*** **What is the most important quality you look for in a supplier partner?**

**Hardin:** We are interested in such qualities as capacity and willingness to collaborate on unique and high-value solutions. In addition, we look for trust, time commitment, and consistency with our faith-based values.

***Repertoire:*** **What is the greatest change we can expect to see in healthcare contracting in the next five years?**

**Hardin:** We are going to see a level of objective rigor in how we evaluate vendor performance to the extent that vendor performance – through key performance indicators – will become an everyday component of our terms and conditions. We will make decisions to continue working with vendors based upon objective data that can be readily pulled and replicated. In select areas, we will do more risk-based arrangements because of our ability to evaluate vendor performance. rep

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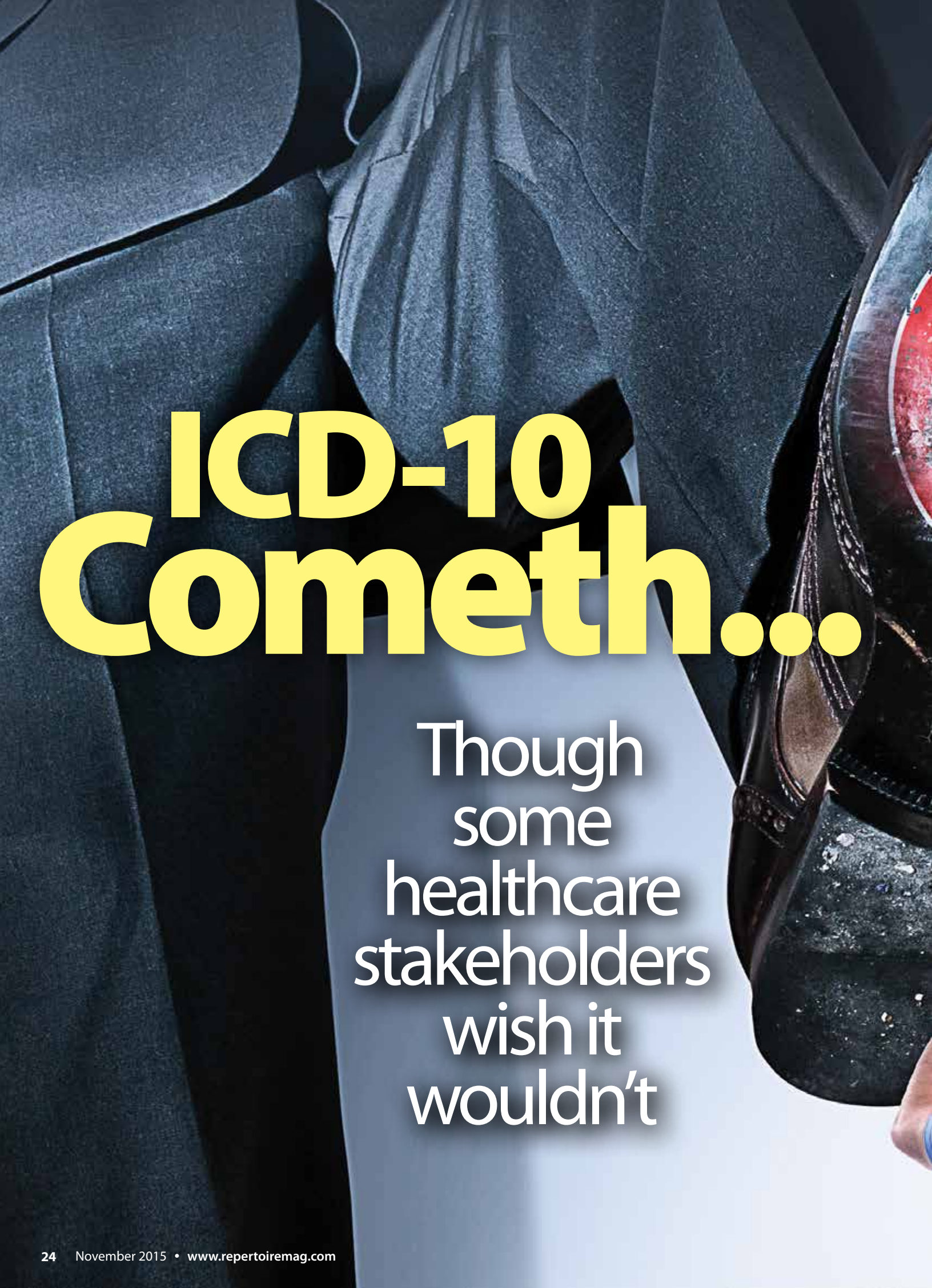


# ICD-10 Cometh...

## Though some healthcare stakeholders wish it wouldn't

As physicians, hospitals, skilled nursing facilities and others faced the Oct. 1 deadline to implement ICD-10 diagnosis codes, many questions remained:

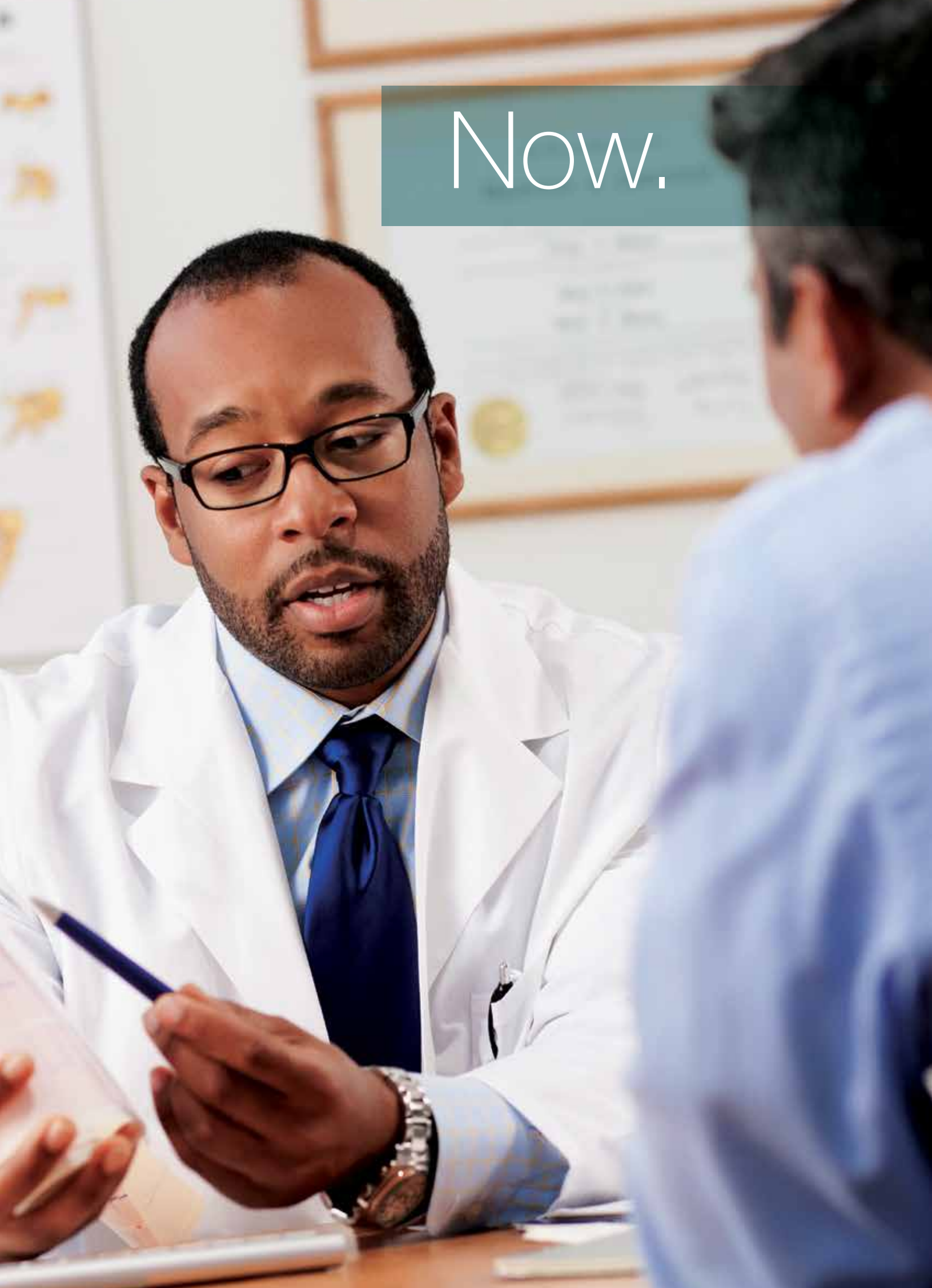
- How difficult will the transition be?
- How tough will payers be in expecting correct coding?
- As a provider, am I going to miss claims? What will that do to cash flow?
- As a distributor, am I facing extended terms and accounts receivable issues?
- Can someone remind me why we're doing this anyway?

After years of delay, the deadline for providers to implement ICD-10 codes finally arrived on Oct. 1. By that date, all providers affected by the Health Insurance Portability Accountability Act (HIPAA) were to have begun providing claims with ICD-10 diagnosis codes. (The change to ICD-10 will not affect CPT coding for outpatient procedures.)

"The International Classification of Diseases, or ICD, is used to standardize codes for medical conditions, diagnoses, and institutional procedures and has not been updated in this country for more than 35 years," wrote Andrew M. Slavitt, acting administrator for the Centers for Medicare & Medicaid Services, in a letter to Medicare providers in July.

"The current code set, ICD-9, contains outdated, obsolete terms that are inconsistent with current medical practice," he wrote. "As we work to modernize our nation's health care infrastructure, the coming implementation of ICD-10 will set the stage for improved patient care and public health surveillance across the country, leading to better identification of illnesses and earlier warning signs of epidemics and pandemics, such as Ebola. Over time, ICD-10 will improve coordination of a patient's care across providers, advance public health research and emergency response through detection of disease and adverse drug events, support innovative payment models that drive quality of care, and enhance fraud detection efforts."

Sounds good. Here's the rub: Whereas ICD-9 had about 13,000 codes, ICD-10 has about 69,000. It's all in the name of granularity.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# ICD-10 Cometh...

For example, ICD-9 offers up to six codes for a sprained ankle; ICD-10 is said to accommodate more than 70. It does so by expanding the number of diagnosis codes from five digits to seven. This expansion of codes doesn't reflect the emergence of new diseases or injuries so much as more specificity. For example, the new codes accommodate laterality. So, instead of indicating merely "sprained ankle," providers must specify which ankle was affected.

"Epidemiologists ran amok with the coding system," says coding consultant, author and speaker Betsy Nicoletti, MS, CPC. "Does it really matter which joint the patient has gout in – whether it's the elbow, shoulder or toe? Does that advance population health? Do we really need to know if a patient has an ear infection in the right ear, left, or both?

"Maybe hospitals will like it. Maybe the epidemiologists will too. But it won't do one thing for physician practices, except slow them down. But if they want to get reimbursed, they have to do it."

> "Does it really matter which joint the patient has gout in – whether it's the elbow, shoulder or toe?"
>
> **– Betsy Nicoletti**

Greg Dean, vice president, technology partners, McKesson Medical-Surgical, has a different perspective.

"I believe the conversion from ICD-9 to ICD-10 is a very positive step," he says. "Although ICD-10 might cause temporary growing pains as the market implements it, in my opinion, the overall outcome is positive. ICD-10 will increase specificity, which in turn provides more detail, and this can help to improve patient care and outcomes. Additionally, ICD-10 could benefit medical research, improve performance, create efficiencies, aid in policy-making, and help in creating new pay-for-performance programs. The increase in detail and specificity can provide more insight for the future of healthcare."

## Why are we doing this?

Even some physician groups voiced support for ICD-10.

"After the initial growing pains, physicians and support staff will be able to communicate easily regarding the specificity of diagnosis and corresponding orders," says Barbie Hays, ICD-10 certified trainer and coding and compliance strategist, American Academy of Family Physicians. "For example, a classic physician order for a sprained ankle may be an X-ray. If the physician forgets to determine right or left in the order, the technician had to stop the test and query the physician. However, with ICD-10-CM, laterality is built into the code – S93.402A."

Others are not as convinced.

"Generally, I feel the costs and risks associated with the transition to ICD-10 at this juncture are ill-advised," says Tom Schwieterman, MD, medical director, Midmark Corp. "The regulatory and compliance complexity already created by Meaningful Use, the [Physician Quality Reporting Initiative, or PQRI], integration of private practices into larger systems, and advancing requirements related to emerging value-based reimbursement has overwhelmed change management initiatives. ICD-10 should be delayed until the dust has settled from previously mandated initiatives."

Robert Tennant, director, health information technology, Medical Group Management Association, points to one of the greatest myths surrounding ICD-10, "We're the last country on earth to convert to ICD-10." Woe is us.

"That's completely false."

The World Health Organization created a baseline set of standards for ICD-10 that called for about 12,000 codes, he explains. Each country is free to modify that set as it wishes. German healthcare providers, for example, use about 13,000 codes. Canada, about 20,000; and if one considers only Canadian physicians and not hospitals, it goes down to about 600 codes. The U.S. version, however, calls for about 69,000 codes. "They took the foundation set and significantly expanded it," says Tennant. U.S.

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# ICD-10 Cometh...

physicians are also reimbursed based on a combination of these diagnosis codes and procedure codes, not typically the case in countries with national health systems.

As if transitioning to this new code set weren't challenging enough, providers are also facing the conversion to Stage 2 of Meaningful Use, a daunting task all on its own, says Tennant. Physician practices are also still focused on implementation of the 5010 transaction set, which dictates how providers conduct electronic administrative transactions, such as eligibility inquiries and remittance advices, he points out. "There has been a lot of time, energy and money spent on health IT lately by physician practices. We need to ensure that this investment translates directly into improved patient care and streamlined administrative processes.

"The difficulty is, no one has done a credible job of explaining how patient care will be improved by the use of these codes or how they will lead to reduced paperwork. That's why physicians have been pushing back [against ICD-10] over the years."

> "Although ICD-10 might cause temporary growing pains as the market implements it, in my opinion, the overall outcome is positive."
>
> **– Greg Dean**

## How prepared?

Starting on Oct. 1, Medicare claims with a date of service on or after that date will only be accepted if they contain a valid ICD-10 code, according to Slavitt. The Medicare claims processing systems will not have the capability to accept ICD-9 codes for dates of service after Sept. 30, 2015, or accept claims that contain both ICD-9 and ICD-10 codes.

That said, for 12 months after ICD-10 implementation, Medicare review contractors have been instructed to refrain from denying physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code, so long as the physician/practitioner uses a code from the right family.

American College of Physicians President Wayne J. Riley, MD, expressed relief when the 12-month grace period was announced in July. "The change from ICD-9 to ICD-10 is one of the largest technically challenging transitions for physicians in the past several decades," Riley wrote in a prepared statement. "Although the coding conventions in ICD-10 are similar to those used in ICD-9, there are many differences. Undoubtedly, these differences will create opportunities for errors in coding accuracy.

"Therefore, ACP appreciates that CMS has directed the Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) not to reject or deny claims based solely on an error due to the lack of accuracy or specificity within the appropriate code family during this transition."

Grace periods aside, the question is, How prepared are physician offices to implement ICD-10 – and get paid for their services?

"Many industry analysts state that a large portion of the independent or private practice market remains unprepared for the upcoming change," said Dean one week prior to the Oct. 1 deadline. "Much of the market has completed some level of educational training to prepare for the upcoming change, but is that enough? Yet some have not completed system upgrades or examined how their business will operate under the new code set.

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# ICD-10 Cometh...

"It is very important to conduct test transactions in order to identify risk and more complex ICD-9 to ICD-10 mapping. If you don't actually test or model your business in ICD-10, how can you actually know the impact of this transition?"

Says Hays, "We do not have any facts or figures. As a whole, we are not hearing the masses cry. Sure, there is some lamenting going on, but that is the case with any change, major or minor. I hope that physicians have taken heed to the warnings that ICD-10-CM is a reality. The majority that I have spoken with have taken steps to ready themselves for the transition."

> "No one has done a credible job of explaining how patient care will be improved by the use of these codes or how they will lead to reduced paperwork."
>
> **– Robert Tennant**

The preparedness of the country's medical practices varies tremendously, says Nicoletti. "The bigger groups are ready. They have had training, they have tested their software, they have looked at their codes. But from the questions I get from some of the smaller groups, it's clear some don't have a book, they don't have codes in their system, and they're waiting for upgrades [from their EHR vendors]."

EHR vendors, on the other hand, are much more prepared, says Nicoletti. "I would think every vendor would have the ICD-10 codes loaded into their system," she said two weeks prior to the deadline date. That said, when going from 16,000 codes to 70,000 codes, mapping or "translation" systems can't be fully trusted.

"Practices are stuck with whatever software they have," she says. "Some doctors will find their codes with an extra 30 seconds of work, for some it will take minutes."

At press time, four state Medicaid systems – California, Maryland, Montana and Louisiana – had obtained waivers from CMS allowing them to continue to use ICD-9 codes. They will take in the ICD-10 codes, then "crosswalk" them back to ICD-9 and adjudicate the claim.

The results could be troublesome. "How many claims does the state of California have?" asks Nicoletti, rhetorically. "This will cause denials. You can't cross back very easily. They can try, but it won't work."

## Payment delays?

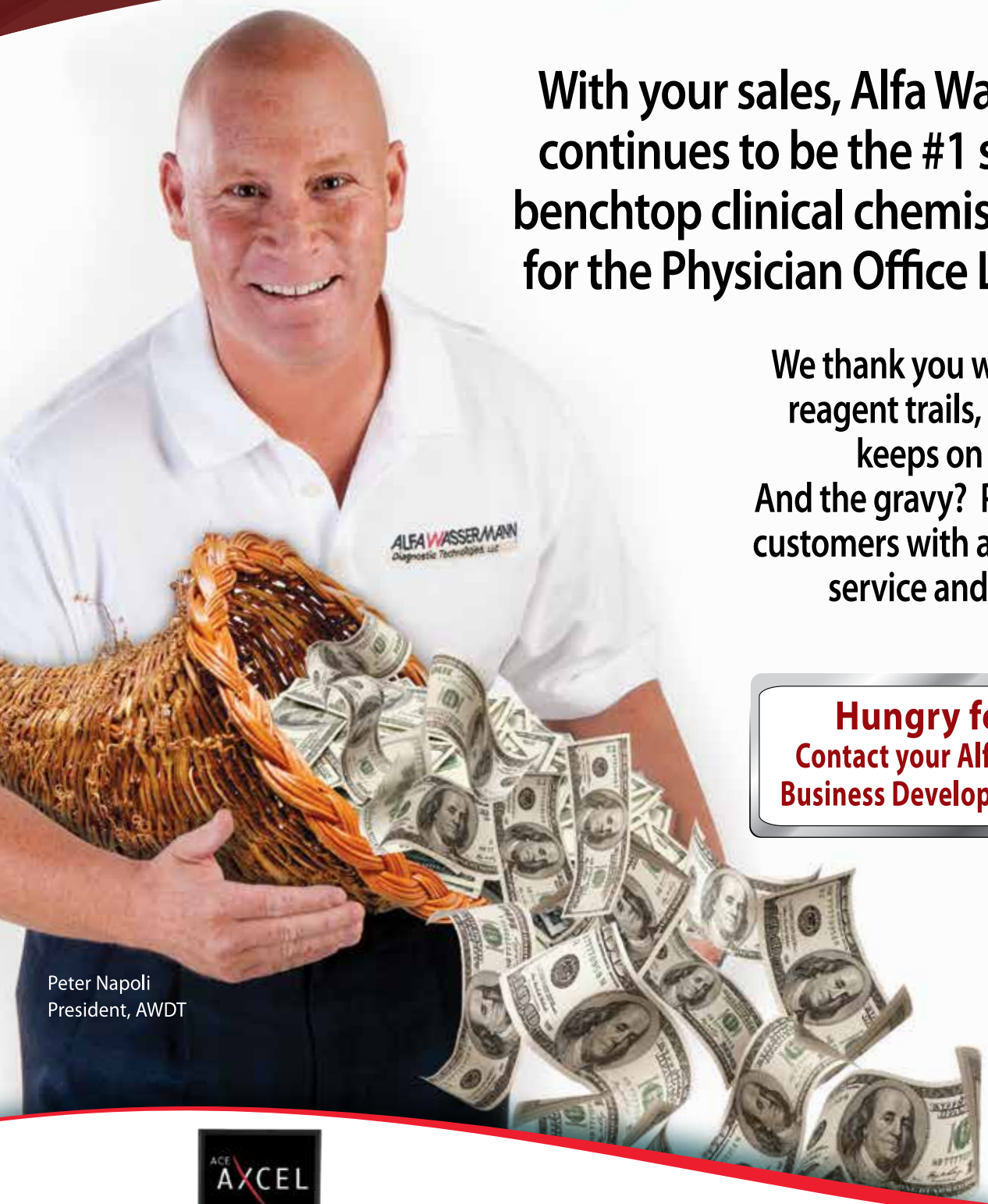
There are fears that lack of preparedness will lead to payment delays, even with the grace period.

"No doubt the claims acceptance rate will fall," says Schwieterman. "I cannot predict how much. With cash flows at smaller institutions already challenged in many cases, any disruption in the revenue cycle from ICD-10 backlogs may prove to be quite impactful to systems with smaller reserves."

"I have heard similar predictions around a decline in claims acceptance rates," says Dean. As a precaution, some practices have been advised to retain six months of cash in reserve, he says. "I do identify with the severity and challenges this transition might present. This is why quality planning and preparedness is critical." The 12-month grace period should help.

AAFP's Hays predicts "there will be some bottleneck at various levels of the payment scale. I anticipate these barriers will be similar to the Form 5010 transition in 2012. However, from that experience, we learned how testing should be done, such as interactivity between systems, between physicians' offices and clearinghouses, clearinghouses to payers, and the resulting return paths. It will be of paramount interest to physicians to follow the claims process closely and daily to determine receipt of information by these entities within the loop.

# We Are Thankful...

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# ICD-10 Cometh...

## AMA: ICD-10 Cost Estimates

| | Typical Small Practice | Typical Medium Practice | Typical Large Practice |
|---|---|---|---|
| Training | $2,700-$3,000 | $4,800-$7,900 | $75,100 |
| Assessment | $4,300-$7,000 | $6,535-$9,600 | $19,320 |
| Vendor/Software Upgrades | $0-$60,000 | $0-$200,000 | $0-$2,000,000 |
| Process Remediation | $3,312-$6,701 | $6,211-$12,990 | $14,874-$31,821 |
| Testing | $15,248-$28,805 | $47,906-$93,098 | $428,740-$880,660 |
| Productivity Loss | $8,500-$20,250 | $72,649-$166,649 | $726,487-$1,666,487 |
| Payment Disruption | $22,579-$100,349 | $75,263-$334,498 | $752,630-$3,344,976 |
| Total Costs | $56,639-$226,105 | $213,364-$824,735 | $2,017,151-$8,018,364 |

"The single most important thing a physician can do is to document. As I just stated, the next thing is to monitor claims activity. Don't take for granted that the path won't have any ruts. Be proactive."

Physician practices may find the greatest difficulty lies in coding laboratory procedures, says Nicoletti. The ICD-10 coding for thyroid testing, for example, is far more detailed than ICD-9. "It explodes to all the covered indications," she says. What's more, the codes for lab procedures span all the chapters in the ICD-10 book. "The covered condition could be anywhere, so that really does change things significantly."

"You've got a perfect storm of problems," says Tennant. "[EHR] vendors have been scrambling to meet the government's requirements for Meaningful Use. Have they been as diligent on the practice management system side for ICD-10? Time will tell."

Vendors are not required by law to do any upgrades for ICD-10, Tennant points out. "It's a business decision." In the months and weeks leading up to the Oct. 1 deadline, many practices were waiting for their vendors to send an ICD-10 upgrade. "Without that upgrade, they can't submit claims through their practice management system. So we are looking at potential payment disruptions, which ultimately could impact access to care."

Tennant found particularly disconcerting CMS's waiver for the four state Medicaid systems. "We have asked for information on state readiness for five years, and were always told, 'Don't worry, they will be ready.' So this was the first inkling that some states are not ready. You could say, 'Well, Medicaid isn't that big,' but it is getting more important and has a bigger footprint because of Obamacare."

> "Any disruption in the revenue cycle from ICD-10 backlogs may prove to be quite impactful to systems with smaller reserves."
>
> **– Tom Schwieterman**

### How to make the transition?

Adding to some physician practices' fears about conversion to ICD-10 is the cost involved. A 2014 study conducted on behalf of the American Medical Association estimated that the potential cost to a small practice could range from $57,000 to $226,000; for a medium practice, anywhere from $213,000 to $825,000; and for a large practice, between $2 million and $8 million. (see sidebar).

"The two largest areas of pre-implementation cost are the training of providers and staff and EHR system upgrades and installation," says Hays. "It is important to note, though, that many EHR and system vendors, such as [those of] EKG machines, are providing upgrades

and training at free or very low-cost price points." Meanwhile, post-implementation costs could include claims management for denials and monitoring, and the potential for additional training and upgrades based on go-live performance.

Practices are going to have to do a few things in order to make a successful transition to ICD-10, says Tennant:

- Clear the decks of any outstanding claims with dates of service prior to Oct.1. "Don't sit on them. Try to get money coming in as soon as possible."
- If its EHR software isn't ready, or if the practice has reasons to doubt its readiness, the practice can make use of a stopgap measure by submitting claims using the payer's "portal" approach on its website. With each payer portal being different and requiring a separate registration and login, practices should have familiarized themselves with the portal prior to the Oct. 1 deadline, so they don't waste time and potentially delay the adjudication process.
- In the event of a significant increase in rejected claims or delays in claims payment, practices should reach out to their local financial institution(s) to establish a line of credit, just in case.
- Practice owners should set aside some cash reserves to make sure they can meet their financial obligations should payments be significantly delayed.

> "The costs and risks associated with the transition to ICD-10 at this juncture are ill-advised."
>
> **– Tom Schwieterman**

Distributors and manufacturers can help.

"In my experience, distribution representatives can oftentimes be excluded from discussions or planning around the financial aspects of a medical office," says Dean. "I would encourage representatives to ask the basic questions surrounding ICD-10, such as, 'Are you prepared for the upcoming ICD-10 conversion?' If yes, ask your customer specifically what they have done to prepare. And lastly, ask your customers if they have tested transactions or modeled their business under the new ICD-10 code set. These questions will help you identify if you can potentially provide additional ICD-10 conversion support to your valued customer."

Distributors can ensure assistance is provided to physicians and their staffs in the form of updated prior authorization forms, says Hays. "Offer to discuss or pave the way with insurers if offices are receiving slow responses for authorizations for procedures or prescriptions. Make sure updated coding 'cheat sheets' are distributed."

Adds Schwieterman, "Manufacturers should understand how ICD-10 will affect coding guidelines for their particular diagnostic device or therapeutic regimen. Providing customers with updated coding guidelines could be very helpful to ease the process of achieving reimbursement.

"Many times, medical devices are not employed within care delivery every day, so such coding aides could help remind clinicians of best practices at the point of care."

## Resources


CMS, ICD-10 Resources, https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ResourcesFlyer20150817.pdf

CMS: "Road to 10: The Small Physician Practice's Route to ICD-10," http://www.roadto10.org

CMS: "ICD-10-CM INDEX TO DISEASES and INJURIES," http://cdn.roadto10.org/wp-uploads/2015/09/2016-ICD-10-CM-Index-to-Diseases-and-Injuries.pdf

CMS, "ICD-10-CM TABULAR LIST of DISEASES and INJURIES," http://cdn.roadto10.org/wp-uploads/2015/09/2016-ICD-10-CM-Tabular-List-of-Diseases-and-Injuries.pdf

# ICD-10 Cometh...

## ICD-10: EHR vendor's perspective

Healthcare providers weren't the only ones trying to get their coding house in order prior to the Oct. 1 implementation date for ICD-10. EHR vendors were hard as work as well.

"The transition to the new ICD-10 set of diagnosis and medical procedure codes marks a monumental change across the healthcare industry," said Shivani Mishra, senior product marketing associate, athenahealth, speaking to *Repertoire* one week before the implementation date. "It requires a lot of work on the part of hospitals, doctors' practices and health insurance companies, and has been a source of stress for physicians especially, who have had to create an ICD-10 implementation plan, a budget and a detailed timeline."

The impact of ICD-10 is massive, she said. "We are coaching clients to make sure they are ready, doing extensive payer outreach to understand the implications on their side, and monitoring our clients' interfaces/vendors to make sure systems are operating smoothly with the transition. Our 24/7 Nerve Center is monitoring both client and payer performance metrics proactively, and ensuring we can respond quickly to changes."

athenahealth's cloud-based software has been ICD-10 ready since February 2014, said Mishra. "We're continuously tracking payer readiness, and keeping our network informed in real time on who can and cannot support ICD-10 codes. Following the ICD-10 transition, athenahealth clients won't have to track which payers are ready for ICD-10 when submitting claims, eliminating the worry of increased denials or disruption to practice revenue."

athenahealth will actively research payer denials for all athenahealth practices, she continued. "Every single denial is added into the system as its own billing rule, with new rules added daily, to prevent each denial from ever happening again at any athenahealth practice.

"To further minimize financial risk, athenahealth is also actively testing interfaces across our cloud-based network to ensure our clients and their vendors are ready to send ICD-10 codes." The vendor had tested 100 percent of charge interfaces prior to Oct. 1.

One week prior to implementation, athenahealth had tested 83 percent of payers. The EHR vendor's discussions with payers prior to the implementation date were especially helpful, as those discussions resulted in payers clarifying whether the root cause of test claim denials were internal payer system issues or truly ICD-10-related, said Mishra.

Despite all the upfront work, some questions remained, she continued. Here are some of the most common myths athenahealth discovered from testing were:

- **Myth 1:** All payers are conducting end-to-end testing. "Not all payers are testing, and fewer are doing end-to-end testing."
- **Myth 2:** All payers are testing with everyone. "Those doing end-to-end testing are often limiting participation to institutional claims or high-impact providers."
- **Myth 3:** Payers are offering unlimited testing. "Testing is often limited to a handful of claims covering their prescribed scenarios."
- **Myth 4:** Successful testing means payer readiness. "Testing results cannot adequately forecast the post-transition environment. Testing alone can't guarantee against issues."

"There's no indication that claims acceptance rates will fall significantly," Mishra said athenahealth would have a better idea after the Oct. 1 deadline.

**EHR vendor's role**

The EHR vendor should act as a partner to the practice and ensure the practice has been working over the past year to create and implement a plan for ICD-10," said Mishra. This should have included testing interfaces, adding ICD-10 to future and standing orders, practicing selecting ICD-10 codes in claims and encounters, planning for cash flow disruption, and having a general contingency plan.

The vendor should also have plans for various post-transition failure scenarios and mitigation strategies. "That means establishing lists of payer escalation contacts and developing a systematic approach to track any rejections and adjust as needed.

"At athenahealth, because of our cloud-based service, we are also able to monitor and track ICD-10 transactions and network performance in real-time immediately following the transition. We'll know practice by practice if providers or billers are having difficulty selecting codes and if this is leading to a delay in charge entry. And as soon as we start seeing ICD-10 related rejections or denials, we'll be ready to respond with updates to our patented Billing Rules Engine. In addition to tracking which payers are ready to receive ICD-10 codes and which are experiencing difficulties, we'll also be tracking new denial codes, new medical necessity edits, and surfacing those trends on any future claims that may be affected."

# ICD What?

## New diagnostic codes apply to long-term care providers

**Diagnostic coding can be complicated in hospital settings.** It can be even more so in long-term care facilities. Nevertheless, it's a requirement for your long-term care customers, and with the recent switch to ICD-10-CM coding, it's more important than ever that they understand the role and importance of these codes and know how to implement them.

As of Oct. 1, 2015, long-term care facilities, along with their hospital and physician counterparts, were required to move from the ICD-9-CM coding system to ICD-10-CM. Much like ICD-9-CM, the new coding system is designed to facilitate the collection and organization of healthcare statistics on the incidence of disease, according to the American Health Information Management Association (AHIMA). Diagnostic coding is used to:

- Collect diagnostic and statistical data about people treated by healthcare providers
- Support clinical decision-making
- Support reimbursement for services provided
- Comply with federal standards for reporting diagnostic data
- Provide data to support clinical research and quality improvement activities

HIPAA requires all providers – including long-term care facilities – to adhere to ICD-10-CM coding, and as such, long-term care administrators must be able to educate their staff who must work with or assign diagnostic codes on the appropriate rules and regulations. To do so requires a working knowledge of the terms and definitions associated with ICD-10-CM coding.

### Terms and definitions

#### Principal diagnosis

Long-term care facilities have varying rules and regulations that require coded data, and at times there may be conflict in the requirements and terminology, notes AHIMA. For instance, the term primary diagnosis is often used to indicate the reason for skilled Medicare services, which may differ from the resident's reason for continued stay, AHIMA points out. Definitions of principal diagnosis include:

- **First-listed diagnosis.** This refers to the diagnosis that is sequenced first. Terms such as principal and primary may be used interchangeably to define this.
- **Principal diagnosis.** This refers to the condition established that is chiefly responsible for the

patient's admission to the hospital. It is always the first-listed diagnosis on the health record and applies to nursing homes as well (as stated in guidelines).

- **Primary diagnosis.** This indicates the reason for the continued stay in the long-term-care facility and is often used interchangeably with the principal diagnosis.

## Principal diagnosis in other regulations

According to the Medicare Program Integrity Manual, the term primary diagnosis refers to the reason for therapy services (also known as the medical diagnosis). The Therapy and Evaluation Plan of Care document for new Medicare Part A stays requires the physician or practitioner to document the medical reason supporting therapy services, according to AHIMA. The diagnosis code representing the medical reason may be identified as primary diagnosis or medical diagnosis on the therapy plan. However, the medical diagnosis may not be the same reason for the continued stay in the facility.

AHIMA provides the following example of the above scenario: A patient with Parkinson's disease returns after a hospitalization for pneumonia to start a new Medicare Part A stay. Pneumonia is identified as the medical diagnosis on the therapy evaluation and plan of care to support the skilled therapy services, along with the appropriate therapy treatment diagnoses. However, Parkinson's disease is the reason for the continued facility stay and continues to be sequenced first on the record and the UB-04. The reason for the new focus of care and Medicare Part A stay (i.e., pneumonia) is sequenced second.

## The use of Z codes in long-term care facilities

Assigning V codes in ICD-9-CM was known to cause confusion and controversy in long-term care facilities. Many facilities were told not to assign V codes as the principal diagnosis, or even at all, according to AHIMA. Z codes in ICD-10-CM are synonymous with V codes in ICD-9-CM. The established ICD-10-CM code and the official guidelines provide specific instruction and guidance to both the coder and billing staff for appropriate use of Z codes in long-term care facilities.

In long-term care, one of the most common reasons for initial admission is rehabilitation, such as physical, occupational and speech-language therapy, notes AHIMA. Unlike ICD-9-CM, there is no equivalent code in ICD-10-CM for admission for, encounter for, or care involving rehabilitation procedures. According to Coding Clinic, patients admitted to a long-term care

facility specifically for rehab following an injury should be assigned the acute injury code. When a patient is being treated at the hospital for an acute medical condition and is subsequently admitted to long-term care for rehab, the acute condition should be coded as the first listed/principal diagnosis, followed by any chronic conditions that will be treated at the skilled nursing facility.

Z codes are often assigned for aftercare following surgical procedures performed in the hospital for which the patient is sent to the long-term care facility to recover. However, aftercare Z codes are not used for aftercare following injuries or fractures.

### Continued treatment of acute care conditions

Acute conditions treated at the hospital that continue to require follow-up or ongoing monitoring should be coded with an acute diagnosis code, as long as the condition persists and requires follow-up. Codes for the acute medical condition treated and resolved in the hospital are assigned and reported by the hospital, but not coded or reported by the long-term care facility. The long-term care facility reports Z codes to identify the provision of aftercare.

### Diagnosis List and UB-04 Claim Form

Residents in long-term care facilities often have numerous chronic conditions. The diagnosis list is a comprehensive listing of these conditions, which are often sequenced in order of focus and complexity of care for the resident, according to AHIMA. The number of diagnoses listed can be extensive and may exceed current reporting capacity with the implementation of the UB-04 (Universal Billing Form, version 5010) on Jan. 1, 2012, which only allows for 25 codes.

Prior to submission of the UB-04 claim, facilities must validate that the ICD-10-CM diagnoses reported on the claim are consistent with the health record documentation and MDS information. This is commonly referred to as a triple-check process, notes AHIMA. Reporting ICD-10-CM diagnosis codes supported by health record documentation and the MDS will support the claim submitted for therapy services. The facility's reimbursement is determined by the Resource Utilization Group (RUG) category based on the MDS assessment data. The triple-check process ensures that the diagnosis data submitted for each payment mechanism is consistent.

The facility's reimbursement is determined by the Resource Utilization Group (RUG) category based on the MDS assessment data. The triple-check process ensures that the diagnosis data submitted for each payment mechanism is consistent.

### Medicare Part B therapy services

The medical diagnosis that identifies the reason for the Part B therapy services should be listed on the MDS after the reason for the continued stay. Other ICD-10-CM codes for chronic conditions that affect the resident's progress may also be reported to support therapy services. In addition, ICD-10-CM codes representing the medical condition that required the treatment are used when there is no code representing the treatment.

A working knowledge of ICD-10-CM coding guidelines is particularly important as long-term care facilities prepare for inspections. In its Compliance Program Guidance for Nursing Facilities, the Office of Inspector General recommends that nursing facilities take all reasonable steps to ensure compliance with federal healthcare programs when submitting information that determines reimbursement decisions. Ensuring accurate information requires ongoing training and evaluation of the staff responsible for coding diagnoses, as well as regular internal audits of coding policies and procedures, AHIMA advises. Accurate coded data will continue to play an important role in the long-term care industry, it adds. rep

**Editor's note:** For more information, AHIMA recommends the "ICD-10-CM Official Guidelines for Coding and Reporting," which is the companion document to the official version of ICM-10-CM published on the National Center for Health Statistics website.

# Deadline No. 2 for unique device numbers

By Beth Gibson

**It has been two years since the passing of the U.S.** Food and Drug Administration's regulation for Unique Device Identification (UDI), and while the labeling requirement for Class III medical devices has long passed (Sept. 24, 2014), a second deadline has placed tremendous pressure on medical device manufacturers and distributors.

By Sept. 24, 2015, all labels and packages of Class II implantable, life-sustaining and life-supporting devices were to have hade a UDI. Corresponding data was to be submitted to the FDA Government Unique Device Identifier Database (GUDID) by Oct. 24, 2015. The September deadline also pertained to life-sustaining and life-supporting devices that are required to have UDI as a permanent direct mark if they are to be used more than once, and reprocessed before each use. Additionally, stand-alone software that is life-sustaining or life-supporting must have a UDI and human-readable dates on labels in the designated format (YYYY-MM-DD).

Many medical device manufacturers were compliant by the deadline. They also modified or established processes and standard operating procedures to maintain compliance going forward.

## Implications for providers

What does this mean for buyers and distributors? While the UDI rule does not spell out any specific requirements of healthcare providers at this time, buyers and users of these medical devices could be taking action to utilize the UDI in their processes and transactions. Leveraging standardized product identifiers within the provider systems and processes has proven to reduce costs associated with product obsolescence, unit-of-measure ordering errors, or simply ordering the wrong product altogether. These examples are just a few that are found on the product logistics and inventory management side of an organization's product-related activities.

The "Holy Grail" of UDI utilization by providers can be achieved when this information is scanned at the point of care and made available as a component of a patient's electronic health record (EHR), reinforcing patient safety. Product information integrated into an individual's EHR can then be used in product recall notifications as well as to determine product efficacy and outcomes.

To address this need, healthcare providers are finding it important to build UDI utilization into their operational business plans. Areas of focus include determining their ERP and EHR system capabilities to house and handle the data, preparing for training in the clinical and materials management areas, and establishing cross-functional teams to manage projects associated with UDI utilization.

Integrating product information into the patient health record will require product identification all the way down to the unit of issue or use. Providers should be working very closely with medical device manufacturers to insist on this level of product identification to make scanning these products effective and efficient.

### Implications for suppliers

In a large number of medical device product transactions, a medical product distributor sits between the device manufacturer and the provider. Under the FDA UDI law, distributors will be expected to be able to seamlessly accept from manufacturers and pass to providers the same data elements associated with device identification. In pharmacy, product track-and-trace aims to facilitate the exchange of information at the individual package level about where a drug has been in the supply chain. So too, certain data elements associated with medical devices will become important to maintain between device manufacturers and end users served through distribution. Additionally, by utilizing product identifiers, including the GS1 Global Trade Item Number® (GTIN®) and other GS1 standards, distributors can leverage many of the same operational benefits that providers achieve around inventory management and improved supply chain efficiencies.

**Integrating product information into the patient health record will require product identification all the way down to the unit of issue or use. Providers should be working very closely with medical device manufacturers to insist on this level of product identification to make scanning these products effective and efficient.**

As the FDA UDI implementation timeline evolves to meet Class II and Class I requirements in 2016 and 2018, respectively, other areas of impact may come to light for manufacturers, distributors and providers. There continues to be much discussion in the healthcare industry among members of the GS1 Healthcare US initiative about the use of unique device identification and other industry standards, as well as the benefits that can be achieved over and above compliance to the FDA UDI rule. While it is important for each area of the supply chain to gain the most benefit from standards adoption, they all agree that their overarching responsibility lies in improving patient safety and providing a better patient experience. That alone seems to be more than enough of a driver to continue to move the industry forward. rep

*Beth Gibson is senior director, industry engagement, medical devices, GS1 US. GS1 US, a member of GS1®, is an information standards organization that brings industry communities together to solve supply-chain problems through the adoption and implementation of GS1 Standards.*

## Class system

The U.S. Food and Drug Administration classifies medical devices based on the risks associated with the device.

- Class I devices are deemed to be low risk and are therefore subject to the least regulatory controls. (FDA example: dental floss.)
- Class II devices are higher-risk devices than Class I and require greater regulatory controls to provide reasonable assurance of the device's safety and effectiveness. (FDA example: condoms.)
- Class III devices are generally the highest-risk devices and are therefore subject to the highest level of regulatory control. Class III devices must typically be approved by the FDA before they are marketed. (FDA example: replacement heart valves.)

# Do your customers know about these incentive and penalty programs?

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### MU: Meaningful Use

Medicare-eligible professionals who do not successfully demonstrate meaningful use of an EHR will be subject to reductions to their Medicare payments. 98.2% of participating athenahealth clients successfully attested for MU Stage 2 in 2014 vs. only 33% nationwide.

### PQRS: Physician Quality Reporting System

Providers are required to report data to CMS on certain quality measures for their Medicare patients. Failure to report PQRS results in automatic reductions to Medicare Part B payments. 93.6% of eligible athenahealth clients avoided PQRS penalties in 2015 vs. only 60% nationwide.

### VM: Value-based Modifier

This program uses PQRS reported data and requires providers to meet quality and cost goals. Incentives are awarded to providers for high-quality, low-cost care. Providers that fall short of national benchmarks are subject to penalty.

### CCM: Chronic Care Management

Medicare has offered reimbursements for chronic care management that occurs outside of office visits. Service must last 20 minutes or more and serve patients with two or more chronic conditions.

### TCM: Transitional Care Management

To avoid preventable readmission costs, TCM is a monthly Medicare reimbursement for all the work that goes into helping patients recover properly during the 30 days following inpatient discharge.

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# So Much Potential

## Benefits – and risks – weighed in the expansion of telemedicine

**Telemedicine is here; it's expanding; and it has great** potential. But the medical profession and healthcare industry needs to balance its benefits against its risks for patients.

"Telemedicine – the use of technology to deliver care at a distance – is rapidly expanding and holds the potential to improve access for patients, enhance patient-physician collaboration, improve health outcomes, and reduce medical costs," said Wayne J. Riley, MD, MPH, MBA, MACP, president of the American College of Physicians. "However, the potential benefits of telemedicine must be measured against the risks and challenges associated with its use, including the potential absence of the physical exam, variation in state practice and licensing regulations, and issues surrounding the establishment of the patient-physician relationship."

> A valid patient-physician relationship must be established for a professionally responsible telemedicine service to take place.
>
> **– American College of Physicians**

Riley made his comments as the ACP published its position paper, "A Guide to the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper," in the Annals of Internal Medicine on Sept. 8. The American College of Physicians represents approximately 143,000 internists, internal medicine subspecialists and medical students.

### Recommendations

The ACP position paper offers 13 policy statements and recommendations for the practice and use of telemedicine in primary care and reimbursement policies associated with telemedicine use.

**1.** ACP supports the expanded role of telemedicine as a method of healthcare delivery that may enhance patient-physician collaborations; improve health outcomes; increase access to care and members of a patient's health care team; and reduce medical costs when used as part of a patient's longitudinal care.

ACP believes:

- The most efficient, beneficial telemedicine use occurs between a patient and physician who have an established, ongoing relationship.
- Telemedicine is a reasonable alternative for patients who lack regular access to medical expertise in their geographic area.
- Episodic, direct-to-patient telemedicine services should be used only as an intermittent alternative to a patient's primary care physician when necessary to meet the patient's immediate acute care needs.

**2.** ACP believes a valid patient-physician relationship must be established for a professionally responsible telemedicine service to take place. A telemedicine encounter itself can establish a patient-physician relationship through real time audio/visual technology.

A physician using telemedicine who has no direct prior contact or existing relationship with a patient must:

- Take appropriate steps to establish a relationship based on the standard of care required for an in-person visit, or
- Consult with another physician who does have a patient-physician relationship and oversees the patient's care.

**3.** ACP recommends that telehealth activities address the needs of all patients without disenfranchising financially disadvantaged populations or those with low literacy or low technological literacy. Specifically, telehealth activities need to consider:

- The literacy level of all materials (including written, printed, and spoken words) provided to patients and/or families.
- Affordability and availability of hardware and Internet access.
- Ease of use, which includes accessible interface design and language.

**4.** ACP supports the ongoing commitment of federal funds to support the broadband infrastructure needed to support telehealth activities.

**5.** ACP believes physicians should use their professional judgment as to whether the use of telemedicine is appropriate for a patient. Physicians should not compromise their ethical obligation to deliver clinically appropriate care for the sake of new technology adoption. If an in-person physical exam or other direct face-to-face encounter is essential to privacy or maintaining the continuity of care between the patient's physician or medical home, telemedicine may not be appropriate.

**6.** ACP recommends physicians ensure their use of telemedicine is secure and compliant with federal and state security and privacy regulations.

**7.** ACP recommends that telemedicine be held to the same standards of practice as if the physician were seeing the patient in-person. The College believes there is a need to develop evidence-based guidelines and clinical guidance for physicians and other clinicians on how to appropriately use telemedicine to improve patient outcomes.

**8.** ACP recommends physicians who use telemedicine should be proactive in protecting themselves against liabilities and ensure their medical liability coverage includes the provision of telemedicine services.

**9.** ACP supports the ongoing commitment of federal funds to establish an evidence base on the safety, efficacy, and cost of telemedicine technologies.

**10.** ACP supports a streamlined process to obtaining multiple medical licenses that would facilitate the ability of physicians and other clinicians to provide telemedicine services across state lines while allowing states to retain individual licensing and regulatory authority.

**11.** ACP supports the ability of hospitals and critical access hospitals to "privilege by proxy" in accordance

with the 2011 Centers for Medicare and Medicaid Services final rule allowing a hospital receiving telemedicine services (distant site) to rely on information from hospitals facilitating telemedicine services (originating site) in providing medical credentialing and privileging to medical professionals providing those services.

**12.** ACP supports lifting geographic site restrictions that currently limit reimbursement of telemedicine and telehealth services by Medicare to those that originate outside of Metropolitan Statistical Areas (MSAs) or for patients who live in or receive service in a Health Professional Shortage Areas (HPSA).

**13.** ACP supports reimbursement for appropriately structured telemedicine communications, whether synchronous or asynchronous and whether solely text-based or supplemented with voice, video, or device feeds in public and private health plans, as this form of communication may be a clinically appropriate comparable service alternative to a face-to-face encounter.

**Source:** Annals of Internal Medicine, doi:10.7326/M15-0498

# **The challenges** of telemedicine

**The integration of telemedicine into the healthcare system** is not without challenges, says the American College of Physicians in "A Guide to the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper," published in the Annals of Internal Medicine on Sept. 8. Those challenges include the following:

- Most laws and regulations relating to reimbursement and the practice of medicine were drafted before the use of telemedicine by larger markets.
- State guidelines on the practice of telemedicine, prescribing, and licensing vary.
- Websites that offer on-demand, episodic care for minor health conditions may disrupt the continuity of care between a patient and his or her physician or medical home, and undermine care coordination.
- Some hesitation remains among physicians and patients.
- Legal barriers to the widespread adoption of telemedicine mainly center on medical licensure, credentialing, and privileging that would allow physicians to practice in several locations.

In addition, says ACP, "Concerns exist about depersonalization of the patient–physician relationship, particularly in the primary care setting, and the risk for harm. The physical interaction between a physician and patient and the in-person examination are important components of a patient's care that allow a physician to gather a comprehensive under- standing of the patient and his or her needs, and build trust and communication."

**Source:** Annals of Internal Medicine, doi:10.7326/M15-0498

# **The hidden** economics of telemedicine

**In his editorial accompanying the American College of** Physicians' "A Guide to the Use of Telemedicine in Primary Care Settings: An American College of Physicians Position Paper," published in the Annals of Internal Medicine on Sept. 8, David Asch, MD, MBA, Center for Health Care Innovation, University of Pennsylvania in Philadelphia, made the following comments:

- "[P]ayers worry that if they reimburse for telemedicine, then every skin blemish that can be photographed risks turning from something that patients used to ignore into a payable insurance claim. Indeed, it is almost certainly true that if you make it easy to access care by telemedicine, telemedicine will promote too much care. However, the same

concern could be reframed this way: An advantage of requiring face-to-face visits is that their inconvenience limits their use. Do we really want to ration care by inconvenience, or do we want to find ways to deliver valuable care as conveniently and inexpensively as possible?"

- "The scalable gains from telemedicine will come from delivering care to populations – sometimes highly specialized care, in totally different ways – often with less physical infrastructure and less of the baggage that accompanies conventional practice. Although the ACP position paper urges parity

"The innovation that telemedicine promises is not just doing the same thing remotely that used to be done face to face, but awakening us to the many things that we thought required face-to-face contact but actually do not."

between telemedicine and face-to-face medicine in how physicians practice and get paid, arguing for parity is a trap if it merely carries forward practice styles and reimbursement requirements from one context to the other. The innovation that telemedicine promises is not just doing the same thing remotely that used to be done face to face, but awakening us to the many things that we thought required face-to-face contact but actually do not."

**Source:** Annals of Internal Medicine, doi:10.7326/M15-0498

# Training Tomorrow's Doctors

## AMA expands initiative to transform medical education

**The American Medical Association is continuing its** effort to redesign undergraduate medical education to better align with the 21st century healthcare system.

Less than two years after the AMA launched its initiative to reshape medical education across the United States, the organization recently announced that it will provide funding for up to 20 additional medical schools to join the AMA's "Accelerating Change in Medical Education Consortium."

The consortium was created by the AMA in 2013 with an $11 million grant initiative to 11 of the country's top medical schools. Each school received a $1 million grant over five years, and together they formed a consortium that is developing curriculum models to help medical students better prepare for delivering care in the rapidly evolving healthcare landscape, according to AMA. The projects currently underway include models for student immersion within the healthcare system from Day 1 of medical school, and competency-based models enabling students to advance through medical school based on individualized learning plans.

As part of the second phase of the "Accelerating Change in Medical Education" initiative, the AMA is calling on medical schools to build upon and implement the education models created by the 11 founding consortium schools, as well as offer unique projects that can be shared with medical schools nationwide. The organization will provide $1.5 million over the next three years to fund up to 20 additional schools' projects that support a significant redesign of undergraduate medical education.

Through a competitive grant process, a national advisory panel will evaluate proposals and select projects that incorporate one of the following themes:

- Developing flexible, competency-based pathways.
- Teaching and/or assessing new content in healthcare delivery science.
- Working with healthcare delivery systems in novel ways.
- Making technology work to support learning and assessment.
- Envisioning the master adaptive learner.
- Shaping tomorrow's leaders.

Projects that do not fall under one of these themes but provide a valuable contribution to the consortium will also be considered, according to the AMA.

Over the course of the initiative, the AMA will continue to track and report on the progress of the medical schools' collective work in order to identify and widely disseminate the best models for transformative educational change. The AMA will also continue to develop ways to collaborate with and incorporate feedback from additional medical schools.

# Education with a Big E

## Surface disinfection can help reduce spread of antibiotic-resistant organisms

**It's true that the prudent use of antibiotics can help** slow the growth of antibiotic resistance in bacteria. In fact, that's a central tenet of the Obama Administration's recently published National Action Plan for Combating Antibiotic-resistant Bacteria. (See July 2015 *Repertoire*.)

But doctors' prescribing habits aren't the only factor that can help control antibiotic resistance. Infection prevention and hospital environmental services staff can play a role too, by properly cleaning and disinfecting hard surfaces in the hospital.

It's a message that the Alliance for the Prudent Use of Antibiotics (APUA) and Clorox Healthcare intend to promote in a new educational partnership announced by the two organizations this fall.

"Education with a big 'E' is important," says Stuart Levy, M.D., co-founder and president of the Alliance for the Prudent Use of Antibiotics. "There are two sides to the coin. One is the prevention of disease by using [surface disinfectants]. The other is prevention of resistance by using these products appropriately. And I think that's something [with which] our partnership can help."

Founded in 1981, APUA has affiliated chapters in more than 65 countries. It conducts research, education and advocacy programs to control antimicrobial resistance and ensure access to effective antibiotics.

### Prevention first

The Centers for Disease Control and Prevention estimates that drug-resistant bacteria cause 2 million illnesses and approximately 23,000 deaths per year in the United States. The spread of drug-resistant infections and *Clostridium difficile* will increase without immediate improvements in infection control and antibiotic stewardship.

Because antibiotic-resistant pathogens are difficult to treat once a patient has been infected, the better course is to prevent their spread in the first place, says Laurie Rabens, senior product manager, Clorox Healthcare. An example is *C. difficile*.

"Though not in itself antibiotic-resistant, *C. difficile* has become a concern due to the overuse of antibiotics," she says. "As a patient embarks on a course of antibiotics, the antibiotics kill many bacteria in the gut that are actually helpful, or at least not harmful, as well as the specific bacterium being targeted. In this kind of environment, *C. difficile* can grow out of control and lead to a potentially deadly infection."

The Centers for Disease Control and Prevention has reported that almost 250,000 people each year require hospital care for *C. difficile* infections. At least 14,000 people in the United States die from such infections every year.

The infected person sheds *C. difficile* spores through his or her stool; if those spores get on his or her hands, then he or she touches a handle, doorknob, TV remote, table, etc., the bacteria can persist on those surfaces for weeks or even months. The next person who touches that surface, then puts his or her hands to her mouth, can become infected as well.

The Centers for Disease Control and Prevention has reported that almost 250,000 people each year require hospital care for *C. difficile* infections. At least 14,000 people in the United States die from such infections every year.

"That's why thorough surface disinfection is so important," says Rabens. "Disinfectants kill bacteria and spores quickly, and thus reduce the spread of bacteria, including antibiotic-resistant organisms."

Clorox Healthcare and APUA will be publishing articles, sponsoring webinars and developing other educational materials about surface disinfection and antibiotic resistance in the coming months. rep

# **Stress** Points

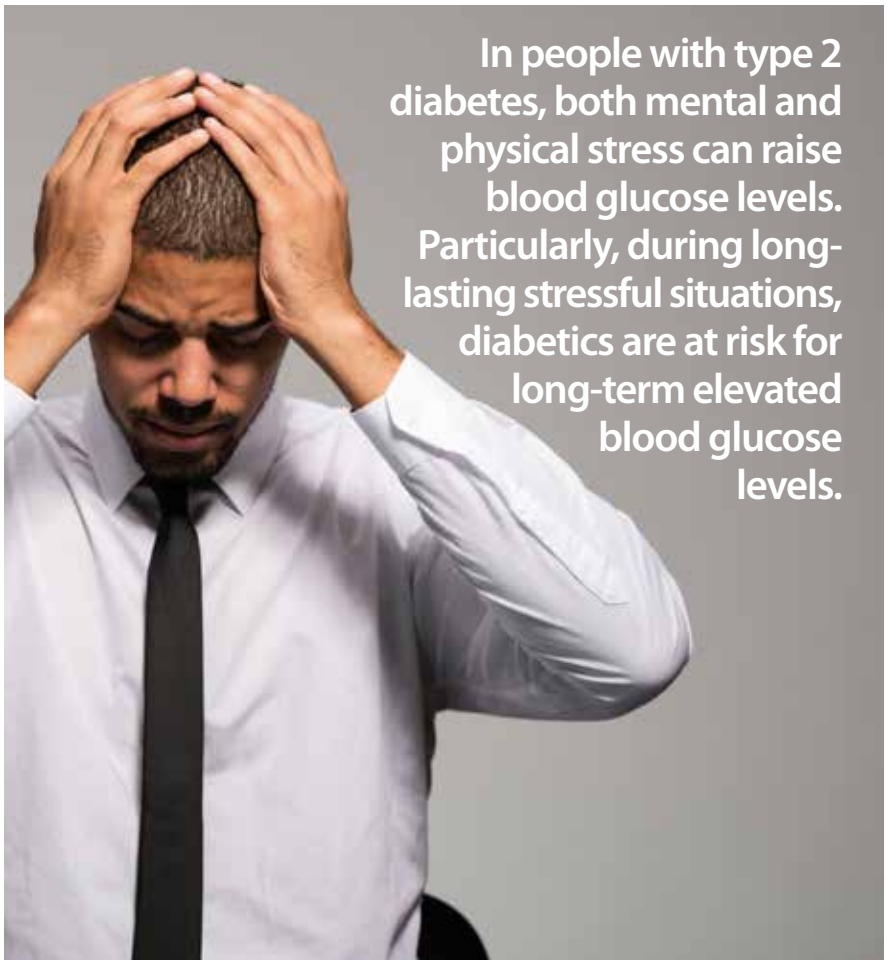
For diabetic patients, stress can present a long-term threat.

**It would be difficult to imagine a scenario where stress** is a good thing. However, it can have a particularly negative impact on people who have diabetes. November is American Diabetes Month ® – an opportunity for sales reps to initiate a discussion with their physician customers about the challenges their diabetic patients face and the solutions available to address those challenges.

## A heavy toll

There is no shortage of stress in life: Health, physical injury, finances, work (or lack of it) and relationships can all play a role. When stress occurs, the body tends to respond with a fight-or-flight action, according to the American Diabetes Association (ADA) website. Levels of hormones increase, causing the body to store additional energy (in the way of glucose and fat) for the cells. The cells, in turn, do their part to protect the body from danger.

In people who have diabetes, however, the fight-or-flight response does not work well, notes the ADA. Their insulin is not always able to allow extra energy into the body's cells, leading to an overload of glucose in their blood. Furthermore, if they are distracted, they may forget to check their glucose levels as often as they should. In people with type 2 diabetes, both mental and physical stress can raise blood glucose levels. Particularly, during long-lasting stressful situations, diabetics are at risk for long-term elevated blood glucose levels.




## A healthy response

Since stress blocks the body from releasing insulin in people with type 2 diabetes, reducing stress in one's life can be helpful. (People with type 1 diabetes don't make insulin, so stress reduction won't have the same effect on them.)

There are several ways to fight stress, such as exercise, dance, volunteering or taking up a new hobby. Sometimes a small change, such as taking a less hectic route to work, can help one reduce stress. Other times, it requires a major change, such as applying for a job transfer or moving to a different part of the country. In addition, the ADA recommends the following:

- **Breathing exercises.** Take deep breaths in and relax your muscles as you breathe out. Breathing exercises should be done at least once a day for 15 or 20 minutes.

- **Progressive relaxation therapy.** Tense the muscles, then relax them.
- **Motion.** Circling, stretching and shaking parts of the body – particularly to music – can be therapeutic.
- **Positive thoughts.** When negative thoughts arise, replace them with happy or proud thoughts. Sometimes a memorized poem, prayer or quote can be used to replace a negative thought.

Living with diabetes – taking medication, checking blood glucose levels regularly and sticking to an appropriate diet – can be stressful in itself. But, compounded by daily or unexpected events, stress levels for people with diabetes can be that much higher. Sales reps can provide a value-added service to their physician customers by reminding them to touch base regularly with their diabetic patients to determine how well they are coping with stress in their lives.

## Hemoglobin A1c testing

A discussion about diabetes is not complete without ensuring physician customers are equipped with A1c tests. While blood glucose tests enable patients to monitor their daily blood glucose levels, they need an A1c test for a broader picture of how well their diabetes treatment plan is working. Also referred to as a glycated hemoglobin or HbA1, the A1c test provides an overview of the patient's average blood glucose control for the past two or three months.

Diabetics should have their A1c levels measured when their diabetes is first diagnosed, and at least twice a year, according to the American Diabetes Association. But, in many cases, levels should be measured every three months, particularly when patients begin a new medication or fall short of blood glucose goals.

Hemoglobin, which is found inside red blood cells, carries oxygen from the lungs to all of the cells in the body. As with all proteins, hemoglobin links up with sugars, such as glucose. Patients with uncontrolled diabetes have too much sugar in their bloodstream. The extra glucose enters the red blood cells and links up – or glycates – with molecules of hemoglobin. As excess glucose builds up in the bloodstream, more hemoglobin is glycated. Diabetic patients on medication may find that one week their blood sugar levels are too high, and the next week they return to normal. But, the red blood cells carry a "memory" of the first week's high blood glucose in the form of extra A1c, according to the American Diabetes Association.

As old blood cells in the body die and new ones with fresh hemoglobin replace them, the record of A1c levels changes. The amount of A1c in the blood reflects blood sugar control for the last 120 days, or the lifespan of the red blood cells. Compared with a non-diabetic patient who has approximately 5 percent of all hemoglobin glycated, a diabetic whose blood glucose levels have been out of control for a long time may have levels as high as 25 percent, according to the American Diabetes Association.

### Know your customer

Physicians who may be interested in A1c testing include:

- Pediatricians
- Internists
- General and family practitioners
- Cardiologists
- Endocrinologists

## Selling hemoglobin A1c tests

Distributor reps should ask potential physician customers how they presently are getting A1c results for patients. Some follow-up questions should include the following:

- "Doctor, have you done any in-office A1c POC testing in the past, or are you considering doing so?"
- "What do you find effective about the way you currently do A1c testing?"
- "What, if anything, would you change about the way you do A1c testing?"

In spite of the quick results using the A1c POC test, some physicians still prefer to send their tests to a lab. Distributor reps should remind customers that rapid test results create an opportunity to provide patients with immediate treatment decisions in the office, as well as educate and counsel them to better manage their disease. There are no follow-up calls to a lab to track down results, no phone-tag trying to connect with patients and no need to schedule follow-up office appointments. rep

# Alere

**Diabetes is one of the most expensive diseases for our** healthcare system and a major cause of disability and death for patients. Twenty-nine million Americans have diabetes – or 9.3 percent of the population – and over one in four do not know they have it. Another 86 million Americans are at risk for developing the disease.[1]

For people with diabetes, the key to minimizing suffering and preventing loss of life is controlling their elevated blood sugar levels (hyperglycemia). For some patients, this means testing themselves for glucose. But for all patients, a long-term measure is needed by both patients and clinicians to determine glycemic control.


Together, improving quality of care and patient satisfaction can make a difference in clinician, practice and health plan performance, and in the lives of people living with diabetes.

This long-term measure – or *truth serum* for a diabetes patient – is hemoglobin A1c (HbA1c or A1C). In its clinical practice recommendations, the American Diabetes Association (ADA) recommends testing A1C twice each year in patients that are well-controlled, and four times each year in patients that are not.[2] The large number of patients with diabetes and the need for frequent testing makes A1C one of the most common laboratory tests.

While A1C tests can be performed by sending a patient or their blood sample to a laboratory, patient care is improved when results are immediately available to the clinician by using a point-of-care method in the office or clinic. The Alere Afinion™ AS100 Analyzer delivers lab quality, is CLIA-waived, and provides A1C test results in three minutes from a fingerstick blood sample.

## Knowing now matters™

Having A1C results available immediately enables earlier therapeutic decisions, which can result in improved diabetic control,[3] better patient outcomes,[3-5] and enhanced clinic efficiency with fewer patient visits and economic benefits for the practice or clinic.[6]

## Probing questions for clinicians

- "What are you currently doing to comply with ADA guidelines to monitor A1C in your patients with diabetes?"
- "Do you have any challenges meeting quality metrics for control of your diabetes patients?"
- "Do you send out your A1C tests, or do you test patients in your office?"
  - If in-office, "What are you using?"
- "How would a faster point-of-care system impact your practice?"

The enhanced quality of care enabled by a three-minute, CLIA-waived, in-office test like Alere Afinion™ HbA1c is recognized by the ADA recommendation that "use of point-of-care testing for A1C provides the opportunity for more timely treatment changes."[2] Knowing now matters™ to patients, too, resulting in improved satisfaction.[5] Together, improving quality of care and patient satisfaction can make a difference in clinician, practice and health plan performance, and in the lives of people living with diabetes.

1. CDC. National Diabetes Statistics Report 2014.
2. ADA. Diabetes Care. 2015; 38 (Suppl.1):S1-93.
3. Bubner TK et al. Med J Aust. 2009; 190:624-6.
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**Editor's note:** Sponsored by Alere

Alere™ Knowing now matters.™

# Alere understands the importance of now.

Access to timely, actionable information means smarter treatment decisions.

The **Alere Afinion™ AS100 Analyzer** provides valuable near patient testing for today's busy healthcare professionals who understand the value of knowing now.

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  - Sample types: capillary and venous whole blood
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  - Increased efficiency
- Reliable, lab quality results
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  - NGSP certified
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**Other Available Tests**

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To learn more contact your Alere Account Executive **1.877.441.7440 | alere.com**

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

### Good driver, bad rap

Driver beware – especially if you are a single, divorced or widowed female driver living in Chicago, Ill. The consumer watchdog, the Consumer Federation of America, reports that this group of drivers is often subject to penalties and disadvantages, particularly from major insurers such as Geico, Farmers and Progressive, according to The Chicago Tribune. Reportedly, when a woman divorces her husband or loses him to a death, she can expect an annual increase in premium of 8 percent at Geico, 20 percent at Farmers and 7 percent at Progressive. On the flip side, a recent InsuranceQuotes.com report found that older, married female Chicagoans generally receive lower rates.

### Stress-free and safe

Studies show that up to 1,500 people are injured or killed in road rage incidents each year, according to Hastings & Hastings. Because stressful driving conditions, such as traffic congestion and weather conditions, can lead to road rage, Hastings & Hastings encourages drivers to consider traffic conditions before they begin their commute. If commuters know ahead of time that they will encounter difficult traffic conditions, they can plan ahead accordingly. For instance, by leaving 15 or 20 minutes early, they can compensate for time lost in backed up traffic. Commuters who are stuck in traffic knowing they will arrive late to their destination experience more stress than those stuck in the same traffic who will be arriving on time, notes the group. And, stress is one of the leading causes of road rage. It can build slowly as a result of several minor incidents, without drivers even realizing it. As a result, drivers may experience intermittent explosive disorder or IED. Getting cut off by another car once or twice may be a minor annoyance; being tailgated, honked at, cut off or passed 10-15 times during a commute could lead to an IED. For more information visit http://www.prnewswire.com/news-releases/hastings--hastings-speaks-out-about-stress-and-road-rage-300136560.html.

Commuters who are stuck in traffic knowing they will arrive late to their destination experience more stress than those stuck in the same traffic who will be arriving on time, notes the group.

### Take your keys!

The National Insurance Crime Bureau (NICB) has warned drivers to take their keys and lock their vehicles, or risk becoming a statistic. Some 45,000 drivers last year admitted that they had left their keys in the car when it was stolen. Indeed, in spite of its warnings, many people make it easy for car thieves, says NICB. Today's vehicles have excellent anti-theft systems, but they don't work unless drivers use them, it adds. Another major concern for insurers and law enforcement is the growing crime of cargo theft. The theft of electronics, retail goods, food and pharmaceuticals is a threat to the economy and can also impact the health and welfare of the American public, NICB points out. An average cargo theft resulted in a loss of $237,000 last year.

### Less is more

Do consumers continue to covet high tech electronics and racy new car technologies? The 2015 Harris Poll AutoTECHCAST℠ – an annual study of consumer awareness and adoption of advanced and emerging automotive technologies – suggests that educating consumers about the value of existing features and cultivating usage may have a more positive effect on both cars sales and customer loyalty. The AutoTECHCAST study surveyed over 14,000 new car buyers in the United States and explored about 60 technologies. The study results suggest that redefining success, with a focus on familiarity, usage, satisfaction and loyalty between users and brands, may better serve the industry than marketing a constant stream of new technologies. Only 16 of the 60 technologies evaluated obtain good familiarity scores. Back-up cameras received a score of 61 percent; satellite radio 51 percent;

# Connect with leading healthcare industry executives and prominent leaders at the HIDA Executive Conference in March.

## Apply for the John Sasen Memorial Scholarship

Professional Women in Healthcare creates leaders by providing opportunities for women to learn and network with the influences of our industry. In honor of our dear friend and mentor, PWH is accepting nominations for *John Sasen Memorial Scholarship*. The scholarship annually award one woman within our industry a one year PWH membership, as well as entry and travel to the HIDA Executive Conference, March 1-4, 2016. To nominate orapply email Julee Prefer, PWH Chair Elect (jprefer@hsg-inc.net) outlining what this scholarship would mean to you or the deserving woman you are nominating, by January 15, 2016. **The scholarship recipient will be announced February 1, 2016.**

John Sasen
Memorial Scholarship

PWH
Professional Women in Healthcare

**For more information visit www.mypwh.org**

and back-up warning systems 42 percent. Technologies such as automatic window tinting and augmented reality dashboard received lower scores of 7 percent; and DMC-Driver mode control received a score of only 6 percent. Over four in ten – or 44 percent – of those surveyed report they've never used one or more of the major infotainment solutions, and low users are significantly less likely to be familiar with infotainment features. Technologies such as real-time navigation, personal assistance services and text-to-speech/speech-to-text options also appear to be underused. The consensus is that consumers feel inundated with technology in their new car purchases, and over four in ten recent car buyers – or 42 percent – believe carmakers add too much technology to their vehicles.

## 2015 top picks

Kelley Blue Book (KBB.com) has announced its "10 Most Awarded Cars of 2015."

### 1. 2015 Honda Civic

- 15 best family cars
- Kelley Blue Book best buy: small car
- Lowest 5-year cost-to-own: sporty compact car
- 10 coolest cars under $18,000
- 10 tech-savviest cars starting under $20,000
- 10 best hybrid cars under $30,000
- 10 coolest cars under $25,000
- 10 best sedans under $25,000

### 2. 2015 Subaru Impreza

- Best resale value award: compact car
- Best resale value award: sporty compact car
- 10 coolest cars under $18,000
- 10 tech-savviest cars starting under $20,000
- 10 best all-wheel-drive vehicles under $25,000
- 10 best sedans under $25,000

### 3. 2015 Honda Accord

- Kelley Blue Book best buy: midsize car
- 15 best family cars
- 10 most comfortable cars under $30,000
- 10 best green cars
- 10 best hybrid cars under $30,000
- 10 best sedans under $25,000

### 4. 2015 Toyota Camry

- 15 best family cars
- Best resale value award: hybrid/alternative energy car
- 10 most comfortable cars under $30,000
- 10 best green cars
- 10 best hybrid cars under $30,000
- 10 best sedans under $25,000

### 5. 2015 Jeep Wrangler

- Best resale value award: compact SUV/crossover
- Best resale value award: midsize SUV/crossover
- Lowest 5-year cost-to-own: midsize SUV/crossover
- 10 most fun SUVs
- 10 coolest cars under $25,000
- 10 best SUVs under $25,000

### 6. 2015 Honda CR-V

- Kelley Blue Book best buy: small SUV
- 15 best family cars
- 10 most comfortable cars under $30,000
- 10 best SUVs under $25,000
- 10 best all-wheel-drive Vehicles under $25,000

### 7. 2015 Jeep Renegade

- 10 coolest cars under $18,000
- 10 tech-savviest cars starting under $20,000
- 10 most fun SUVs
- 10 best SUVs under $25,000
- 10 best all-wheel-drive vehicles under $25,000

### 8. 2015 Chevrolet Impala

- Kelley Blue Book best buy: full-size car
- 15 best family cars
- Lowest 5-year cost-to-own: full-size car
- 10 most comfortable cars under $30,000

### 9. 2015 Honda Fit

- Best resale value: subcompact car
- 10 coolest cars under $18,000
- 10 tech-savviest cars starting under $20,000

### 10. 2015 Mazda Mazda3

- 10 coolest cars under $18,000
- 10 tech-savviest cars starting under $20,000
- 10 best sedans under $25,000

To see KBB.com's full coverage of the 10 Most Awarded Cars of 2015 visit http://www.kbb.com/car-reviews-and-news/top-10/most-awarded-cars-2015/2000012395/.

# Claflin celebrates big year

**Claflin Company and its sister company, Claflin Medi-**cal Equipment, continue to expand their offering of products and services so their customers can focus on the business of delivering healthcare, Anne-Marie Johnson, vice president of administration, told *Repertoire* following the companies' national sales meeting this summer. Claflin and CME are separate corporate entities under the control of parent holding company Almon Co.

For Claflin Medical Equipment, 2015 was a big year, beginning with its February merger with Hospital Associates, an Anaheim, Calif.-based medical equipment distributor; and its acquisition in May of RSI Equipment, a New York-based medical equipment distributor. CME President Normand Chevrette gave attendees an interactive presentation on the strategies and growth of the new national company.

From left: Jay Stotlar, Halyard Health; Ted Almon, Claflin; Mike O'Brien, Medtronic.

A vendor fair attracted approximately 30 of Claflin's top suppliers. "We have been holding the event for several years, and the unique format has been very well-received by the manufacturers who participate," says President and CEO Ted Almon. "Several of these guest companies have both equipment and follow-on supplies in their lines, such that both [Claflin Co. and CME] might have occasion to get involved with them."

The vendor fair incorporates all aspects of the company's supply chain partnership, to include finance, operations, replenishment, contracting, customer service, etc., said Johnson. "Claflin strives to treat our vendor supply chain partners as customers. We acknowledge the value they bring to the healthcare industry and want to work together to improve the opportunities for our customers to support the best clinical outcomes."

Claflin also continues to promote "creative solutions for the challenges facing healthcare providers today," she continued. "Our resources are not limited to basic 'off-the-shelf' distribution. Education, technology and innovation are supported by industry networking." Ted Almon, for example, is very active in the healthcare reform debate and a valuable resource to the local healthcare community and governing representatives, she said.

From left: Greg Seiders, Claflin; Scott Adams, MDSI; Tom McInerney and Martin Jewell, Ansell.

At the meeting, a number of individuals and companies were recognized with awards:

- Mike Hollis, Encompass.
- Dan Ingersoll, Molnlycke Health Care.
- Nicole Macleod, DeRoyal.
- Kathy Libutti, Smith & Nephew.
- Sarah Romano, Bionix Medical Technologies.
- Laurie Reline, NDC.
- Penny Caicedo, Halyard Health.

**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

## An earful

Let the earbuds do the heavy lifting. The new Jabra Sport Pace™ Wireless earbuds, designed to let music lovers get more out of their fitness endeavors, provide training management through the Jabra Sport Life app. When used with the app, the Jabra Sport Pace earbuds reportedly become an easy-to-use training partner for experienced and novice workouts alike. Jabra Sport Pace is designed to enhance workouts by providing training statistics and tests for users, while at the same time allowing them to listen to music without the distraction of wires.

Key features of the Jabra Sport Pace include:

- Premium stereo sound
- Enhanced training with the Sport Life app, which provides evaluation and tips.
- Five hours of talk and music time, as well as rapid charging
- Ergonomic design for a secure fit
- Water-, shock-, sand- and dust-resistance
- Reflective neck cord for nighttime running

The battery reportedly supplies up to five hours of music or talk time, along with 15-minute charging. The Jabra Sport Pace Wireless is available online, as well as at Best Buy and Dick's Sporting Goods stores for $99. For more information visit www.jabra.com/pace.

## Game manager

SEGA® Europe Ltd. and Sports Interactive recently introduced Football Manager ™, an opportunity for sports fans to manage their favorite team Due for release in mid-November, Football Manager 2016 will comprise a suite of simulations, designed to provide a football management experience for the widest possible audience. In addition to Football Manager 2016 on PC and Macintosh, the squad also includes Football Manager Touch (for both computer and high-end tablets) and Football Manager Mobile (for all iOS and Android devices).

Previously known as Football Manager Classic, Football Manager Touch has previously been available as a quick-play mode within the full simulation. As of this month, it will be available separately through Steam (for PC and Macintosh), as well as for high-end tablets. Football Manager Mobile was formerly known as Football Manager Handheld. Those who pre-purchase Football Manager 2016 from a participating digital retailer will be rewarded with a download key for "An Alternative Reality: the Football Manager Documentary." In addition, they will also have access to a fully-playable Beta version of the game, which will be available roughly two weeks prior to the official release date. Fans who pre-order a boxed copy from a participating retailer will receive a limited edition version of Football Manager 2016, which also will include "An Alternative Reality: the Football Manager Documentary."

## McApp experience

McDonald's anyone? APPsolutely! McDonald's is going digital, and it wants you to be part of the experience. Beginning in Philadelphia, users will have access to its new McDonald's Mobile App. The digital app is designed to engage customers by providing convenient ways to interact with the McDonald's brand, including a store locator, nutritional facts, career information, Ronald McDonald House Charities® information and product promotions. rep


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# A Journey to Freedom

Nasser Dayzadeh knows what it's like to lose everything – and through hard work how to rebuild.

**In 1979, the U.S.S.R. invaded Afghanistan. The U.K. suf-**fered historic labor strife, followed by the election of Margaret Thatcher as Prime Minister. And Michael Jackson released a career-changing album, Off the Wall.

That year signified a beginning to the Iranian Revolution, as well. After nearly 15 years in exile, Ayatollah Ruhollah Khomeini returned to power, following the forced departure of Shah Mohammad Reza Pahlavi. In addition to forcing all foreigners – including 1,000 U.S. State Department workers – to leave the country, Khomeini supported the country's return to the principles of Islam, barring outside interference and Westernization. But, for many Iranians, the start of the Revolution also marked the beginning of a new struggle for their freedom.

Dayzadeh family

## A shooting star

For Nasser Dayzadeh, president of California-based Bergman Supply, Inc., prior to the Revolution, Iran had been a country of opportunity. "If we went about our business, we were fine," he recalls. Indeed, after a college and graduate school education in mining engineering in Germany, followed by a yearlong stint with a coal mine in Germany, he returned to Iran where he began a successful career. "I worked for two years in a lead and copper mine in the Sahara Desert," he explains. "I married my wife, Fery, in 1967 and soon afterward was hired by the Industrial and Mining Development Bank of Iran where I was in charge of mining projects and also worked on the industrial project evaluation for loans."

Dayzadeh stayed with the bank for 15 years, assuming more and more responsibility. "I was transferred to the loan supervision department, and then became a trouble shooter," he recalls. "The bank sent me to Switzerland to complete a deputy management course, similar to receiving an MBA," he says. "It was a very focused course and considered very prestigious." Within a couple of years, he was promoted to deputy general manager.

Upon returning to Iran, he continued as deputy general manager, as well as headed the bank's investment department. Within a couple of years, he was also assigned as general manager for one of the bank's largest investors – a paper manufacturing company. During this time, he would travel to the southern part of the country for work during the week, and return home to his family in Tehran on weekends. "I worked with the paper manufacturing company for five years," he says. "It was a huge company, with about 2,650 employees. During this time, I hired people from all over the world." In spite of his long work hours and time away from family, he enjoyed

his responsibility. Yet, the growing political unrest in Iran made him increasingly wary.

## A turn of events

Indeed, all was not well in Iran. "The Shah had organized the Savak, a political organization much like a secret police, which had branches all over the country," Dayzadeh recalls. "One day, in 1978, just one year before the Revolution, I was in my office when an employee came to me crying. He told me he had been tortured at the local Savak office that weekend. I asked him if he knew who gave his name to the Savak, and it turned out to be another employee." Dayzadeh immediately fired the untrustworthy employee – a decision that impacted the next six years of his life.

"This man was angry," he explains, and the fact that Dayzadeh is Jewish did not help the matter. "From that point on, he began sending letters [besmirching Dayzadeh's reputation] to the Secretary of Industry, the newspaper and the bank, where I worked. At first, no one paid attention. People knew me to be honest." But, his former employee persisted, and in 1979, following the Revolution, he joined the new Islamic government, which gave him much more power to take his revenge. "One weekend, I was returning to the paper factory after visiting my family in Tehran. Because it was becoming dangerous to fly, I had started taking the train." A prudent move on his part, he adds. "I later learned that this man had organized a group with guns to come after me at the airport!"

It was becoming clear to Dayzadeh that moving his family to the United States was essential, and five months after the Revolution, he sent his wife, Fery, and children – an 8-year-old daughter and a 5-year-old son – to join relatives in the United States. "My mother-in-law moved to the United States a few months after my family," he explains. "She had connections there and was able to help my family." In addition, Fery had attended Brandeis University and she, as well as their children, spoke fluent English. "Although we had no plans to move to America before the Iranian Revolution, we wanted our children to learn English," Dayzadeh says. Fery's degree in psychology from an American university helped her obtain a pre-school teaching position, and the children quickly assimilated into their new school. With relatives in the area, including Dayzadeh's niece and nephew, a brother-in-law and a brother (a general surgeon in New York City who moved to California to be near family), Fery and the children fared well. Unfortunately, the same could not be said for Dayzadeh at home in Iran.

While it had been his plan to join his family in California, his former employee eventually did manage to catch the ear of government officials, and the post-revolution Iranian government was in no hurry to permit Dayzadeh to leave the country. Ironically, because his employee had turned in so many people under the Shah's regime, the new government arrested and jailed him. He was responsible for many people being tortured before the Revolution, notes Dayzadeh. "He had many against him." But, prison and self-made enemies were not enough to inhibit this villain.

**For Nasser Dayzadeh, president of California-based Bergman Supply, Inc., prior to the Revolution, Iran had been a country of opportunity. "If we went about our business, we were fine."**

"While in jail, he continued to make accusations against me," says Dayzadeh. "He reported that I was connected with Mossad (the Israeli counterpart to the U.S. Central Intelligence Agency). Upon his release from prison, he persisted with his letter writing, eventually convincing the new government that Dayzadeh was an enemy of Iran. For the next five years, Dayzadeh would not be permitted to leave the country nor continue at his job.

## A struggle for freedom

From that point forward, two things mattered to Dayzadeh: clearing his name and joining his family in the States. It was his word against that of his accuser, and no matter how many times he was questioned – and no matter that none of the accusations panned out – the Iranian government refused to lift its travel ban.

In addition to being accused of working with Mossad, Dayzadeh was believed to have Zionist ties. His former employee claimed that one of the paper manufacturer's contracts with a Finnish company was actually a front for his Zionist activity, he explains. Then came the accusations that he had traveled to Israel for suspect reasons. "My former employee knew I had traveled there to accompany my wife for surgery. She wanted to have her surgery in Israel because they are known to have better doctors there. I was questioned over and over about this and [repeatedly] told them, 'Israel has good doctors.'

"I was also accused of spending the paper manufacturer's money unwisely," he continues, noting his years of employment at the bank and paper manufacturer were scrutinized. "In Iran, it was very common for supervisors to give heads of departments a small gift to celebrate the New Year," he says. Even that, they used against him, he says.

"It took me six years to prove all of this was nonsense," says Dayzadeh. "But, during those six years, I was at peace knowing my family was safe and that I had done nothing wrong. I never misused a penny while working for the bank and the paper manufacturer. I never could have predicted that my own government would turn on me." And, it cost him dearly. "I missed out on my children growing up," he points out. "That will always be the greatest loss in my life."

**"I have always been very thankful to the U.S. government for welcoming my family. I am very thankful for the freedom we have in America. I have traveled all over the world, and no country offers the same opportunity that this country does."**

## A new beginning

There's much to be said about the American Dream, but it doesn't always come easy. "When I finally came to America in 1985, I had nothing to do," says Dayzadeh. He studied contract law and took a minimum wage job ($3.25/hour) "just to get out" while he determined his course. Then, one morning in 1987, while reading the newspaper, it came to him what he could do. "AIDS had become an epidemic, and the U.S. government was asking doctors and dentists to wear latex gloves," he recalls. "While reading about this in the paper, it dawned on me that I could bring latex gloves to America."

However, latex gloves were not easy to come by during that time. "Supplies were booked," he says. "Nothing was available. Then a Korean company I reached out to put me in touch with a glove company in Los Angeles, and I began to distribute gloves locally. I established my company, Bergman Dental and Medical Supply, out of my home. My garage was my warehouse, and my living room was my office. I would take orders every day until 2 p.m., when my wife would come home from teaching school. Then, Fery would handle the phone calls and orders, and I would make my deliveries." Within a year, his customers began asking for other products, such as masks and gowns. "I would find out where to purchase these supplies and add them to my business." In 1992, he joined IMCO, giving him greater access to more medical suppliers. "My association with IMCO boosted sales of my medical products," he says.

"My experiences had taught me how to work with people," says Dayzadeh. "I knew how to be persistent. I was honest. And, I knew how to work hard." And, so marked the start of a distributorship that has thrived for nearly three decades. "I have always been very thankful to the U.S. government for welcoming my family," he says. "I am very thankful for the freedom we have in America. I have traveled all over the world, and no country offers the same opportunity that this country does."

Indeed, perspective is everything, and Dayzadeh is not one to mourn lost opportunities. He takes pride in his family's success. "I am happy that my son is a successful immigration attorney and my daughter is a CPA with a beautiful family," he says. "Although I missed out on my children growing up, we now have two grandsons and a young granddaughter who looks much like my daughter when she was that age." He makes it a point to see his grandchildren every other day – an opportunity to experience the years he lost with his own children, he adds. rep

# Industry News

## Cardinal Health completes $1.944B acquisition of Cordis

Cardinal Health (Dublin, OH) completed the acquisition of Cordis (Fremont, CA), Johnson & Johnson's (New Brunswick, NJ) cardiology and endovascular device business, for $1.944 billion. Cordis products will continue to be sold under the Cordis brand name but with a logo that identifies Cordis as a Cardinal Health company. The business will report to Don Casey, Cardinal Health's Medical segment chief executive officer. David Wilson remains as Cordis' worldwide president, and the Cordis team continues to be based in the San Francisco Bay Area. In addition, global headquarters and a Europe, Middle East and Africa hub have been established in Zug, Switzerland. Singapore will serve as the Asia-Pacific hub, and Puerto Rico will serve as the Latin American hub. Approximately 3,000 employees will join Cardinal Health when all integration work and transitions are completed over the next few years. The organization will have operations in countries around the world.

## Owens & Minor names W. Marshall Simpson as chief commercial officer

Owens & Minor Inc (Richmond, VA) named W. Marshall Simpson as EVP and chief commercial officer effective October 4, 2015. Simpson most recently served as CEO of Dominions Medical (Richmond, VA), a consulting firm he founded to advise new and existing medical and technology companies. Prior to that, he worked for twenty years at Owens & Minor, eventually serving as SVP of sales, operations, and marketing from 2007 to 2011.

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Statement of Ownership, Management, and Circulation
PS Form 3526-R

1. Publication Title: Repertoire
2. Publication Number: 1520-7587
3. Filing Date: 10/01/2015
4. Issue Frequency: Monthly
5. Number of Issues Published Annually: 12
6. Annual Subscription Price: $49.00 US, $59.00 Canada
7. Office of Publication: 1735 N Brown Rd Ste 140 / Lawrenceville, GA 30043-8153
   Contact Person: Laura Gantert 770-416-0071
8. General Business Office: 1735 N Brown Rd Ste 140 / Lawrenceville, GA 30043-8153
9. Publisher: Brian Taylor / 1735 N Brown Rd Ste 140 / Lawrenceville, GA 30043-8153
   Editor: Mark Thill / 1735 N Brown Rd Ste 140 / Lawrenceville, GA 30043-8153
   Managing Editor: Graham Garrison / 1735 N Brown Rd Ste 140 / Lawrenceville, GA 30043-8153
10. Owner: John Pritchard / 1735 N Brown Rd Ste 140 / Lawrenceville, GA 30043-8153
11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1Percent or More of Total Amount of Bonds, Mortgages, or Other Securities: None
12. n/a
13. Publication Title: Repertoire
14. Issue Date for Circulation Data: 11/2015
15. Extent and Nature of Circulation:

| | | Average No. Copies Each Issue During Preceding 12 Months | No. Copies of Single Issue Published Nearest to Filing Date Sept 2012 |
|---|---|---|---|
| Total Number of Copies (Net Press Run) | | 10943 | 10507 |
| Legitimate Paid and/or Requested Distribution | Outside County Paid/Requested Mail Subscriptions | 5842 | 5719 |
| | In-County Paid/Requested Mail Subscriptions | | |
| | Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid or Requested Distribution Outside USPS. | 479 | 396 |
| | Requested Copies Distributed by Other Mail Classes The USPS | 87 | 70 |
| Total Paid and/or Requested Circulation | | 6407 | 6185 |
| Nonrequested Distribution | Outside County Nonrequested Copies | 3505 | 3557 |
| | In-County Nonrequested Copies | | |
| | Nonrequested Copies Distributed Through the USPS by Other Classes of Mail | 287 | 247 |
| | Nonrequested Copies Distributed outside the Mail | 52 | 43 |
| Total Nonrequested Distribution | | 3844 | 3847 |
| Total Distribution | | 10251 | 10032 |
| Copies not Distributed | | 404 | 471 |
| Total | | 10655 | 10503 |
| Percent Paid and/or Requested Circulation | | 62.50 | 61.65 |
| Publication of Statement of Ownership will be printed in the November '12 issue of this publication. | | | |
| Laura Gantert. Dir. Circulation & Admin. 10/1/2015 | | | |
| I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties) | | | |

Delivering Efficiency to Healthcare

**DIRECTOR, VENDOR MARKETING**

NDC, Inc., a $300M company and a leader in the healthcare supply chain, is seeking an energetic and detail-oriented individual to lead the effort of planning, directing and coordinating annual marketing programs for our vendor partners, which are a win-win for the achievement of revenue goals. This includes all elements of tiered vendor programs, our annual exhibition, and other added value campaigns by proactively and innovatively developing differentiated marketing initiatives, both short and long term, respective of current healthcare industry trends. The director will analyze and monitor the progress and results of each marketing effort to better determine future strategies designed to maximize penetration of products and services into each of the specific healthcare market segments.

Healthcare industry experience is important to understanding the complexity of our business model. Sales experience, strong communication skills and reporting analysis capabilities are critical to the position, along with a confident and comfortable presentation style. A passion for the value of our model is tantamount to the success of the program.

This position is based in Nashville, TN and you can expect to travel as necessary to meet customer needs. Music City is a rapidly growing mecca of cultural diversity, fantastic restaurants, professional sports, the arts, and of course, music of all genres! If you believe you have what it takes to take on this important and challenging position, please send your credentials to **HR@NDC-INC.com.**



Delivering Efficiency to Healthcare

**TERRITORY MANAGER – NORTHEAST REGION**

NDC, Inc. is a leader in the healthcare supply chain industry serving over 1,000 independent medical, physical therapy, rehabilitation, laboratory, veterinarian and dental product distributors throughout North America. We negotiate and maintain manufacturer contracts on behalf of our distribution network, which affords the manufacturer a single ship-to and consolidated receivable. From our origin as a small buying cooperative, ABCO Dealers, Inc., to our evolution as NDC, Inc., we have been serving independent healthcare distributors since 1953.

The Territory Manager will identify medical distributors who should be taking advantage of our products and services and promote participation in NDC's programs. He/she will act as an account manager for current members within the territory ensuring that they are profiting from their membership and utilizing all the services available to them. Further, he/she will work closely with manufacturing partners to increase mind share and grow sales volumes within target accounts.

- The ideal candidate will be a creative, results-oriented individual with an entrepreneurial spirit and willingness to get deeply involved to get things done.
- He/she must possess a minimum of four years sales experience in medical product distribution or a related field, and be able to apply their training and industry knowledge to drive company strategies and meet sales plan objectives.
- Having an understanding of healthcare organizational structure as it relates to vendor relations, contract management, product evaluation and brand management is important.
- Healthcare product procurement knowledge to include manufacturing, request for proposals and a fundamental understanding of a healthcare distribution organization (i.e., GPO's, IDN's), is critical.
- Key will be his/her ability to inspire trust and build credibility with the NDC membership and the industry at large.
- Expect 50% travel.
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NDC offers a competitive benefits package including medical, dental, vision, 401k with match, life and disability insurances, and more. If you meet the above prerequisites and are confident that you will make a difference at NDC, please submit a cover letter including salary requirements, along with your resume to **HR@NDC-INC.com.**

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By Laurie Morgan, Capko & Morgan

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

# ICD-10 in the Rear-View Mirror

**In small ways for several years, and in a big way for the past** several months, ICD-10 preparation has diverted physician and practice manager attention. Now ICD-10 is here. Over the next several months, most practices will face new coding challenges and possibly strained cash flow as a result of the switchover. But by early 2016, normal patient flow and billing should be restored – or at least be visible on the horizon.

Hopefully, this will mean that doctors and practice managers will have more bandwidth available. Many strategic opportunities have emerged for practices in the past few years, but they've sometimes been crowded out by the urgency of ICD-10 conversion.

Here are just a few trends and opportunities we'll be encouraging our clients to take a more focused look at in 2016 as the ICD-10 dust settles – and that may spell opportunity for your business, too.

With patients assuming financial responsibility for a greater portion of the cost of services than ever before, these technologies can address a critical and growing practice need.

## Chronic Care Management (CCM), Patient-Centered Medical Homes (PCMH), and other new reimbursement models

Several programs that reward care coordination activities, including the CCM reimbursement program and the PCMH initiative, have been advanced by the Affordable Care Act (ACA). Many of these programs offer practices the opportunity to get paid more for offering the kind of services they want to offer (or already offer) anyway. For example, the CCM reimbursement code that the CMS introduced in January provides a path to reimbursement for the work that clinical staff does to distribute information among providers and help keep patients on track with care plans. A properly established CCM workflow inside a practice has the potential not just to engage patients and generate more revenue every month, but also provide a growth path for back-office employees and boost morale and retention.

## EHRs in the spotlight

More practices will enter or complete Meaningful Use Stage 2 in 2016, a process that will require them to think about engaging patients more fully via technology. Those that have struggled with promoting their patient portals or getting electronic lab reporting to work reliably will see much more incentive to optimize with Stage 3 around the corner – especially in conjunction with CCM, PCMH, and other programs that reward better care coordination and communication. For some practices, this will require more willingness to dig into their EHR data, more training, more investment in add-ons and customizations – or all three. In some cases, it will be time to consider a new EHR – perhaps a third or fourth in some cases – with the stakes much higher to get it right this time.

## Patient payment technologies

One of the most exciting areas of innovation in the practice management world is the proliferation of new technologies to help practices collect more effectively from patients. With patients assuming financial responsibility for a greater portion of the cost of services than ever before, these technologies can address a critical and growing practice need. Some of the tools that have recently emerged include out-of-pocket estimators, real-time eligibility and authorization checking, and mobile payment tools patients can use on their own devices. This latter category, in particular, can benefit practices by improving cash flow and allowing patients to connect and pay with the platforms that are most comfortable for them.

Some skeptical practices have been reluctant to even try some of these technologies – especially with the great unknown of the ICD-10 conversion. But these tools can help solve very thorny problems and deliver huge upside for practices. We hope and expect to see a dramatic increase in trial (and opportunity for these vendors) now that the timing of the ICD-10 conversion and its impact on practice workflow is no longer a looming question. rep

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